Falls Risk Assessment and Management Plan (FRAMP)

Evidence Table

WA Health Falls Network Community of Practice for hospital settings

Metro Working Group

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# Introduction

The Falls Community of Practice (CoP) Metropolitan Working Group (FCM) is a Working Group of the Western Australian Falls CoP for hospital settings. The FCM meets regularly and works collaboratively to progress a number of initiatives in the metropolitan area, including the Falls Risk Assessment and Management Plan (FRAMP) evidence table. The FRAMP development methodology is documented separately and can be accessed on the Department of Health WA corporate [Falls Risk Assessment and Management Plan website](http://ww2.health.wa.gov.au/Corporate/Articles/F_I/Falls-Risk-Assessment-and-Management-Plan).

In order to support the implementation of the FRAMP, this document has been created to provide easily accessible information about the clinical evidence base for the FRAMP design and content.

Where the evidence is **of limited or of uncertain application** (such as guidelines that may be more recent but were not developed for the Australian population) **or** **emerged after compilation of the best practice guidelines** additional references are cited to support the information in the FRAMP and/or notation is made regarding the decision process.

It is anticipated that this document will also be useful when the FRAMP is due for review.

Please note that this evidence table refers to the Statewide FRAMP. A small number of amendments to the FRAMP are permitted at site level per the [WA Health FRAMP policy](http://www.health.wa.gov.au/CircularsNew/attachments/975.pdf), so the FRAMP at your site may vary slightly from the items in this table.

# Referencing system

This document contains a combination of referencing styles to enhance the experience for the reader. Upon initial citation each reference is numbered and relates to the full reference provided at the end of the document. In addition a standalone abbreviation is used for frequently used references throughout the document. For instance, the Australian Best Practice Guidelines (ABPG) and the National Safety and Quality Health Service (NSQHS) Standard 10 Safety and Quality Improvement Guide (SQIG) are abbreviated for easier identification for the reader without further reference to the end of the document. All references to SQIG relate to NSQHS Standard 10 unless otherwise stated.

# Further information

The purpose of this document is to support the implementation of the FRAMP by demonstrating the integration of the best practice guidelines, related best practice information and NSQHS Standards into the FRAMP. For further information about the FRAMP and associated resources please see the [WA Health Falls Prevention Network website](http://www.healthnetworks.health.wa.gov.au/network/fallsprevention.cfm).

# Related websites

* Falls risk assessment and management plan: <http://ww2.health.wa.gov.au/Corporate/Articles/F_I/Falls-Risk-Assessment-and-Management-Plan>
* WA Health FRAMP Policy: <http://www.health.wa.gov.au/CircularsNew/attachments/975.pdf>
* WA Health Falls Prevention Network website: <http://www.healthnetworks.health.wa.gov.au/network/fallsprevention.cfm>

# FRAMP Evidence Table 2014

| **Item** | **NSQHS Standard** | **Evidence details** | **Reference** | **Further information (e.g. if a best practice guideline is not available, evidence is inconclusive or may not fit population profile)** |
| --- | --- | --- | --- | --- |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsA fall is an event which results in a person coming to rest inadvertently on the ground or other lower level.  | ReferenceABPG (1) p4 | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsMany falls can be prevented. | ReferenceABPG pxvi | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsA multifactorial approach to preventing falls should be part of routine care for all older people in hospital settings. | ReferenceABPG p21 | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsA best practice approach for preventing falls in hospitals includes: 1. the implementation of standard falls prevention strategies (minimum interventions)
2. identification of falls risk
3. implementation of individualised interventions to address risks which are regularly monitored and reviewed.
 | ReferenceABPG pxvi | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsThere are a number of risk factors for falling among older people in hospital settings, and a person’s risk of falling increases as their number of risk factors accumulates. Risk factors can be intrinsic (factors that relate to a person’s behaviour or condition) and extrinsic (factors that relate to a person’s environment or their interaction with the environment).Intrinsic factors include: * Previous fall
* Postural instability, muscle weakness
* Cognitive impairment, delirium and disturbed behaviour
* Urinary frequency and incontinence
* Postural hypotension
* Medications
* Visual impairment

