Government of **Western Australia**
Department of **Health**

Development of the Falls Risk Assessment and Management Plan

Falls Prevention Community of Practice and the Falls Prevention Health Network

Preventing falls and harm from falls

health.wa.gov.au

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Contents

1. Introduction

The Falls Risk Assessment and Management Plan (FRAMP) (see Appendix 1) is a bi-fold document designed for use in the general adult inpatient population in WA Health hospitals.

It summarises the key practices outlined by both the:

- National Standard 10 (external site)
- Australian falls prevention best practice guidelines (external site)

The document is set out in a simple, logical format that guides staff through the essential falls screening, assessment and management processes.

Features of the plan include:

- a screening process in flow chart format
- specific interventions targeted to the individual
- a place for multidisciplinary input
- space to easily record the involvement of the patient and, where required, the carer in their falls risk management plan
- a mechanism to record most of the patient's falls related information in the one form reducing the number of places staff have to look for information about the patient's falls risk and management.

The FRAMP was developed by the Falls Prevention Community of Practice for hospital settings and was based on the first version of the tool, known as the Falls Risk Management Tool (see Appendix 2).

This document outlines the process for the development of the FRAMP.

2. Background

2.1 Falls Prevention Community of Practice

The WA Falls Prevention Community of Practice for hospital settings commenced in 2009 and provides a support network to a variety of staff involved in falls prevention. This open, informal group works collaboratively to standardise key processes at a statewide level.

Anyone with an interest in falls prevention in hospitals settings is welcome to join. Membership consists of clinicians, researchers and health administrators involved in falls prevention throughout WA, spanning the public and private sectors.

The group meets quarterly and communicates via email out of session. Small time limited working groups are formed as needed to work on particular projects. For instance, a working group was formed to drive the review of the FRMT and the development of the FRAMP.

2.2 Falls Risk Management Tool

Prior to the introduction of the FRAMP, all WA public hospitals were using the Falls Risk Management Tool (FRMT) (see Appendix 2). Different versions of the FRMT were being used for quite some time and this created inconsistencies between hospital sites across WA. In an attempt to minimise variability between FRMT versions, provide an opportunity for data collection, and introduce governance for a single and agreed version of the FRMT, the Falls Prevention Community of Practice created a single version of the tool in 2010. The FRMT was used to help assess and manage patients at risk of falling in an inpatient setting. This project was driven by a small working group of members from the Community of Practice.

3. Development process

3.1 Working Group

In 2013 a multidisciplinary, multisite working group comprised of members from the Community of Practice commenced the review of the FRMT. The working group members included:

Khye Davey	Project Lead Physiotherapist, Royal Perth Hospital
Tina Williamson	A/Clinical Nurse Coordinator, Falls Prevention Program, Royal Perth Hospital
Diane Connor	Patient Safety Project Officer, Fremantle Hospital
Zi Foo	Physiotherapist, Bentley Hospital
Anne Matthews	Clinical Nurse Specialist, Sir Charles Gairdner Hospital
Su Kitchen	Clinical Nurse Specialist/Clinical Practice Improvement, Sir Charles Gairdner Hospital
Michelle Stirling	Project Officer, Safety & Quality, Armadale Health Service
Nicole Deprazer	Senior Policy Officer, Health Strategy and Networks, Department of Health WA
Dr Nicholas Waldron	Clinical Lead, Falls Prevention Health Network
Malcolm Hare	Clinical Review Audit Analyst, South Metropolitan Health Service
Katie Burr	Physiotherapy, Royal Perth Hospital
Nik Booker	A/District Manager, Busselton District Hospital, WACHS South West

The working group had regular face-to-face meetings as well as out of session communication via email throughout the FRMT review and FRAMP development process.

3.2 Review of the Falls Risk Management Tool

The first task of the working group was to commence the review of the FRMT. The aim of the FRMT review was to have significant multi-site consultation with clinical staff to gather information that would guide the:

- integration of the National Standards for accreditation

- updating of assessment and interventions that reflected the latest evidence-based, best practice
- development of a more comprehensive but more easily communicated falls management plan for individuals.

