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)** |
| --- | --- | --- | --- | --- |
| Item Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  A fall is an event which results in a person coming to rest inadvertently on the ground or other lower level. | Reference  ABPG (1) p4 | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  Many falls can be prevented. | Reference  ABPG pxvi | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  A multifactorial approach to preventing falls should be part of routine care for all older people in hospital settings. | Reference  ABPG p21 | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  A 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. | Reference  ABPG pxvi | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  There 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). | Reference  ABPG p15 | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  A 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. | Reference  ABPG p14 | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  Managing the risk for falls (e.g. delirium or balance problems) will have wider benefits beyond falls prevention. | Reference  ABPG pxvi | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  Engaging older people is an integral part of preventing falls and minimising harm from falls. | Reference  ABPG pxvi | Further information  No further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  The 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. | Reference  ABPG pxvi | Further Information.  No Further information |
| Item  Definition, Background Information and Key Messages | NSQHS Standard  10 | Evidence details  While 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. | Reference  ABPG p15 | Further information  No further information |
| Item Falls Risk Screen | NSQHS Standard  10.5.1  10.8.1 | Evidence details  A best practice screening tool is used by the clinical workforce to identify the risk of falls. | Reference  SQIG (2) p17 | Further information  N/A |
| Item  Falls Risk Screen | NSQHS Standard  10.5.1  10.8.1 | Evidence details  You must ensure that the results of falls risk screening are recorded appropriately in the patient clinical record and action taken. | Reference  SQIG p17 | Further information  N/A |
| Item  Falls Risk Screen | NSQHS Standard  10.5.1  10.8.1 | Evidence details  Do not use falls risk prediction tools to predict inpatients risk of falling in hospital. | Reference  NICE 161 (3)  rec. 1.2.1.1 | Further information  The 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). |
| Item  Falls Risk Screen | NSQHS Standard  10.5.1  10.8.1 | Evidence details  Regard 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. | Reference  NICE 161 rec. 1.2.1.2 | Further information  The 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). |
| Item  Falls Risk Screen | NSQHS Standard  10.5.1  10.8.1 | Evidence details  A falls risk screen should be undertaken when a change in health or functional status is evident or when the patient’s environment changes. | Reference  ABPG p29 | Further information  No further information |
| Item  Does the patient meet any of the following: | NSQHS Standard  Nil | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Had a fall in the past 12 months? | NSQHS Standard  Nil | Evidence details  Documenting a history of recent falls is a good screening question for identifying people at higher risk of falls during their hospital stay. | Reference  ABPG p30 | Further information  No further information |
| Item  Had a fall in the past 12 months? | NSQHS Standard  Nil | Evidence details  A previous fall is a risk factor for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Had a fall in the past 12 months? | NSQHS Standard  Nil | Evidence details  Approximately 50% of falls are in patients who have already fallen. | Reference  ABPG p29 | Further information  No further information |
| Item  Unsteady when walking / transferring or uses a walking aid? | NSQHS Standard  Nil | Evidence details  Postural instability and muscle weakness are risk factors for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Confused, known cognitive impairment or incorrectly answers any of the following: age, date of birth, current year or place? | NSQHS Standard  Nil | Evidence details  Cognitive impairment (including agitation, delirium and dementia) is a major risk factor for falls. | Reference  ABPG p27 | Further information  No further information |
| Item  Confused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence details  Identifying the presence of cognitive impairment should form part of the falls risk assessment process. | Reference  ABPG p37 | Further information  No further information |
| Item  Confused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence details  The presence of confusion or disorientation has been independently associated with falls and fractures in hospital patients. | Reference  ABPG p50 | Further information  No further information |
| Item  Confused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence details  Cognitive 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. | Reference  ABPG p50 | Further information  No further information |
| Item  Confused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place? | NSQHS Standard Nil | Evidence details  The 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. | Reference  Scofield et al 2010(4) | Further information  No further information |