Some risk factors (e.g. confusion, unsafe gait and antidepressant medications) are associated with an increased risk of multiple falls in hospital. Extrinsic factors include: * Environmental risk factors (most falls in hospital occur around the bedside and in the bedroom)
* Time of day (falls commonly occur at times when observational capacity is low – i.e. shower time and meal times and outside visiting hours).
 | ReferenceABPG p15 | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsA snapshot of studies that have reported fall data consistently indicates the bedside is the most common place for falls to occur, the bathroom is frequently mentioned; a high percentage of falls are associated with elimination and toileting; falls occur across all age groups, but there is an increasing prevalence of falls in older people; a high percentage of falls are unwitnessed.  | ReferenceABPG p14 | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsManaging the risk for falls (e.g. delirium or balance problems) will have wider benefits beyond falls prevention. | ReferenceABPG pxvi | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsEngaging older people is an integral part of preventing falls and minimising harm from falls.  | ReferenceABPG pxvi | Further informationNo further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsThe consequences of falls resulting in minor or no injury are often neglected, but factors such as fear of falling and reduced activity level can profoundly affect function and quality of life, and increase the risk of seriously harmful falls. | ReferenceABPG pxvi | Further Information.No Further information |
| ItemDefinition, Background Information and Key Messages | NSQHS Standard 10 | Evidence detailsWhile the body of knowledge regarding the risks of falls and how to reduce these risks is continually growing, one key message prevails: multifactorial, multidisciplinary approaches are best in the hospital setting.  | ReferenceABPG p15 | Further informationNo further information |
| ItemFalls Risk Screen | NSQHS Standard 10.5.110.8.1 | Evidence detailsA best practice screening tool is used by the clinical workforce to identify the risk of falls. | ReferenceSQIG (2) p17 | Further informationN/A  |
| ItemFalls Risk Screen | NSQHS Standard 10.5.110.8.1 | Evidence detailsYou must ensure that the results of falls risk screening are recorded appropriately in the patient clinical record and action taken. | ReferenceSQIG p17 | Further informationN/A |
| ItemFalls Risk Screen | NSQHS Standard 10.5.110.8.1 | Evidence detailsDo not use falls risk prediction tools to predict inpatients risk of falling in hospital. | ReferenceNICE 161 (3)rec. 1.2.1.1 | Further informationThe FRAMP does not use a scoring method to predict falls risk. The FRAMP uses an intervention based screen, which aligns known risk factors with evidence based interventions. If adults do not screen “positive”, the interventions in the FRAMP will be of limited if any benefit in addressing fall risk factors. (Consensus WA Falls Prevention Network CoP). |
| ItemFalls Risk Screen | NSQHS Standard 10.5.110.8.1 | Evidence detailsRegard the following groups of inpatients as being at risk of falling – aged 65 years and over, 50 to 64 if clinically judged to be at higher risk of falling.  | ReferenceNICE 161 rec. 1.2.1.2 | Further informationThe FRAMP screen does not isolate age as an indicator of increased falls risk, the FRAMP is intended for all adult inpatients, as a significant proportion of adults in the under 50 age group fall in hospital. (Consensus WA Falls Prevention Network CoP). |
| ItemFalls Risk Screen | NSQHS Standard 10.5.110.8.1 | Evidence detailsA falls risk screen should be undertaken when a change in health or functional status is evident or when the patient’s environment changes.  | ReferenceABPG p29 | Further informationNo further information  |
| ItemDoes the patient meet any of the following: | NSQHS StandardNil | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemHad a fall in the past 12 months? | NSQHS StandardNil | Evidence detailsDocumenting a history of recent falls is a good screening question for identifying people at higher risk of falls during their hospital stay. | ReferenceABPG p30 | Further informationNo further information |
| ItemHad a fall in the past 12 months? | NSQHS StandardNil | Evidence detailsA previous fall is a risk factor for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemHad a fall in the past 12 months? | NSQHS StandardNil | Evidence detailsApproximately 50% of falls are in patients who have already fallen. | ReferenceABPG p29 | Further informationNo further information |
| ItemUnsteady when walking / transferring or uses a walking aid? | NSQHS StandardNil | Evidence detailsPostural instability and muscle weakness are risk factors for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemConfused, known cognitive impairment or incorrectly answers any of the following: age, date of birth, current year or place? | NSQHS StandardNil | Evidence detailsCognitive impairment (including agitation, delirium and dementia) is a major risk factor for falls.  | ReferenceABPG p27 | Further informationNo further information |
| ItemConfused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence detailsIdentifying the presence of cognitive impairment should form part of the falls risk assessment process. | ReferenceABPG p37 | Further informationNo further information |
| ItemConfused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence detailsThe presence of confusion or disorientation has been independently associated with falls and fractures in hospital patients. | ReferenceABPG p50 | Further informationNo further information |
| ItemConfused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence detailsCognitive impairment is common among hospital patients. Although it is most commonly associated with increasing age, it is a complex problem that may exist in all age groups.  | ReferenceABPG p50 | Further informationNo further information |
| ItemConfused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence detailsThe four questions form the AMT4, a validated cognitive screen that has been shown to be significantly more reliable and sensitive than the nurse’s subjective impression. | ReferenceScofield et al 2010(4) | Further informationNo further information |
| ItemHas urinary or faecal frequency / urgency or Nocturia?  | NSQHS StandardNil | Evidence detailsUrinary frequency and incontinence are risk factors for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemHas urinary or faecal frequency / urgency or Nocturia?  | NSQHS StandardNil | Evidence detailsA high percentage of falls are associated with elimination and toileting. | ReferenceABPG p14 | Further informationNo further information |
| ItemScreening and Assessment | NSQHS Standard 10.7.1 | Evidence detailsThe screen should be used to guide more detailed assessment and subsequent targeted interventions. When the threshold of a screening tool is: * Exceeded: a falls risk assessment should be done as soon as practicable
* not exceeded: the patient is considered to be at low risk of falling, and standard falls prevention strategies apply
 | ReferenceABPG p32 | Further informationNo further information |