The review commenced with an online survey of the FRMT in December 2012 to find out what aspects of the FRMT and falls management were working and what were challenging. See Appendix 3 for a list of the FRMT survey questions. A total of 479 responses were received from medical, nursing and allied health staff across WA Health.

Some of the key findings from the survey included:

- The majority of respondents (69%) had received specific education on how to utilise the FRMT.
- Of those who had received education, the most common source was formal ward education by a staff development nurse or other senior nurse (56%).
- The most common time the respondents indicated they would refer to a patient's FRMT was on admission to the ward (79%). This was followed by a change in status (70%) and post fall (67%).
- 51% of people did not think there were any barriers in using the FRMT to help manage a patient's risks for falling. However of those who did think there were barriers, the most common reported barrier was that they don't think other people will follow it (46%).
- Helping identify patients that are at risk of falling was reported as the most useful aspect of the FRMT. Whilst documentation of strategies was found to be the least useful aspect of the FRMT.
- The majority of respondents did not think the management strategies on the back of the FRMT were difficult to implement (64%).
- Of those that did think the strategies were difficult to implement, follow-up podiatry referral was the most commonly selected strategy as being difficult (68%).

The results from the FRMT survey then formed the basis of the FRAMP development.

3.3 Drafting and trialling the Falls Risk Assessment and Management Plan

Early on in the drafting process, the working group decided to change the name of the FRMT to the Falls Risk Assessment and Management Plan (FRAMP) as this name was deemed to be more descriptive and would help to clarify the purpose of the tool.

The results from the FRMT survey were considered, discussed and analysed by the working group in order to determine what implications the feedback would have on the structure, content and format of the FRAMP.

The content of the original FRMT was largely informed by the Australian Commission On Safety and Quality in Health Care Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009[1]. This resource, along with more contemporary literature[2], was reviewed to ensure the changes made throughout the

document were a reflection of evidence based best practice. The working group also took into consideration new policies[3] in WA Health and the required actions outlined by the National Standards for accreditation[4] to ensure the FRAMP would align with key documents at both a state and national level.

Clinicians from a variety of specialties were continually consulted throughout the process to ensure the form was pragmatic and could be applied in a broad number of clinical areas.

The Falls Risk Assessment and Management Plan (FRAMP) Evidence Table outlines in more detail the evidence and decision making processes that were used to revise or develop each component of the FRAMP. Refer to the page linked above for the Evidence Table.

Once the working group had developed the draft FRAMP, the document was trialled across several wards at Bentley Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Royal Perth Hospital. The trials took place in June to August 2014 and varied in length from 4 to 6 weeks. It should be noted that a regional site was not included in the trial of the FRAMP as the working group had been informed that the WA Country Health Service (WACHS) did not intend to use the final FRAMP at that stage. This was due to the fact that during the development of the FRAMP, a process had begun to roll out a WACHS version of the FRAMP across several of the regions. The WACHS FRAMP had been in development prior to the review of the FRMT commencing and had already been trialled in a regional setting.

Staff working on the wards where the FRAMP was trialled were invited to complete a survey at the end of the trial. See Appendix 4 for a list of the FRAMP survey questions. 149 Staff responded and some of the key findings from the trial were:

- The majority of respondents (78%) reported they were given specific education on how to use the FRAMP.
- The most common time the respondents indicated they would refer to a patient's FRAMP was on admission to the ward (84%). This was followed by when staff were required to sign the FRAMP for the shift (74%) and after a fall (68%).
- The majority of respondents believed the FRAMP was extremely or very useful for the following purposes:
    - providing an intuitive process to follow for screening, assessment and management of falls (58%)
    - prompting staff when to perform a re-screen of a patient's falls risk (55%)
    - providing appropriate intervention options (59%)
    - monitoring the implementation of falls interventions (54%).
- 43% of respondents reported the risk screening on the FRAMP was 'about the same' as the FRMT, and 42% reported it as much easier or easier to use.
- 49% of respondents reported that the space for other disciplines to collaborate and document interventions made no difference, and 45% reported it was very helpful or helpful.
- Majority of respondents reported that signing the FRAMP shift by shift made them look at the FRAMP more than they did with the FRMT (58%).