| Item  Has urinary or faecal frequency / urgency or Nocturia? | NSQHS Standard  Nil | Evidence details  Urinary frequency and incontinence are risk factors for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Has urinary or faecal frequency / urgency or Nocturia? | NSQHS Standard  Nil | Evidence details  A high percentage of falls are associated with elimination and toileting. | Reference  ABPG p14 | Further information  No further information |
| Item Screening and Assessment | NSQHS Standard  10.7.1 | Evidence details  The 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 | Reference  ABPG p32 | Further information  No further information |
| Item  Screening and Assessment | NSQHS Standard  10.7.1 | Evidence details  Falls 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. | Reference  SQIG p22 | Further information  No further information |
| Item Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  Effective interventions to prevent falls are important as they will have significant health benefits. Interventions targeting multiple risk factors reduced falls in hospitals. | Reference  Cochrane Review (5) | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  Because 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. | Reference  SQIG p21 | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  The outcomes of the falls risk assessment, together with the recommended strategies to address identified risk factors, need to be documented. | Reference  ABPG p36 | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  Interventions 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. | Reference  ABPG p36 | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  As 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. | Reference  ABPG p29 | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  All 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. | Reference  SQIG p21 | Further information  No further information |
| Item  Risk Assessment Identification and Individualised Intervention Section | NSQHS Standard  10.6.1  10.7.1  1.8.2 | Evidence details  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. | Reference  SQIG p22 | Further information  No further information |
| Item Mobility Risks | NSQHS Standard  10.6.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Require assistance with mobility/transfer? | NSQHS Standard10.6.1 | Evidence details  Postural instability and muscle weakness are risk factors for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Have poor coordination, balance, gait or uncorrected visual impairment? | NSQHS Standard  10.6.1 | Evidence details  Postural instability and muscle weakness are risk factors for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Have poor coordination, balance, gait or uncorrected visual impairment? | NSQHS Standard  10.6.1 | Evidence details  Use hospitalisation as an opportunity to screen systematically for visual problems that can have an effect both in the hospital setting and after discharge. | Reference  ABPG p83 | Further information  No further information |
| Item Functional ability risks | NSQHS Standard  10.6.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Is the patient unsteady, disorganised or require assistance when attending to Activities of Daily Living (ADLs)? | NSQHS Standard  10.6.1 | Evidence details  Different 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). | Reference  ABPG p42 | Further information  No further information |
| Item Interventions | NSQHS Standard  10.7.1 | Evidence details  Nil | Reference  N/A | Further information  No further information |
| Item  Assess, document and provide mobility aids and level of assistance required | NSQHS Standard10.7.1 | Evidence details  Communicate to staff and the patient the limits of the patient’s mobility status using written, verbal and visual communication. | Reference  ABPG p23 | Further information  No further information |
| Item  Assess, document and provide mobility aids and level of assistance required | NSQHS Standard10.7.1 | Evidence details  Balance 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. | Reference  ABPG p42 | Further information  No further information |
| Item  Discuss 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 details  Implicit in the multifactorial approach is the engagement of the patient and their carer(s) (where appropriate), as the centre of any falls prevention program. | Reference  ABPG p15 | Further information  No further information |
| Item  Discuss 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 details  A high percentage of falls are unwitnessed. | Reference  ABPG p14 | Further information  No further information |
| Item  Refer to Physiotherapist for a comprehensive mobility assessment | NSQHS Standard  10.7.1 | Evidence details  Organise routine physiotherapy review for patients with mobility difficulties, including transfers. | Reference  ABPG p23 | Further information  No further information |
| Item  Refer to Physiotherapist for a comprehensive mobility assessment | NSQHS  Standard  10.7.1 | Evidence details  Patients 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. | Reference  ABPG p21 | Further information  No further information |
| Item  Refer to Occupational Therapist (OT) for functional assessment | NSQHS Standard  10.7.1 | Evidence details  Patients at higher risk of falling should be referred to an Occupational Therapist for needs and training specific to home environment and equipment. | Reference  ABPG p21 | Further information  No further information |
| Item Medications/ Medical Conditions Risks | NSQHS Standard  10.6.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  **Has the patient been prescribed:** | NSQHS Standard  Nil | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Psychoactive medication e.g. benzodiazepines, antipsychotics or antidepressants? | NSQHS Standard  Nil | Evidence details  A number of studies have shown an association between medication use and falls in older people. | Reference  ABPG p78 | Further information  No further information |