| ItemScreening and Assessment | NSQHS Standard 10.7.1 | Evidence detailsFalls prevention and harm minimisation plans that are based on best practice can improve patient outcomes. You should have in place effective falls prevention and harm minimisation plans that rely on comprehensive screen and assessment (where appropriate), the identification of all potential risks and the development of tailored prevention plans for patients at risk of falling.  | ReferenceSQIG p22 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsEffective interventions to prevent falls are important as they will have significant health benefits. Interventions targeting multiple risk factors reduced falls in hospitals. | ReferenceCochrane Review (5) | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsBecause falls are multifactorial and complex in nature, interventions should be implemented in combination rather than in isolation. Using any one intervention on its own is unlikely to reduce the number of falls. | ReferenceSQIG p21 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsThe outcomes of the falls risk assessment, together with the recommended strategies to address identified risk factors, need to be documented. | ReferenceABPG p36 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsInterventions delivered as a result of assessment provide benefit, rather than the assessment itself; therefore, it is essential that interventions systematically address the risk factors identified.  | ReferenceABPG p36 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsAs part of a multifactorial program for patients with increased risk of falls in hospital, conduct a systematic and comprehensive multidisciplinary falls risk assessment to inform the development of an individualised plan of care to prevent falls. | ReferenceABPG p29 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsAll implementation should be documented to ensure that health professionals involved in the patients care are aware of planned and current falls prevention interventions and the basis for them. | ReferenceSQIG p21 | Further informationNo further information |
| ItemRisk Assessment Identification and Individualised Intervention Section | NSQHS Standard 10.6.1 10.7.11.8.2 | Evidence detailsYou should have in place effective falls prevention and harm minimisation plans that rely on comprehensive screen and assessment (where appropriate), the identification of all potential risks, and the development of tailored prevention plans for patients at risk of falling. | ReferenceSQIG p22 | Further informationNo further information |
| ItemMobility Risks | NSQHS Standard 10.6.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemRequire assistance with mobility/transfer? | NSQHS Standard10.6.1 | Evidence detailsPostural instability and muscle weakness are risk factors for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemHave poor coordination, balance, gait or uncorrected visual impairment? | NSQHS Standard10.6.1 | Evidence detailsPostural instability and muscle weakness are risk factors for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemHave poor coordination, balance, gait or uncorrected visual impairment? | NSQHS Standard10.6.1 | Evidence detailsUse hospitalisation as an opportunity to screen systematically for visual problems that can have an effect both in the hospital setting and after discharge. | ReferenceABPG p83 | Further informationNo further information |
| ItemFunctional ability risks | NSQHS Standard 10.6.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemIs the patient unsteady, disorganised or require assistance when attending to Activities of Daily Living (ADLs)? | NSQHS Standard10.6.1 | Evidence detailsDifferent combinations of muscle actions are required to maintain balance (i.e. prevent falling) during the wide range of everyday mobility tasks (e.g. standing, reaching, walking climbing stairs).  | ReferenceABPG p42 | Further informationNo further information |
| ItemInterventions | NSQHS Standard 10.7.1 | Evidence detailsNil | ReferenceN/A | Further informationNo further information |
| ItemAssess, document and provide mobility aids and level of assistance required  | NSQHS Standard10.7.1 | Evidence detailsCommunicate to staff and the patient the limits of the patient’s mobility status using written, verbal and visual communication. | ReferenceABPG p23 | Further informationNo further information |
| ItemAssess, document and provide mobility aids and level of assistance required | NSQHS Standard10.7.1 | Evidence detailsBalance and mobility are often poorer when a person is in hospital, compared with their usual level of mobility and may further deteriorate during a hospital stay. Therefore, as part of a mobility assessment it is important to establish whether a patient’s level of mobility in hospital is usual for them. | ReferenceABPG p42 | Further informationNo further information |
| ItemDiscuss and confirm with the patient what level of level of assistance they require (including mobility aids), and/or their need to call and wait for assistance | NSQHS Standard10.7.1 | Evidence detailsImplicit in the multifactorial approach is the engagement of the patient and their carer(s) (where appropriate), as the centre of any falls prevention program. | ReferenceABPG p15 | Further informationNo further information |
| ItemDiscuss and confirm with the patient what level of level of assistance they require (including mobility aids), and/or their need to call and wait for assistance | NSQHS Standard10.7.1 | Evidence detailsA high percentage of falls are unwitnessed. | ReferenceABPG p14 | Further informationNo further information |
| ItemRefer to Physiotherapist for a comprehensive mobility assessment | NSQHS Standard10.7.1 | Evidence detailsOrganise routine physiotherapy review for patients with mobility difficulties, including transfers. | ReferenceABPG p23 | Further informationNo further information |
| ItemRefer to Physiotherapist for a comprehensive mobility assessment | NSQHS Standard 10.7.1 | Evidence detailsPatients considered to be at higher risk of falling should be referred to an Occupational Therapist and a Physiotherapist for needs training specific to the home environment, to maximise safety and continuity from hospital to home. | ReferenceABPG p21 | Further informationNo further information |
| ItemRefer to Occupational Therapist (OT) for functional assessment | NSQHS Standard10.7.1 | Evidence detailsPatients at higher risk of falling should be referred to an Occupational Therapist for needs and training specific to home environment and equipment. | ReferenceABPG p21 | Further informationNo further information |
| ItemMedications/ Medical Conditions Risks | NSQHS Standard 10.6.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| Item**Has the patient been prescribed:** | NSQHS StandardNil | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemPsychoactive medication e.g. benzodiazepines, antipsychotics or antidepressants? | NSQHS StandardNil | Evidence detailsA number of studies have shown an association between medication use and falls in older people. | ReferenceABPG p78 | Further informationNo further information |
| ItemPsychoactive medication e.g. benzodiazepines, antipsychotics, antidepressants? | NSQHS StandardN/A | Evidence detailsA number of factors can affect an older person’s ability to deal with and respond to medication, which can lead to an increased risk of falls. | ReferenceABPG p78 | Further informationNo further information |
| ItemNew or old medication that may affect their blood pressure? | NSQHS StandardNil | Evidence detailsCertain classes of medication are more likely to increase the risk of falls. | ReferenceABPG p78 | Further informationNo further information |
| ItemDoes the patient take greater than 5 medications of any sort? | NSQHS StandardNil | Evidence detailsTaking more medications is associated with an increased risk of falls. | ReferenceABPG p78 | Further informationNo further information |
| ItemDoes the patient report dizziness or presented following a fall/collapse? | NSQHS StandardNil | Evidence detailsDizziness in the hospital setting remains a difficult diagnostic problem because it has many potential causes and may result from disease in multiple systems. | ReferenceABPG p72 | Further informationNo further information |
| ItemDoes the patient report dizziness or presented following a fall/collapse? | NSQHS StandardNil | Evidence detailsPatients who report unexplained falls or episodes of collapse should be assessed for the underlying cause. | ReferenceABPG p67 | Further informationNo further information |