- Having a place to record communication to patients/carers prompted majority of the respondents to discuss falls planning with their patients/carers more often (62%).
- Overall, most respondents reported that the FRAMP was much easier, easier or about the same as using the FRMT (83%).

Following the trial, minor amendments were made to the FRAMP in response to staff feedback before it was finalised by the working group.

3.4 Developing the Falls Risk Assessment and Management Plan Operational Directive

In order to achieve standardisation in relation to the screening, assessment and management of falls risk in inpatients, the Falls Prevention Health Network Executive Advisory Group and the Falls Prevention Community of Practice agreed to release the new FRAMP as an operational directive. The Falls Prevention Health Network led the development of the operational directive in consultation with the Community of Practice. Following consultation across WACHS, they decided to also use the new version of the FRAMP in order to achieve a standard approach across the entire state. Therefore, the operational directive (due for release in late 2014) mandates the use of the FRAMP for the general adult inpatient population across WA Health sites.

The Falls Prevention Health Network developed a template for the FRAMP. Sites must use this artwork when printing their local version of the FRAMP for use at their site. Minor changes to the FRAMP by hospitals and health services are permitted if required to suit local settings, policies, circumstances and available resources. The operational directive provides further advice on the types of changes that are permitted.

4 Implementation

Members of the Falls Prevention Community of Practice continue to collaborate to develop tools that will assist in the implementation and monitoring of the FRAMP. These tools include:

- an e-learning package for staff on falls prevention and management in hospital settings
- a step-by-step presentation outlining how to use the FRAMP
- an audit tool to monitor compliance with the FRAMP.

These tools will be accessible via the Falls Prevention Health Network website as they become available.

References

1. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people: Best practice guidelines for Australian hospitals 2009: Commonwealth of Australia; 2009.