| Item  Psychoactive medication e.g. benzodiazepines, antipsychotics, antidepressants? | NSQHS Standard  N/A | Evidence details  A 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. | Reference  ABPG p78 | Further information  No further information |
| Item  New or old medication that may affect their blood pressure? | NSQHS Standard  Nil | Evidence details  Certain classes of medication are more likely to increase the risk of falls. | Reference  ABPG p78 | Further information  No further information |
| Item  Does the patient take greater than 5 medications of any sort? | NSQHS Standard  Nil | Evidence details  Taking more medications is associated with an increased risk of falls. | Reference  ABPG p78 | Further information  No further information |
| Item  Does the patient report dizziness or presented following a fall/collapse? | NSQHS Standard  Nil | Evidence details  Dizziness in the hospital setting remains a difficult diagnostic problem because it has many potential causes and may result from disease in multiple systems. | Reference  ABPG p72 | Further information  No further information |
| Item  Does the patient report dizziness or presented following a fall/collapse? | NSQHS Standard  Nil | Evidence details  Patients who report unexplained falls or episodes of collapse should be assessed for the underlying cause. | Reference  ABPG p67 | Further information  No further information |
| Item Interventions | NSQHS Standard  10.7.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Liaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard  10.7.1 | Evidence details  Review medication, particularly high risk medications such as sedatives, antidepressants, antipsychotics and centrally acting pain relief. | Reference  SQIG p21. | Further information  See note under “Other Individualised Interventions” p22. |
| Item  Liaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard  10.7.1 | Evidence details  Older people admitted to hospital should have their medications (prescribed and non-prescribed) reviewed and modified appropriately (and particularly in cases of multiple drug use). | Reference  ABPG p77 | Further information  Also: see note under “Other Individualised Interventions” p22. |
| Item  Liaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls | NSQHS Standard  10.7.1 | Evidence details  Patients on psychoactive medication should have their medication reviewed and, where possible, discontinued gradually to minimise side effects and reduce their risk of falling. | Reference  ABPG p77 | Further information  Also: see note under “Other Individualised Interventions” p22. |
| Item  If 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 details  Monitor and record postural blood pressure. | Reference  ABPG p69 | Further information  No further information |
| Item  If 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  N/A | Evidence details  Assessment 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. | Reference  ABPG p67 | Further information  No further information |
| Item  Educate patient to stand up slowly and wait until dizziness resolves before mobilising.  If dizziness persists, discuss plan of care with MO | NSQHS Standard  10.7.1 | Evidence details  Encourage patient to sit up slowly from lying, stand up slowly from sitting and wait a short time before walking. | Reference  ABPG p69 | Further information  No further information |
| Item  Educate patient to stand up slowly and wait until dizziness resolves before mobilising.  If dizziness persists, discuss plan of care with MO | NSQHS Standard  10.7.1 | Evidence details  When patients describe being “dizzy”, “giddy” or “faint”, this may mean anything from anxiety or fear of falling, to postural disequilibrium, vertigo or presyncope. | Reference  ABPG p72 | Further information  No further information |
| Item  Educate patient to stand up slowly and wait until dizziness resolves before mobilising.  If dizziness persists, discuss plan of care with MO | NSQHS Standard  10.7.1 | Evidence details  An important step in minimising the risk from falls associated with dizziness is to assess vestibular function. | Reference  ABPG p73 | Further information  No further information |
| Item Cognitive State Risks | NSQHS Standard  10.6.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Previous delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence details  Dementia has been associated with falls in hospital. | Reference  ABPG p50 | Further information  No further information |
| Item  Previous delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence details  Patients with dementia are more susceptible to delirium. | Reference  ABPG p51 | Further information  No further information |
| Item  Previous delirium or known diagnosis of dementia? | NSQHS Standard 10.6.1 | Evidence details  Older people with cognitive impairment have an increased risk of falls. | Reference  ABPG p50 | Further information  No further information |
| Item  New or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence details  Repeatedly 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. | Reference  ABPG p51 | Further information  No further information |
| Item  New or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence details  The presence of confusion or disorientation has been independently associated with falls and fracture in hospital patients. | Reference  ABPG p50 | Further information  No further information |