| ItemInterventions | NSQHS Standard 10.7.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemLiaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard10.7.1 | Evidence detailsReview medication, particularly high risk medications such as sedatives, antidepressants, antipsychotics and centrally acting pain relief. | ReferenceSQIG p21. | Further information See note under “Other Individualised Interventions” p22. |
| ItemLiaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard10.7.1 | Evidence detailsOlder people admitted to hospital should have their medications (prescribed and non-prescribed) reviewed and modified appropriately (and particularly in cases of multiple drug use). | ReferenceABPG p77 | Further informationAlso: see note under “Other Individualised Interventions” p22. |
| ItemLiaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard10.7.1 | Evidence detailsPatients on psychoactive medication should have their medication reviewed and, where possible, discontinued gradually to minimise side effects and reduce their risk of falling. | ReferenceABPG p77 | Further informationAlso: see note under “Other Individualised Interventions” p22. |
| ItemIf reporting dizziness, check lying/standing blood pressure. If a drop >20mmHg systolic or 10mmHg diastolic is present, discuss plan of care with MO | NSQHS Standard 10.7.1 | Evidence detailsMonitor and record postural blood pressure. | ReferenceABPG p69 | Further informationNo further information |
| ItemIf reporting dizziness, check lying/standing blood pressure. If a drop >20mmHg systolic or 10mmHg diastolic is present, discuss plan of care with MO | NSQHS StandardN/A | Evidence detailsAssessment and management of postural hypotension and review of medications, including medications associated with pre-syncope and syncope should form part of a multifactorial assessment and management plan.  | ReferenceABPG p67 | Further informationNo further information |
| ItemEducate patient to stand up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO | NSQHS Standard10.7.1 | Evidence detailsEncourage patient to sit up slowly from lying, stand up slowly from sitting and wait a short time before walking. | ReferenceABPG p69 | Further informationNo further information |
| ItemEducate patient to stand up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO | NSQHS Standard10.7.1 | Evidence detailsWhen patients describe being “dizzy”, “giddy” or “faint”, this may mean anything from anxiety or fear of falling, to postural disequilibrium, vertigo or presyncope. | ReferenceABPG p72 | Further informationNo further information |
| ItemEducate patient to stand up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO | NSQHS Standard10.7.1 | Evidence detailsAn important step in minimising the risk from falls associated with dizziness is to assess vestibular function. | ReferenceABPG p73 | Further informationNo further information |
| ItemCognitive State Risks | NSQHS Standard 10.6.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemPrevious delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence detailsDementia has been associated with falls in hospital. | ReferenceABPG p50 | Further informationNo further information |
| ItemPrevious delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence detailsPatients with dementia are more susceptible to delirium. | ReferenceABPG p51 | Further informationNo further information |
| ItemPrevious delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence detailsOlder people with cognitive impairment have an increased risk of falls. | ReferenceABPG p50 | Further informationNo further information |
| ItemNew or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence detailsRepeatedly and regularly check for the presence of delirium. Rapid diagnosis and treatment of a delirium and its underlying cause (e.g. infection, dehydration, constipation, and pain) are crucial. | ReferenceABPG p51 | Further informationNo further information |
| ItemNew or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence detailsThe presence of confusion or disorientation has been independently associated with falls and fracture in hospital patients. | ReferenceABPG p50 | Further informationNo further information |
| ItemNew or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence detailsAny changes in the environment such as room change or ward change can increase confusion. | ReferenceABPG p50 | Further informationNo further information |
| ItemDrowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence detailsCognitive impairment, delirium and disturbed behaviour are risk factors for falling in hospitals. | ReferenceABPG p15 | Further informationNo further information |
| ItemDrowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence detailsThe key signs to look for are that the patient:* cannot answer your questions
* is inattentive or easily distracted
* has disorganised thinking
* has an altered level of consciousness
* is agitated
* is overly sleepy – this may be hypoactive delirium
 | ReferenceABWTC(6) (clinicians) p4 | Further information [A Better Way To Care](http://www.safetyandquality.gov.au/search/a%2Bbetter%2Bway%2Bto%2Bcare) (ABWTC) are a series of resources developed by the ACSQHC to guide services in improving care of people with cognitive impairment within the context of the NSQHS Standards. There are separate resources for clinicians, health service managers and patients /carers. |
| ItemDrowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence detailsHypoactive delirium is subtype of delirium characterised by people who become withdrawn, quiet and sleepy. Hypoactive (or mixed) delirium can be more difficult to recognise. | ReferenceNICE 103 (7) | Further informationNo further information  |
| ItemDrowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence detailsDepressive symptoms were found to be consistently associated with falls in older people, despite the use of different measures of depressive symptoms and falls and varying length of follow-up and statistical methods. | ReferenceKvelde et al. 2013 (8) | Further information Settings were community and rehabilitation. There was no difference between community samples and those with identified healthcare needs with respect to depressive symptoms being a risk factor for falls. |
| ItemInterventions | NSQHS Standard 10.7.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemEstablish a baseline cognitive screen. For example the abbreviated Mental Test (AMT) or as per local guidelines. | NSQHS Standard 10.7.1 | Evidence detailsIdentifying the presence of cognitive impairment should form part of the falls risk assessment process. | ReferenceABPG p37 | Further informationNo further information |
| ItemEstablish a baseline cognitive screen e.g. Abbreviated Mental Test (AMT) or as per local guidelines | NSQHS Standard 10.7.1 | Evidence detailsThink of cognition as another vital sign that needs to be monitored. | ReferenceABWTC (clinicians) p5 | Further informationNo further information |
| ItemIf result abnormal (e.g. AMT <8) refer to OT or MO for prompt review. | NSQHS Standard 10.7.1 | Evidence detailsThe screening tool is not expected to diagnose, but to detect cognitive impairment and to trigger further investigation and action. | ReferenceABWTC(9) (Managers) p40 | Further information The score for an abnormal result will depend on the tool/s in use at each site. For instance for the AMT 4 any score <4 will be abnormal and a trigger for further review. |
| ItemIf result abnormal (e.g. AMT <8) refer to OT or MO for prompt review | NSQHS Standard 10.7.1 | Evidence detailsTreat medical conditions that may contribute to an alteration in cognitive status. | ReferenceABPG p51 | Further information The score for an abnormal result will depend on the tool/s in use at each site. For instance for the AMT 4 any score <4 will be abnormal and a trigger for further review. |