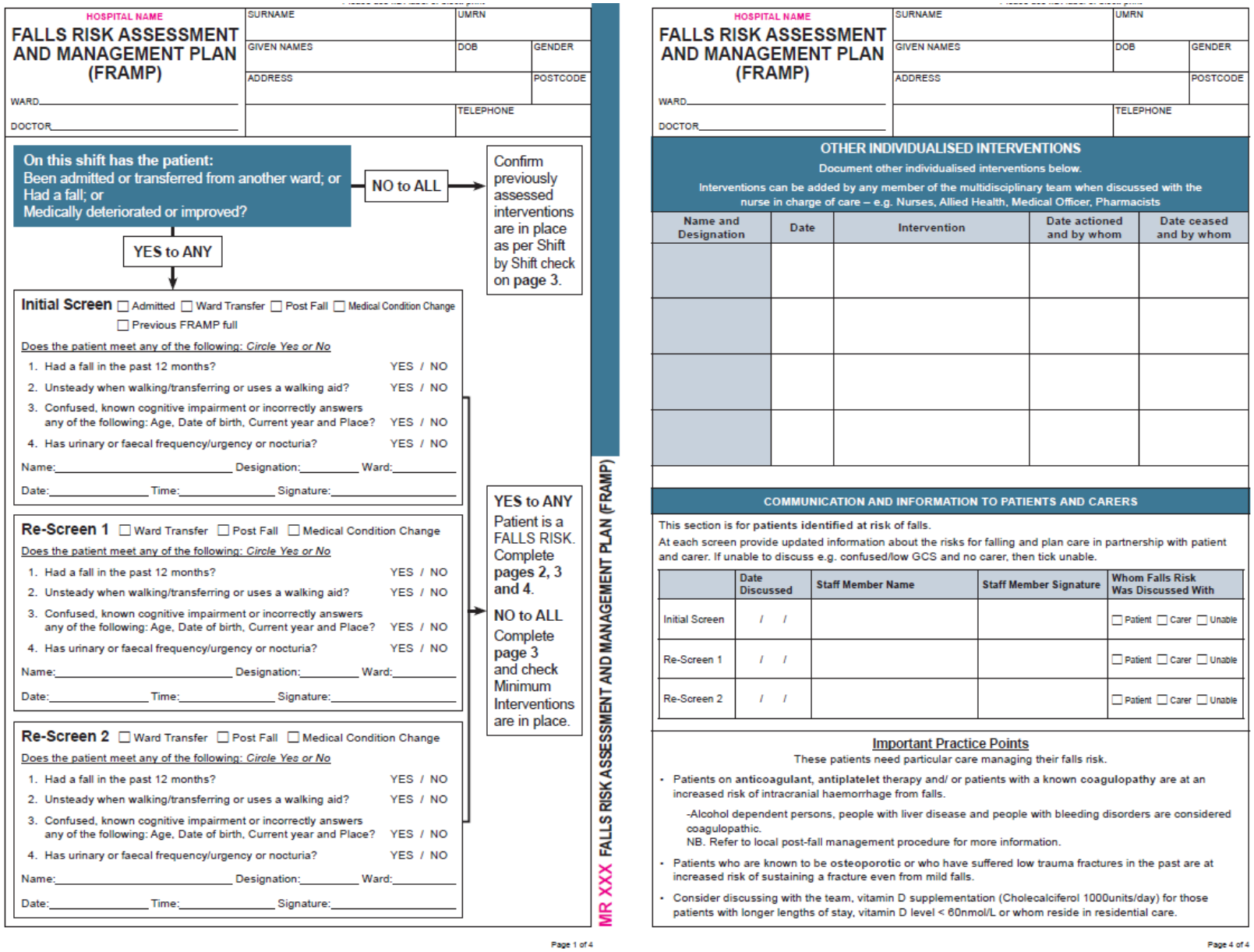
2. Cameron ID, Gillespie LD, Robertson MC, Murray GR, Hill KD, Cumming RG, et al. Interventions for preventing falls in older people in care facilities and hospitals. Cochrane Database Syst Rev 2012;12:CD005465.

3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards (September 2012). Sydney. ACSQHC, 2012.

4. Department of Health, Western Australia. Falls Prevention Model of Care. Perth: Health Strategy and Networks, Department of Health, Western Australian; 2014.

Appendices

Appendix 1: Falls Risk Assessment and Management Plan



HOSPITAL NAME

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

SURNAME | UMRN

GIVEN NAMES | DOB | GENDER

ADDRESS | POSTCODE

TELEPHONE

WARD

DOCTOR

On this shift has the patient:
Been admitted or transferred from another ward; or
Had a fall; or
Medically deteriorated or improved?

NO to ALL → Confirm previously assessed interventions are in place as per Shift by Shift check on page 3.

YES to ANY

Initial Screen ☐ Admitted ☐ Ward Transfer ☐ Post Fall ☐ Medical Condition Change ☐ Previous FRAMP full

Does the patient meet any of the following: *Circle Yes or No*

1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO

Name:_____ Designation:_____ Ward:_____

Date:_____ Time:_____ Signature:_____

Re-Screen 1 ☐ Ward Transfer ☐ Post Fall ☐ Medical Condition Change

Does the patient meet any of the following: *Circle Yes or No*

1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO

Name:_____ Designation:_____ Ward:_____

Date:_____ Time:_____ Signature:_____

Re-Screen 2 ☐ Ward Transfer ☐ Post Fall ☐ Medical Condition Change

Does the patient meet any of the following: *Circle Yes or No*

1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO

Name:_____ Designation:_____ Ward:_____

Date:_____ Time:_____ Signature:_____

YES to ANY
Patient is a FALLS RISK. Complete **pages 2, 3 and 4.**

NO to ALL
Complete **page 3** and check Minimum Interventions are in place.