| Item  New or worsening memory impairment, confusion or disorientation? | NSQHS Standard 10.6.1 | Evidence details  Any changes in the environment such as room change or ward change can increase confusion. | Reference  ABPG p50 | Further information  No further information |
| Item  Drowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence details  Cognitive impairment, delirium and disturbed behaviour are risk factors for falling in hospitals. | Reference  ABPG p15 | Further information  No further information |
| Item  Drowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence details  The 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 | Reference  ABWTC(6) (clinicians) p4 | Further information  [A Better Way To Care](http://www.safetyandquality.gov.au/search/a+better+way+to+care) (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. |
| Item  Drowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence details  Hypoactive delirium is subtype of delirium characterised by people who become withdrawn, quiet and sleepy. Hypoactive (or mixed) delirium can be more difficult to recognise. | Reference  NICE 103 (7) | Further information  No further information |
| Item  Drowsiness, is easily distracted, withdrawn or depressed? | NSQHS Standard 10.6.1 | Evidence details  Depressive 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. | Reference  Kvelde 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. |
| Item Interventions | NSQHS Standard  10.7.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Establish a baseline cognitive screen. For example the abbreviated Mental Test (AMT) or as per local guidelines. | NSQHS Standard  10.7.1 | Evidence details  Identifying the presence of cognitive impairment should form part of the falls risk assessment process. | Reference  ABPG p37 | Further information  No further information |
| Item  Establish a baseline cognitive screen e.g. Abbreviated Mental Test (AMT) or as per local guidelines | NSQHS Standard  10.7.1 | Evidence details  Think of cognition as another vital sign that needs to be monitored. | Reference  ABWTC (clinicians) p5 | Further information  No further information |
| Item  If result abnormal (e.g. AMT <8) refer to OT or MO for prompt review. | NSQHS Standard  10.7.1 | Evidence details  The screening tool is not expected to diagnose, but to detect cognitive impairment and to trigger further investigation and action. | Reference  ABWTC(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. |
| Item  If result abnormal (e.g. AMT <8) refer to OT or MO for prompt review | NSQHS Standard  10.7.1 | Evidence details  Treat medical conditions that may contribute to an alteration in cognitive status. | Reference  ABPG 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. |
| Item  If result abnormal (e.g. AMT <8) refer to OT or MO for prompt review | NSQHS Standard  10.7.1 | Evidence details  Older patients with a progressive decline in cognition should undergo a detailed assessment so treatment can be provided to the reversible causes. | Reference  ABPG 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. |
| Item  Remain 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 details  A staff member should remain with patients with cognitive impairment and a high risk of falls while the patient is in the bathroom. | Reference  ABPG p97 | Further information  No further information |
| Item  If agitated commence behaviour observation chart to assist behaviour management plan. | NSQHS Standard  10.7.1 | Evidence details  Identify causes of agitation, wandering and impulsive behaviour, and reduce or eliminate them. | Reference  ABPG p53 | Further information  No further information |
| Item  Avoid use of bedrails due to climbing/ entrapment risk and consider low-low bed. | NSQHS Standard  10.7.1 | Evidence details  Minimise the use of restraint and bedside rails. | Reference  SQIG p21 | Further information  No further information |
| Item  Avoid use of bedrails due to climbing/entrapment risk and consider low-low bed. | NSQHS Standard  10.7.1 | Evidence details  Avoid the use of physical restraints as they make delirium worse and increase the risk of falls. | Reference  ABWTC (clinicians) p28 | Further information  No further information |
| Item  Set an alarm system in place to alert when patient is trying to get up unaided. | NSQHS Standard  10.7.1 | Evidence details  Use fall alarm devices to alert staff that patients are attempting to mobilise. | Reference  ABPG p52 | Further information  No further information |
| Item  Re-orientate patient and ask family to assist in orientating and settling patient. | NSQHS Standard  10.7.1 | Evidence details  Establish orientation programmes using environmental cues. Repeat orientation and safety instructions regularly. | Reference  ABPG p53 | Further information  No further information |
| Item  Re-orientate patient and ask family to assist in orientating and settling patient | NSQHS Standard  10.7.1 | Evidence details  Encourage family members or carers to spend time sitting with the patient. | Reference  ABPG p97 | Further information  No further information |
| Item  Increase frequency of patient checks to proactively attend to patient needs. | NSQHS Standard  10.7.1 | Evidence details  Place high-risk patients within view of, and close to, the nursing station. | Reference  SQIG p21 | Further information  No further information |
| Item  Increase frequency of patient checks to proactively attend to patient needs | NSQHS Standard  10.7.1 | Evidence details  Falls commonly occur at times when observational capacity is low. | Reference  ABPG p15 | Further information  No further information |
| Item  Increase frequency of patient checks to proactively attend to patient needs | NSQHS Standard  10.7.1 | Evidence details  Provide 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. | Reference  ABPG p52 | Further information  No further information |