| ItemIf result abnormal (e.g. AMT <8) refer to OT or MO for prompt review | NSQHS Standard 10.7.1 | Evidence detailsOlder patients with a progressive decline in cognition should undergo a detailed assessment so treatment can be provided to the reversible causes. | ReferenceABPG p51 | Further information The score for an abnormal result will depend on the tool/s in use at each site. For instance for the AMT 4 any score <4 will be abnormal and a trigger for further review. |
| ItemRemain in attendance at all times when the patient is toileting or showering as this is a high risk activity for the patient. | NSQHS Standard 10.7.1 | Evidence detailsA staff member should remain with patients with cognitive impairment and a high risk of falls while the patient is in the bathroom. | ReferenceABPG p97 | Further informationNo further information |
| ItemIf agitated commence behaviour observation chart to assist behaviour management plan. | NSQHS Standard 10.7.1 | Evidence detailsIdentify causes of agitation, wandering and impulsive behaviour, and reduce or eliminate them.  | ReferenceABPG p53 | Further informationNo further information |
| ItemAvoid use of bedrails due to climbing/ entrapment risk and consider low-low bed. | NSQHS Standard 10.7.1 | Evidence detailsMinimise the use of restraint and bedside rails. | ReferenceSQIG p21 | Further informationNo further information |
| ItemAvoid use of bedrails due to climbing/entrapment risk and consider low-low bed. | NSQHS Standard 10.7.1 | Evidence detailsAvoid the use of physical restraints as they make delirium worse and increase the risk of falls. | ReferenceABWTC (clinicians) p28 | Further informationNo further information |
| ItemSet an alarm system in place to alert when patient is trying to get up unaided. | NSQHS Standard 10.7.1 | Evidence detailsUse fall alarm devices to alert staff that patients are attempting to mobilise. | ReferenceABPG p52 | Further informationNo further information |
| ItemRe-orientate patient and ask family to assist in orientating and settling patient. | NSQHS Standard 10.7.1 | Evidence detailsEstablish orientation programmes using environmental cues. Repeat orientation and safety instructions regularly. | ReferenceABPG p53 | Further informationNo further information |
| ItemRe-orientate patient and ask family to assist in orientating and settling patient | NSQHS Standard 10.7.1 | Evidence detailsEncourage family members or carers to spend time sitting with the patient. | ReferenceABPG p97 | Further informationNo further information |
| ItemIncrease frequency of patient checks to proactively attend to patient needs. | NSQHS Standard 10.7.1 | Evidence detailsPlace high-risk patients within view of, and close to, the nursing station. | ReferenceSQIG p21 | Further informationNo further information |
| ItemIncrease frequency of patient checks to proactively attend to patient needs | NSQHS Standard 10.7.1 | Evidence detailsFalls commonly occur at times when observational capacity is low. | ReferenceABPG p15 | Further informationNo further information |
| ItemIncrease frequency of patient checks to proactively attend to patient needs | NSQHS Standard 10.7.1 | Evidence detailsProvide more frequent observation, supervision and assistance to ensure that older patients with delirium or dementia who are not capable of standing and walking safely receive help with all transfers. | ReferenceABPG p52 | Further informationNo further information |
| ItemContinence/ Elimination Risks | NSQHS Standard 10.6.1 | Evidence detailsNil | ReferenceNil | Further informationNo further information |
| ItemRequire assistance with toileting? | NSQHS Standard 10.6.1 | Evidence detailsAssess and address functional considerations, such as reduced dexterity or mobility, which can affect toileting. | ReferenceABPG p58 | Further informationN/A |
| ItemRequire assistance with toileting? | NSQHS Standard 10.6.1 | Evidence detailsNumerous falls in hospital occur when people go to or return from the toilet.  | ReferenceABPG p57 | Further informationNo further information |
| ItemHave constipation, urinary or faecal frequency/ urgency or nocturia? | NSQHS Standard 10.6.1 | Evidence detailsObtain a continence history from the patient. | ReferenceABPG p58 | Further informationNo further information |
| ItemHave constipation, urinary or faecal frequency/urgency or nocturia? | NSQHS Standard 10.6.1 | Evidence detailsIncontinence, urinary frequency and assisted toileting have been identified as risk factors for falls in the hospital. People will often make extraordinary efforts to avoid an incontinent episode, including placing themselves at increased risk of falling. | ReferenceABPG p56 | Further informationNo further information |
| ItemHave constipation, urinary or faecal frequency/urgency or nocturia? | NSQHS Standard 10.6.1 | Evidence detailsTransient incontinence is present in 50% of older hospital patients. | ReferenceABPG p56 | Further informationNo further information |
| ItemInterventions | NSQHS Standard 10.7.1 | Evidence detailsN/A | ReferenceNil | Further informationNo further information |
| ItemMonitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard 10.7.1 | Evidence detailsObtain a continence history from the patient, which may include a bladder chart. | ReferenceABPG p58 | Further informationNo further information |
| ItemMonitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard 10.7.1 | Evidence detailsCheck post void residuals in incontinent older patients. | ReferenceABPG p58 | Further informationNo further information |
| ItemMonitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard 10.7.1 | Evidence detailsConsider risk factors for falling related to incontinence, along with the symptoms and signs of bladder and bowel dysfunction. | ReferenceABPG p58 | Further informationNo further information |
| ItemReview toileting needs with patient daily including frequency, patient’s requirement for continence/ toileting aids and assistance required to access toilet facilities. | NSQHS Standard 10.7.1 | Evidence detailsEstablish a plan of care for bowel and bladder function.  | ReferenceSQIG p21 | Further informationNo further information |
| ItemReview toileting needs with patient daily including frequency, patient’s requirement for continence/ toileting aids and assistance required to access toilet facilities | NSQHS Standard 10.7.1 | Evidence detailsAssess functional considerations such as mobility and accessibility of the toilet. | ReferenceABPG p58 | Further informationNo further information |
| ItemReview toileting needs with patient daily including frequency, patient’s requirement for continence/ toileting aids and assistance required to access toilet facilities | NSQHS Standard 10.7.1 | Evidence detailsAs part of multifactorial intervention, toileting protocols and practices should be in place for patients at risk of falling. | ReferenceABPG p55 | Further informationNo further information |
| ItemReview toileting needs with patient daily including frequency, patient’s requirement for continence/ toileting aids and assistance required to access toilet facilities | NSQHS Standard 10.7.1 | Evidence detailsManaging problems with urinary tract function is effective as part of a multifactorial approach to care. | ReferenceABPG p55 | Further informationNo further information |
| ItemComplete urinalysis. If abnormal, discuss with MO if MSU indicated. | NSQHS Standard 10.7.1 | Evidence detailsOrganise routine screening urinalysis to identify urinary tract infections. | ReferenceSQIG p21 | Further informationNo further information |
| ItemComplete urinalysis. If abnormal, discuss with MO if MSU indicated | NSQHS Standard 10.7.1 | Evidence detailsWard urinalysis should form part of routine assessment for older people with a risk of falling.  | ReferenceABPG p55 | Further informationNo further information |