MR XXX FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

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HOSPITAL NAME

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

SURNAME | UMRN

GIVEN NAMES | DOB | GENDER

ADDRESS | POSTCODE

TELEPHONE

WARD

DOCTOR

OTHER INDIVIDUALISED INTERVENTIONS

Document other individualised interventions below.

Interventions can be added by any member of the multidisciplinary team when discussed with the nurse in charge of care – e.g. Nurses, Allied Health, Medical Officer, Pharmacists

Name and Designation	Date	Intervention	Date actioned and by whom	Date ceased and by whom

COMMUNICATION AND INFORMATION TO PATIENTS AND CARERS

This section is for **patients identified at risk** of falls.
At each screen provide updated information about the risks for falling and plan care in partnership with patient and carer. If unable to discuss e.g. confused/low GCS and no carer, then tick unable.

	Date Discussed	Staff Member Name	Staff Member Signature	Whom Falls Risk Was Discussed With
Initial Screen	/ /			☐ Patient ☐ Carer ☐ Unable
Re-Screen 1	/ /			☐ Patient ☐ Carer ☐ Unable
Re-Screen 2	/ /			☐ Patient ☐ Carer ☐ Unable

Important Practice Points

These patients need particular care managing their falls risk.

- Patients on **anticoagulant, antiplatelet** therapy and/ or patients with a known **coagulopathy** are at an increased risk of intracranial haemorrhage from falls.
  - -Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.
  - NB. Refer to local post-fall management procedure for more information.
- Patients who are known to be **osteoporotic** or who have suffered **low trauma fractures** in the past are at increased risk of sustaining a fracture even from mild falls.
- Consider discussing with the team, vitamin D supplementation (Cholecalciferol 1000units/day) for those patients with longer lengths of stay, vitamin D level < 60nmol/L or whom reside in residential care.

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DATE			
RISK ASSESSMENT and INDIVIDUALISED INTERVENTIONS	**Initial Screen**	**Re-Screen 1**	**Re-Screen 2**
MOBILITY RISKS Does the patient:	**If risk identified initial box**		
Require assistance with mobility/transfer?			
Have poor coordination, balance, gait or uncorrected visual impairment?			
FUNCTIONAL ABILITY RISKS			
Is the patient unsteady, disorganised or require assistance when attending to ADLs?			
INTERVENTIONS	*Initial if appropriate for patient*		
Assess, document and provide mobility aids and level of assistance required.			
Discuss and confirm with the patient what level of assistance they require (including mobility aids), and/or their need to call and wait for assistance.			
Refer to Physiotherapist for a comprehensive mobility assessment.			
Refer to Occupational Therapist (OT) for functional assessment.			
MEDICATIONS/MEDICAL CONDITION RISKS Some medications are associated with falls. Has the patient been prescribed:	**If risk identified initial box**		
-Psychoactive medication e.g. benzodiazepines, antipsychotics, antidepressants?			
-New or old medication that may affect their blood pressure?			
Does the patient take more than 5 medications of any sort?			
Does the patient report dizziness or presented following a fall/collapse?			
INTERVENTIONS	*Initial if appropriate for patient*		
Liaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls.			
If reporting dizziness, check lying/standing blood pressure. If a postural drop >20mmHg systolic or >10mmHg diastolic present, discuss plan of care with MO.			
Educate patient to stand up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO.			
COGNITIVE STATE RISKS Does the patient have:	**If risk identified initial box**		
Previous delirium or known diagnosis of dementia?			
New or worsening memory impairment, confusion or disorientation?			
Drowsiness, is easily distracted, withdrawn or depressed?			
INTERVENTIONS	*Initial if appropriate for patient*		
Establish a baseline cognitive screen eg Abbreviated Mental Test (AMT).			
If result abnormal (e.g. AMT <8) refer to OT or MO for prompt review.			
Remain in attendance at all times when the patient is toileting or showering as this is a high risk activity for the patient.			
If agitated commence behaviour observation chart to assist behaviour management plan.			
Avoid use of bedrails due to climbing/entrapment risk and consider low-low bed.			
Set an alarm system in place to alert when patient is trying to get up unaided.			
Re-orientate patient and ask family to assist in orientating and settling patient.			
Increase frequency of patient checks to pro-actively attend to patient needs.			
CONTINENCE/ELIMINATION RISKS Does the patient:	**If risk identified initial box**		
Require assistance with toileting?			
Have constipation, urinary or faecal frequency/urgency or nocturia?			
INTERVENTIONS	*Initial if appropriate for patient*		
Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation.			
Review toileting needs with patient daily including frequency, patients requirement for continence/ toileting aids and assistance required to access toilet facilities.			
Complete urinalysis. If abnormal, discuss with MO if MSU indicated.			
PATIENT REQUIRES INTERVENTIONS OTHER THAN ABOVE (SEE PAGE 4)			