| Item Continence/ Elimination Risks | NSQHS Standard  10.6.1 | Evidence details  Nil | Reference  Nil | Further information  No further information |
| Item  Require assistance with toileting? | NSQHS Standard  10.6.1 | Evidence details  Assess and address functional considerations, such as reduced dexterity or mobility, which can affect toileting. | Reference  ABPG p58 | Further information  N/A |
| Item  Require assistance with toileting? | NSQHS Standard  10.6.1 | Evidence details  Numerous falls in hospital occur when people go to or return from the toilet. | Reference  ABPG p57 | Further information  No further information |
| Item  Have constipation, urinary or faecal frequency/ urgency or nocturia? | NSQHS Standard  10.6.1 | Evidence details  Obtain a continence history from the patient. | Reference  ABPG p58 | Further information  No further information |
| Item  Have constipation, urinary or faecal frequency/urgency or nocturia? | NSQHS Standard  10.6.1 | Evidence details  Incontinence, 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. | Reference  ABPG p56 | Further information  No further information |
| Item  Have constipation, urinary or faecal frequency/urgency or nocturia? | NSQHS Standard  10.6.1 | Evidence details  Transient incontinence is present in 50% of older hospital patients. | Reference  ABPG p56 | Further information  No further information |
| Item Interventions | NSQHS Standard  10.7.1 | Evidence details  N/A | Reference  Nil | Further information  No further information |
| Item  Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard  10.7.1 | Evidence details  Obtain a continence history from the patient, which may include a bladder chart. | Reference  ABPG p58 | Further information  No further information |
| Item  Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard  10.7.1 | Evidence details  Check post void residuals in incontinent older patients. | Reference  ABPG p58 | Further information  No further information |
| Item  Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation. | NSQHS Standard  10.7.1 | Evidence details  Consider risk factors for falling related to incontinence, along with the symptoms and signs of bladder and bowel dysfunction. | Reference  ABPG p58 | Further information  No further information |
| Item  Review 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 details  Establish a plan of care for bowel and bladder function. | Reference  SQIG p21 | Further information  No further information |
| Item  Review 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 details  Assess functional considerations such as mobility and accessibility of the toilet. | Reference  ABPG p58 | Further information  No further information |
| Item  Review 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 details  As part of multifactorial intervention, toileting protocols and practices should be in place for patients at risk of falling. | Reference  ABPG p55 | Further information  No further information |
| Item  Review 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 details  Managing problems with urinary tract function is effective as part of a multifactorial approach to care. | Reference  ABPG p55 | Further information  No further information |
| Item  Complete urinalysis. If abnormal, discuss with MO if MSU indicated. | NSQHS Standard  10.7.1 | Evidence details  Organise routine screening urinalysis to identify urinary tract infections. | Reference  SQIG p21 | Further information  No further information |
| Item  Complete urinalysis. If abnormal, discuss with MO if MSU indicated | NSQHS Standard  10.7.1 | Evidence details  Ward urinalysis should form part of routine assessment for older people with a risk of falling. | Reference  ABPG p55 | Further information  No further information |
| Item Minimum Interventions | NSQHS Standard  10.4 | Evidence details  Environmental modifications should be included as part of a multifactorial intervention. | Reference  ABPG p91 | Further information  No further information |
| Item  Provide ongoing orientation for patient to bed area, toilet facilities and ward. | NSQHS Standard  10.4 | Evidence details  Orient the patient to the bed area, room, ward or unit facilities. Some patients might need repeated orientation because of cognitive impairment. | Reference  ABPG p24 | Further information  No further information |
| Item  Demonstrate the use of call bell; ensure it is in reach and that they can use it effectively. | NSQHS Standard  10.4 | Evidence details  Tell patients how they can obtain help when they need it. | Reference  ABPG p24 | Further information  No further information |
| Item  Ensure frequently used items including mobility aids are within easy reach of patient. | NSQHS Standard  10.4 | Evidence details  Make sure that the patient’s personal belongings and equipment are easy and safe for them to access. | Reference  ABPG p91 | Further information  No further information |
| Item  Encourage patient to use their aids such as glasses or hearing aids. | NSQHS Standard  10.4 | Evidence details  Ensure that patients have their usual spectacles and visual aid to hand. | Reference  SQIG p21 | Further information  No further information |
| Item  Encourage patient to use their aids such as glasses or hearing aids | NSQHS Standard  10.4 | Evidence details  Make sure that the patient’s personal belongings and equipment are easy and safe for them to access. | Reference  ABPG p91 | Further information  No further information |
| Item  Adjust bed and chair to appropriate height for patient. | NSQHS Standard  10.4 | Evidence details  Ensure 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). | Reference  ABPG p24 | Further information  No further information |