| ItemMinimum Interventions | NSQHS Standard 10.4 | Evidence detailsEnvironmental modifications should be included as part of a multifactorial intervention.  | ReferenceABPG p91 | Further informationNo further information |
| ItemProvide ongoing orientation for patient to bed area, toilet facilities and ward. | NSQHS Standard 10.4 | Evidence detailsOrient the patient to the bed area, room, ward or unit facilities. Some patients might need repeated orientation because of cognitive impairment.  | ReferenceABPG p24 | Further informationNo further information |
| ItemDemonstrate the use of call bell; ensure it is in reach and that they can use it effectively. | NSQHS Standard 10.4 | Evidence detailsTell patients how they can obtain help when they need it. | ReferenceABPG p24 | Further informationNo further information |
| ItemEnsure frequently used items including mobility aids are within easy reach of patient. | NSQHS Standard 10.4 | Evidence detailsMake sure that the patient’s personal belongings and equipment are easy and safe for them to access. | ReferenceABPG p91 | Further informationNo further information |
| ItemEncourage patient to use their aids such as glasses or hearing aids. | NSQHS Standard 10.4 | Evidence detailsEnsure that patients have their usual spectacles and visual aid to hand. | ReferenceSQIG p21 | Further informationNo further information |
| ItemEncourage patient to use their aids such as glasses or hearing aids | NSQHS Standard 10.4 | Evidence detailsMake sure that the patient’s personal belongings and equipment are easy and safe for them to access. | ReferenceABPG p91 | Further informationNo further information |
| ItemAdjust bed and chair to appropriate height for patient. | NSQHS Standard 10.4 | Evidence detailsEnsure the bed is a the appropriate height for the patient (in most cases it should be at a height that allows the patient’s feet to be flat on the floor, with their hips, knees and ankles at 90-degree angles when sitting on the bed or chair). | ReferenceABPG p24 | Further informationNo further information |
| ItemMinimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may lead to falls. | NSQHS Standard 10.4 | Evidence detailsIn addition to structured training programs, hospital staff should provide the patient with opportunities to be as active as possible throughout the day. The patient’s bed rest should be minimised during the day and the patient should be encouraged to be mobile by increasing the amount of incidental activity (e.g. walking to the toilet with appropriate supervision). | ReferenceABPG p46 | Further informationNo further information |
| ItemPlace IV pole and all other devices/ attachments on exit side of bed. | NSQHS Standard 10.4 | Evidence detailsMake the environment safe. | ReferenceSQIG p21 | Further informationNo further information |
| ItemPlace IV pole and all other devices/attachments on exit side of bed | NSQHS Standard 10.4 | Evidence detailsCheck all aspects of the environment and modify as necessary to reduce the risk of falls. | ReferenceABPG p91 | Further informationNo further information |
| ItemRemove clutter and obstacles from room. | NSQHS Standard 10.4 | Evidence detailsMake the environment safe. | ReferenceSQIG p21 | Further informationNo further information |
| ItemRemove clutter and obstacles from room | NSQHS Standard 10.4 | Evidence detailsReduce clutter and other trip hazards in patients’ wards and rooms. | ReferenceABPG p92 | Further informationNo further information |
| ItemProvide adequate lighting according to patient activities/needs. | NSQHS Standard 10.4 | Evidence detailsEnsure adequate lightning is supplied based on the patient’s needs, particularly at night. | ReferenceABPG p24 | Further informationNo further information |
| ItemEncourage patient to adequate fluids and nutrition. | NSQHS Standard 10.4 | Evidence detailsPoor nutrition and dehydration may affect 20-50% of older patients in the hospital setting and are associated with adverse outcomes. | ReferenceACSQCH (10) p13 | Further informationNo further information |
| ItemEncourage patient to adequate fluids and nutrition | NSQHS Standard 10.4 | Evidence detailsPrecipitating factors for delirium include dehydration and under-nutrition.Dehydration and malnutrition are risk factors for harm in patients who have a cognitive impairment.  | ReferenceABWTC(Managers)p14 &17 | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsIn addition to using standard falls risk assessments, screen patients for ill-fitting or inappropriate footwear on admission to hospital. | ReferenceABPG p61 | Further information The evidence indicates that a well-fitting shoe with safe characteristics is the most appropriate footwear, however not all patients own such shoes and/or bring them to hospital, and often do not put on shoes if they need to get up overnight. Some individuals/cultural groups might prefer not to wear footwear. |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsInclude an assessment of footwear and foot problems as part of an individualised, multifactorial intervention. | ReferenceABPG p61 | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsHospital staff should educate patients and provide information about footwear features that may reduce the risk of falls. | ReferenceABPG p61 | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsSafe footwear characteristics include: shoes with thinner, firmer soles appear to improve foot position sense; a tread sole may further prevent slips on slippery surfaces; a low square heel further improves stability; shoes with a supporting collar improve stability. | ReferenceABPG p61 | Further information The evidence for nonslip socks versus bare feet is inconclusive, but the studies listed in the reference column indicate that, in the absence of well-fitting safe shoes (and infection risk) these options are safer than regular socks and compression stockings. |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsWalking barefoot or in socks is associated with a 10-13 fold increased risk of falling and athletic shoes are associated with the lowest risk. | ReferenceABPG p62 | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsDiscourage people from walking in socks, because this is associated with a 10 fold increased risk of falling. Patients should not walk in anti-embolism stockings without appropriate footwear on their feet. | ReferenceABPG p64 | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsBare feet provide better slip resistance than non-slip socks and therefore might represent a safer foot condition. | ReferenceChari et al. 2009 (11) | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsWalking with socks, compared with walking barefoot, might present a greater balance threat for older adults. Clinically, safety precautions about walking in socks should be considered to be given to older adults, especially those with balance deficits. | ReferenceYi-Ju Tsai, Sang-I Lin. *2*013 (12) | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsBarefoot or nonslip socks may be a safer footwear option than standard cotton socks for older people walking indoors on potentially slippery surfaces. Compared with wearing standard socks, wearing nonslip socks improves gait performance and may be beneficial in reducing the risk of slipping in older people. | ReferenceHatton et al. 2013 (13) | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsNo significant differences were observed between the barefoot and non-slip socks conditions. Non-slip socks improved slip-resistance during gait when compared to conventional socks and [backless] slippers. | ReferenceHubscher et al. 2011 (14) | Further informationNo further information |
| ItemOptimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable. | NSQHS Standard 10.4 | Evidence detailsPatients with a high risk foot should not walk bare foot. Peripheral neuropathy is implicated in the development of a foot ulcer where chronic trauma (e.g. ill-fitting footwear) or acute injury goes unrecognised in the insensate foot leading to skin breakdown. The resultant wound is prone to soft tissue sepsis, secondary osteomyelitis, and ultimately amputation. | ReferenceHigh risk foot MOC (15) p16 &p3 | Further information For the purposes of this model the High Risk Foot is defined as a foot with progressive deformity, ulceration, infection and/or amputation as a result of a patient’s underlying medical condition, with consideration given to those at risk. [High Risk Foot model of care](http://www.healthnetworks.health.wa.gov.au/modelsofcare/docs/High_Risk_Foot_Model_of_Care.pdf),p3. |
| ItemEducate that all inpatients are at increased risk of falling due to injury / illness/ medications. | NSQHS Standard 10.4 | Evidence detailsThe physical environment takes on greater significance for people with diminished physical, sensory or cognitive capacity. | ReferenceABPG p94 | Further informationNo further information |
| ItemShift by Shift Check | NSQHS Standard 10.5.3 | Evidence detailsBest practice in fall and injury prevention includes implementing standard fall prevention strategies, identifying falls risk and implementing targeted individualised strategies that are monitored and regularly reviewed. | ReferenceAPBG pxvi | Further informationNo further information |
| ItemShift by Shift Check | NSQHS Standard10.5.3 | Evidence detailsAn evaluation of the preventing falls and harm from falls in older people best practice guidelines for Australian hospitals found that only 13% of patients had their falls risk reviewed during their ward admission. | ReferenceEAPBG (16) p25 | Further informationNo further information |
| ItemShift by Shift Check | NSQHS Standard10.5.3 | Evidence detailsIn the evaluation of the FRAMP trial 58% of staff reported that signing the FRAMP each shift made them look at the FRAMP more than they did with the FRMT. | Reference[FRAMP education PowerPoint](http://www.healthnetworks.health.wa.gov.au/docs/FRAMP.ppt) | Further informationNo further information |
| ItemRe-screen for Falls Risk **after a fall, ward transfer or improvement or deterioration in medical condition** | NSQHS Standard 10.5. | Evidence detailsA falls risk assessment should be done as soon as practicable after admission. | ReferenceABPG p33 | Further informationNo further information |
| ItemRe-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard 10.5. | Evidence detailsA falls risk screen should be undertaken when a change in health or functional status is evident or when the patient’s environment changes. | ReferenceABPG p29 | Further informationNo further information |
| ItemRe-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence detailsA previous fall is a risk factor for falling in hospital. | ReferenceABPG p15 | Further informationNo further information |
| ItemRe-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence detailsApproximately 50% of falls are in patients who have already fallen.  | ReferenceABPG p29 | Further informationNo further information |
| ItemRe-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence detailsAny changes in the environment, including transfers within or between rooms can increase confusion and agitation, and may also increase risk of falls. | ReferenceABPG p50 | Further informationNo further information |
| Item**Other Individualised Interventions** | NSQHS Standard 10.7.1 | Evidence detailsEach patient has a unique set of falls risk factors and personal preferences, and requires an individualised plan of action to minimise falls and harm from falls. | ReferenceABPG p22 | Further information This section is provided to record interventions that may be required in addition to the options listed on page 2 of the FRAMP. |
| ItemOther Individualised Interventions | NSQHS Standard10.7.1 | Evidence detailsThe most effective approach to falls prevention is likely to be one that includes all staff in health care facilities engaged in a multifactorial falls prevention program.  | ReferenceABPG pxvi | Further informationThis section facilitates multidisciplinary input and the recording of falls prevention interventions in one medical record document. This section also has the potential to be used to record when medication reviews for falls risk are conducted and also facilitate audit of same. An evaluation of the best practice guidelines (EABPG) found that only 6% of high falls risk patients had a documented medication review for falls prevention and 37% of high falls risk patients were taking psychoactive medications. It was also noted that there did not seem to be standardised process for recording when a medication review was undertaken for the purpose of falls prevention as opposed to other purposes, such as pain management. |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard 10.9.1 & 10.10.1 | Evidence detailsPatient information on falls and prevention strategies is provided to patients and their carers’ in a format that is understood and meaningful. | ReferenceSQIG p27 | Further information Outputs may include: patient clinical record audit and care plan audit undertaking to ensure patient and carer input in falls prevention plans. |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsFalls prevention plans are developed in partnership with patients and carers. | ReferenceSQIG p27 | Further informationNo further information |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsYou should document that the patient is aware of the assessment findings and has participated in the care planning. | ReferenceSQIG p27 | Further informationNo further information |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsProvide relevant and useful information to allow patients and their carers to take part in discussions and decisions about preventing falls. | ReferenceSQIG p27 | Further informationNo further information |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsFind out what changes a patient is willing to make to prevent falls, so that appropriate and acceptable recommendations can be made. | ReferenceABPG p17 | Further informationNo further information |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsAsk a family member to assist in falls prevention strategies. | ReferenceABPG p17 | Further informationNo further information |
| ItemCommunication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence detailsIn the evaluation of the FRAMP trial 62% of staff reported that having a place to record communication to patients / carers prompted them to discuss falls planning with patients / carers more often. | Reference[FRAMP education PowerPoint](http://www.healthnetworks.health.wa.gov.au/docs/FRAMP.ppt) | Further informationNo further information |
| ItemImportant Practice Points | NSQHS StandardNil | Evidence detailsPatients who are on anti-coagulant, antiplatelet therapy and/or patients with a known coagulopathy are at increased risk of intracranial haemorrhage from falls. | ReferenceWA PFMG (17) p10 | Further informationNo further information |
| ItemImportant Practice Points | NSQHS StandardNil | Evidence detailsBoth Australian and international data highlight an increased risk of subsequent fracture after any low trauma fracture, particularly at the hip and spine and beyond which can be explained by low bone mineral density alone. This phenomenon, termed the ‘fracture cascade’, highlights the need to identify and treat individuals at risk of fracture in a timely fashion in an attempt to arrest the fracture cascade and minimise disability. | ReferenceWA OMC (18) P48 | Further informationNo further information |
| ItemImportant Practice Points | NSQHS StandardNil | Evidence detailsConsider vitamin D supplementation as a routine management strategy for mobile older patients. | ReferenceSQIG p21 | Further informationNo further information |