HOSPITAL NAME

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

WARD_____

DOCTOR_____

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

MINIMUM INTERVENTIONS
To be implemented for ALL patients as appropriate

- Provide ongoing orientation for patient to bed area, toilet facilities and ward.
- Demonstrate the use of call bell, ensure it is in reach and that they can use it effectively.
- Ensure frequently used items including mobility aids are within easy reach of patient.
- Encourage patient to use their aids such as glasses or hearing aids.
- Adjust bed and chair to appropriate height for patient.
- Minimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may lead to falls.
- Place IV pole and all other devices/attachments on exit side of bed.
- Remove clutter and obstacles from room.
- Provide adequate lighting according to patient activities/needs.
- Encourage patient to take adequate fluids and nutrition.
- 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.
- Educate that all inpatients are at increased risk of falling due to injury / illness / medications.

SHIFT BY SHIFT CHECK
If the patient has had a FALL or MEDICAL CONDITION CHANGE or WARD TRANSFER re-screen on page 1

Instructions:
Please date and initial below to confirm which interventions are implemented each shift.

Week 1	Date / /			Date / /			Date / /			Date / /			Date / /			Date / /			Date / /		
	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND
Minimum Interventions ONLY OR																					
Minimum AND Individualised Interventions																					

Week 2	Date / /			Date / /			Date / /			Date / /			Date / /			Date / /			Date / /		
	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND
Minimum Interventions ONLY OR																					
Minimum AND Individualised Interventions																					

Week 3	Date / /			Date / /			Date / /			Date / /			Date / /			Date / /			Date / /		
	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND
Minimum Interventions ONLY OR																					
Minimum AND Individualised Interventions																					

Week 4	Date / /			Date / /			Date / /			Date / /			Date / /			Date / /			Date / /		
	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND	AM	PM	ND
Minimum Interventions ONLY OR																					
Minimum AND Individualised Interventions																					

Appendix 2: Falls Risk Management Tool (superseded by FRAMP)

Government of Western Australia
Department of Health

STAY ON YOUR FEET WA®
FALLS RISK MANAGEMENT TOOL

Family name: URN:

Given name:

D.O.B: Sex: ☐ M ☐ F

Complete the *full* assessment (see over) if the patient meets any of the following criteria:
- ☐ Has had a slip, trip or fall in the past 6 months
- ☐ Unsafe when walking or transferring
- ☐ Is confused

If no criteria met, ensure minimum standards are in place but do not complete assessment interventions.