| Item  Minimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may lead to falls. | NSQHS Standard  10.4 | Evidence details  In 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). | Reference  ABPG p46 | Further information  No further information |
| Item  Place IV pole and all other devices/ attachments on exit side of bed. | NSQHS Standard  10.4 | Evidence details  Make the environment safe. | Reference  SQIG p21 | Further information  No further information |
| Item  Place IV pole and all other devices/attachments on exit side of bed | NSQHS Standard  10.4 | Evidence details  Check all aspects of the environment and modify as necessary to reduce the risk of falls. | Reference  ABPG p91 | Further information  No further information |
| Item  Remove clutter and obstacles from room. | NSQHS Standard  10.4 | Evidence details  Make the environment safe. | Reference  SQIG p21 | Further information  No further information |
| Item  Remove clutter and obstacles from room | NSQHS Standard  10.4 | Evidence details  Reduce clutter and other trip hazards in patients’ wards and rooms. | Reference  ABPG p92 | Further information  No further information |
| Item  Provide adequate lighting according to patient activities/needs. | NSQHS Standard  10.4 | Evidence details  Ensure adequate lightning is supplied based on the patient’s needs, particularly at night. | Reference  ABPG p24 | Further information  No further information |
| Item  Encourage patient to adequate fluids and nutrition. | NSQHS Standard  10.4 | Evidence details  Poor nutrition and dehydration may affect 20-50% of older patients in the hospital setting and are associated with adverse outcomes. | Reference  ACSQCH (10) p13 | Further information  No further information |
| Item  Encourage patient to adequate fluids and nutrition | NSQHS Standard  10.4 | Evidence details  Precipitating factors for delirium include dehydration and under-nutrition.  Dehydration and malnutrition are risk factors for harm in patients who have a cognitive impairment. | Reference  ABWTC(Managers)p14 &17 | Further information  No further information |
| Item  Optimise 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 details  In addition to using standard falls risk assessments, screen patients for ill-fitting or inappropriate footwear on admission to hospital. | Reference  ABPG 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. |
| Item  Optimise 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 details  Include an assessment of footwear and foot problems as part of an individualised, multifactorial intervention. | Reference  ABPG p61 | Further information  No further information |
| Item  Optimise 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 details  Hospital staff should educate patients and provide information about footwear features that may reduce the risk of falls. | Reference  ABPG p61 | Further information  No further information |
| Item  Optimise 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 details  Safe 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. | Reference  ABPG 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. |
| Item  Optimise 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 details  Walking barefoot or in socks is associated with a 10-13 fold increased risk of falling and athletic shoes are associated with the lowest risk. | Reference  ABPG p62 | Further information  No further information |
| Item  Optimise 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 details  Discourage 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. | Reference  ABPG p64 | Further information  No further information |
| Item  Optimise 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 details  Bare feet provide better slip resistance than non-slip socks and therefore might represent a safer foot condition. | Reference  Chari et al. 2009 (11) | Further information  No further information |
| Item  Optimise 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 details  Walking 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. | Reference  Yi-Ju Tsai, Sang-I Lin. *2*013 (12) | Further information  No further information |
| Item  Optimise 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 details  Barefoot 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. | Reference  Hatton et al. 2013 (13) | Further information  No further information |
| Item  Optimise 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 details  No 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. | Reference  Hubscher et al. 2011 (14) | Further information  No further information |
| Item  Optimise 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 details  Patients 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. | Reference  High 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. |
| Item  Educate that all inpatients are at increased risk of falling due to injury / illness/ medications. | NSQHS Standard  10.4 | Evidence details  The physical environment takes on greater significance for people with diminished physical, sensory or cognitive capacity. | Reference  ABPG p94 | Further information  No further information |
| Item Shift by Shift Check | NSQHS Standard  10.5.3 | Evidence details  Best 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. | Reference  APBG pxvi | Further information  No further information |
| Item  Shift by Shift Check | NSQHS Standard10.5.3 | Evidence details  An 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. | Reference  EAPBG (16) p25 | Further information  No further information |