# Supplementary Information Table - NSQHS standards

| **National Standard** | **Requirement** | **Reference** | **Achieved via:**  |
| --- | --- | --- | --- |
| National Standard1.9.2 | Requirement The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.  | Reference SQIG Standard 1 p30 | Achieved via:Design elements of the FRAMP prompt for and record standard 10 requirements as much as possible.  |
| National Standard10.1.1 | Requirement Policies should include areas such as: * falls prevention requirements
* falls screening and assessment
* management of falls risks including:
	+ balance and mobility
	+ cognitive impairment
	+ continence
	+ feet and footwear
	+ syncope
	+ dizziness and vertigo
	+ medication
	+ vision
	+ environmental considerations
	+ individual surveillance and observation
	+ restraint
	+ requirement for minimising injury
	+ protective equipment
	+ adequacy of calcium and vitamin D
* management of falls
 | Reference SQIG p10 | Achieved via:The FRAMP facilitates the operationalisation and documentation of many of the NSQHS standard 10 policy requirements. Policy/procedure documents can direct staff to complete the FRAMP to meet these requirements.It also provides prompts for issues such as calcium and vitamin D adequacy and post fall management. |
| National Standard10.1.2 | Requirement The use of policies, procedures and / or protocols is regularly monitored. You should audit the patient clinical record to confirm policies procedure and protocols are in use.  | Reference SQIG p11 | Achieved via:The FRAMP both facilitates the operationalisation and documentation of many of the NSQHS standard 10 policy requirements and is an easily audited clinical record providing the most efficient means for each clinical area/ ward/ unit to provide evidence to meet these standards. |
| National Standard1.9.2 | Requirement The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.  | Reference SQIG Standard 1 p30 | Achieved via:Design elements of the FRAMP prompt for and record standard 10 requirements as much as possible.  |
| National Standard10.4.1 | Requirement Identify and facilitate access to the equipment and devices required for the patient population being served. You should adjust the environment for the patient risk profile and equipment should be available for the patient to mitigate the risk of falling. Ensuring a call bell is within reach of patients at risk, as well as personal items including mobility equipment, is important.  | ReferenceNil | Achieved via:The FRAMP contains information of minimum interventions which should implemented for all patients as appropriate, including call bell and personal items including mobility aid within reach. Shift by shift sign prompts and records review of both minimum and individual interventions.  |
| National Standard10.5.1 | Requirement You must ensure that the results of the falls risk screening are recorded appropriately in patient clinical record and the action taken. | Reference SQIGp17 | Achieved via:The FRAMP provides both a prompt for appropriate screening and facilitates efficient documentation of same.  |
| National Standard10.5.2 | Requirement Use of the [best practice] screening tool is monitored to identify the proportion of at-risk patients that were screened for falls.  | Reference SQIG p17 | Achieved via:The FRAMP is an easily audited clinical record, providing the most efficient means for each clinical area/ ward/ unit to provide evidence to meet these standards. |
| National Standard10.6.1 | Requirement You should ensure that the results of falls risk assessments are recorded and used to formulate the patient care plan.  | Reference SQIQ p19 | Achieved via:The FRAMP provides both the prompt for appropriate assessment and facilitates efficient documentation of same. |
| National Standard10.6.2 | Requirement Use of the [best practice] assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment. | Reference SQIG p19 | Achieved via:The FRAMP is an easily audited clinical record, providing the most efficient means for each clinical area/ward/unit to provide evidence to meet these standards. |
| National Standard10.7.1 | Requirement Use of the best practice multifactorial falls prevention and harm minimisation plan is documented in the patient clinical record. | Reference SQIG p22 | Achieved via:The FRAMP can provide a documented record of the best practice multifactorial falls prevention and harm minimisation plan in the patient clinical record. The FRAMP also records the implementation and regular review of the best practice multifactorial fall prevention and harm minimisation plan via the shift by shift sign.  |
| National Standard1.181. | Requirement Patients and carers are partners in the planning for their treatment | Reference SQIG Standard 1 p46 | Achieved via:Achieved via:The FRAMP prompts for and facilitates the recording of information given to patients and their carer regarding falls risks and prevention strategies and provides an easily auditable clinical record of this. |
| National Standard1.18.2 | Requirement Mechanisms are in place to monitor and improve documentation of informed consent | Reference SQIG Standard 1 p46 | Achieved via:The FRAMP prompts for and facilitates the recording of information given to patients and their carer regarding falls risks and prevention strategies and provides an easily auditable clinical record of this. |
| National Standard10.9.1 | Requirement Patient information on falls and prevention strategies is provided to patients and their carers in a format that is understood and meaningful. | Reference SQIG p27 | Achieved via:The FRAMP prompts for and facilitates the recording of information given to patients and their carer regarding falls risks and prevention strategies and provides an easily auditable clinical record of this. |
| National Standard10.10.1 | Requirement Falls prevention plans are developed in partnership with patients and carers. | Reference SQIG p27 | Achieved via:The FRAMP prompts for and facilitates the recording patients and carer input into the falls prevention plan each time it is developed and provides an easily auditable clinical record of this. |

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