Minimum Standards – To be implemented for ALL patients
- Orientate patient to bed area, toilet facilities and ward
- Educate patient and family and provide information about the risk of falling and safety issues
- Demonstrate the use of call bell to patient and ensure it is in reach of patient
- Ensure frequently used items including mobility aids are within easy reach of patient
- Provide appropriate mobility assistance
- Bed and chair at appropriate height for patient
- Ensure bed brakes are employed at all times
- Position over-bed table on non-exit side of bed
- Place IV pole and all other devices/attachments (as appropriate) on exit side of bed
- Remove clutter and obstacles from room
- Ensure patient is using appropriate aids such as glasses or hearing aids
- Ensure patient wears appropriate footwear if ambulant
- Use bed rails as appropriate

Initial Assessment (IA)

Name:_____ Designation:_____ Date: _____ Time:_____

Interventions selected ☐ **OR** for Minimum standards only ☐

Re-Assessment Codes:
- **Post fall (PF)**
- **Post medical condition change (MCC)**
- **On Ward Transfer (WT)**

Re- Assessment 1: **PF** ☐ **WT** ☐ **Post MCC** ☐

Name:_____ Designation:_____ Date: _____ Time:_____

Interventions selected ☐ **OR** for Minimum standards only ☐

Re- Assessment 2: **PF** ☐ **WT** ☐ **Post MCC** ☐

Name:_____ Designation:_____ Date: _____ Time:_____

Interventions selected ☐ **OR** for Minimum standards only ☐

Re- Assessment 3: **PF** ☐ **WT** ☐ **Post MCC** ☐

Name:_____ Designation:_____ Date: _____ Time:_____

Interventions selected ☐ **OR** for Minimum standards only ☐

FALLS RISK MANAGEMENT TOOL

MR #

Instructions 1) Identify risk factors in shaded boxes. 2) Select appropriate interventions. 3) Attach a blue band onto patient & explain reason. 4) Document "FRMT strategies implemented" and "Falls min standards" in NCP. 5) Document any additional strategies in NCP 6) Check FRMT and sign NCP each shift. 7) Document outcomes in patient notes as required.	**DATE:**			
	IA	**1**	**2**	**3**
MOBILITY/FUNCTIONAL ABILITY **Does the patient:**	Initial if patient has any one of these risk factors			
▪ Require assistance with mobility/transfer?				
▪ Have impaired gait/limb weakness?				
▪ Have poor coordination or balance?				
▪ Report foot pain and other foot problems?				
INTERVENTIONS	Initial if appropriate for this patient			
➢ Refer to Physiotherapist				
➢ Refer to Occupational Therapist				
➢ Document mobility aids and appropriate level of assistance required				
➢ Provide appropriate level of assistance				
➢ Encourage participation in functional activities and exercise and minimise prolonged bed-rest				
➢ Follow-up Podiatry referral				
MEDICATIONS/MEDICAL CONDITIONS **Has the patient been prescribed:**	Initial if patient has any one of these risk factors			
▪ Sedatives/hypnotics, laxatives and/or diuretics?				
▪ Any medication that may affect their balance or blood pressure?				
Does the patient have a medical condition that:				
▪ Causes dizziness or unsteadiness?				
▪ Causes severe fatigue?				
INTERVENTIONS	Initial if appropriate for this patient			
➢ Liaise with Medical Practitioner or Pharmacist for medication review				
➢ Check lying/standing blood pressure				
➢ Encourage patient to sit up or stand up slowly				
COGNITIVE STATE **Is the patient:**	Initial if patient has any one of these risk factors			
▪ Confused, disorientated or depressed?				
INTERVENTIONS	Initial if appropriate for this patient			
➢ Conduct Abbreviated Mental Test (AMT)				
➢ Assess and document need for supervision in toilet and shower				
➢ Supervise in toilet and shower at all times				
➢ Commence behaviour observation chart				
➢ Place bed against wall and use appropriate equipment (ie falls alarm mats and/or Low bed)				
➢ Avoid use of bedrails				
➢ Re-orientate patients as required				
➢ Document and provide increased surveillance strategies				
➢ Refer to Occupational Therapist (if AMT <8)				
CONTINENCE/ ELIMINATION NEEDS **Does the patient:**	Initial if patient has any one of these risk factors			
▪ Require assistance with toileting?				
▪ Have urinary or faecal frequency/urgency or nocturia?				
INTERVENTIONS	Initial if appropriate for this patient			
➢ Assess and document patient's normal toileting patterns				
➢ Implement individual toileting plan (ie offer toileting 2-3 hourly)				
➢ Encourage fluids				
➢ Ensure patient has easy access to toilet facilities (eg bottle, commode)				