| Item  Shift by Shift Check | NSQHS Standard10.5.3 | Evidence details  In 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 information  No further information |
| Item  Re-screen for Falls Risk **after a fall, ward transfer or improvement or deterioration in medical condition** | NSQHS Standard  10.5. | Evidence details  A falls risk assessment should be done as soon as practicable after admission. | Reference  ABPG p33 | Further information  No further information |
| Item  Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard  10.5. | Evidence details  A falls risk screen should be undertaken when a change in health or functional status is evident or when the patient’s environment changes. | Reference  ABPG p29 | Further information  No further information |
| Item  Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence details  A previous fall is a risk factor for falling in hospital. | Reference  ABPG p15 | Further information  No further information |
| Item  Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence details  Approximately 50% of falls are in patients who have already fallen. | Reference  ABPG p29 | Further information  No further information |
| Item  Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition | NSQHS Standard10.5. | Evidence details  Any changes in the environment, including transfers within or between rooms can increase confusion and agitation, and may also increase risk of falls. | Reference  ABPG p50 | Further information  No further information |
| Item **Other Individualised Interventions** | NSQHS Standard  10.7.1 | Evidence details  Each 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. | Reference  ABPG 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. |
| Item  Other Individualised Interventions | NSQHS Standard10.7.1 | Evidence details  The 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. | Reference  ABPG pxvi | Further information  This 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. |
| Item Communication and Information to Patients and Carers | NSQHS Standard  10.9.1 & 10.10.1 | Evidence details  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 | Further information  Outputs may include: patient clinical record audit and care plan audit undertaking to ensure patient and carer input in falls prevention plans. |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  Falls prevention plans are developed in partnership with patients and carers. | Reference  SQIG p27 | Further information  No further information |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  You should document that the patient is aware of the assessment findings and has participated in the care planning. | Reference  SQIG p27 | Further information  No further information |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  Provide relevant and useful information to allow patients and their carers to take part in discussions and decisions about preventing falls. | Reference  SQIG p27 | Further information  No further information |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  Find out what changes a patient is willing to make to prevent falls, so that appropriate and acceptable recommendations can be made. | Reference  ABPG p17 | Further information  No further information |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  Ask a family member to assist in falls prevention strategies. | Reference  ABPG p17 | Further information  No further information |
| Item  Communication and Information to Patients and Carers | NSQHS Standard10.9.1 & 10.10.1 | Evidence details  In 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 information  No further information |
| Item Important Practice Points | NSQHS Standard  Nil | Evidence details  Patients who are on anti-coagulant, antiplatelet therapy and/or patients with a known coagulopathy are at increased risk of intracranial haemorrhage from falls. | Reference  WA PFMG (17) p10 | Further information  No further information |
| Item  Important Practice Points | NSQHS Standard  Nil | Evidence details  Both 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. | Reference  WA OMC (18) P48 | Further information  No further information |
| Item  Important Practice Points | NSQHS Standard  Nil | Evidence details  Consider vitamin D supplementation as a routine management strategy for mobile older patients. | Reference  SQIG p21 | Further information  No further information |

# Supplementary Information Table - NSQHS standards

| **National Standard** | **Requirement** | **Reference** | **Achieved via:** |
| --- | --- | --- | --- |
| National Standard  1.9.2 | 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 Standard  10.1.1 | 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 Standard  10.1.2 | 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 Standard  1.9.2 | 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 Standard  10.4.1 | 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. | Reference  Nil | 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 Standard  10.5.1 | 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 Standard  10.5.2 | 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 Standard  10.6.1 | 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 Standard  10.6.2 | 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 Standard  10.7.1 | 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 Standard  1.181. | 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 Standard  1.18.2 | 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 Standard  10.9.1 | 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 Standard  10.10.1 | 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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