Appendix 3: 2013 Falls Risk Management Tool (FRMT) staff survey questions

Question 1: What area of health do you work in?

- North Metropolitan Health Service (NMHS)
- South Metropolitan Health Service (SMHS)
- WA Country Health Service (WACHS)
- Child and Adolescent Health Service (CAHS)
- Agency
- Other Please specify

Question 2: What speciality do you currently work in?

- Medical
- Surgical
- Rehabilitation
- Cancer and Neurosciences
- Critical Care
- Adult Mental Health
- Older Adult Mental Health
- General ward
- Aged Care
- Other, please specify

Question 3: Have you had specific education on how to utilise the FRMT to manage patient fall risks?

- Yes or No

Question 4: If yes, what were the source/s of education?

- Formal ward education by staff development nurse or other senior nurse
- Hospital wide education
- Falls champion or falls team
- eLearning
- Informal 1:1 with a colleague
- Other (please specify)

Question 5: During a patient's admission how often would you refer to a patient's FRMT?

- At the beginning of the shift
- On admission to the ward
- When there is a change in status
- After a fall
- No specific time
- When signing the nursing care plan
- Other (please specify)

Question 6: Do you think there are any barriers in using the FRMT to help manage a patients' risks for falling?

- Yes. Please proceed to question 7. No. Please skip to question 8.

Question 7: What do you feel are some of the barriers?

Question 8: What 3 aspects of the FRMT are most useful?

- Helping identifying patients that are at risk of falling
- Information and prompts on the minimum standards
- Identifying specific areas of risk for a patient
- Identifying specific strategies to put in place

- Documentation of strategies
- Knowing when a patient needs to be reassessed
- Other. Please describe:

Question 9: What 3 aspects of the FRMT are least useful?

- Helping identifying patients that are at risk of falling
- Information and prompts on the minimum standards
- Identifying specific areas of risk for a patient
- Identifying specific strategies to put in place
- Documentation of strategies
- Knowing when a patient needs to be reassessed
- Other. Please describe:

Question 10: Do you feel any of the management strategies on the back of the FRMT are difficult to implement or not very useful when put in place?

- Yes. Please proceed to question 11. No. Please skip to question 12.

Question 11: Please Indicate which of the following management strategies on the back of the FRMT are difficult to implement or not very useful when put in place. Please comment on the reason for your choices below.

- Refer to physiotherapist
- Refer to occupational therapist
- Follow-up Podiatry referral
- Check lying/standing blood pressure
- Conduct Abbreviated Mental Test
- Avoid use of bedrails
- Commence behaviour observation chart
- Implement individual toileting plan
- Encourage fluids
- Re-orientate patients as required
- Provide appropriate level of assistance
- Document mobility aids and appropriate level of assistance required
- Encourage participation in functional activities and exercise and minimise bed rest
- Liaise with Medical Practitioner or Pharmacist for medication review
- Encourage patients to sit up or stand up slowly
- Assess and document need for supervision in toilet and shower
- Supervise in toilet and shower at all times
- Place bed against wall and use appropriate equipment
- Document and provide increased surveillance strategies
- Refer to Occupational Therapist (if AMT <7)
- Assess and document patient's normal toileting patterns
- Ensure patient has easy access to toilet facilities

Question 12: How would you change the FRMT or documentation in the Nursing Care Plan to help communicate management of a patient’s fall risks from shift to shift?

Question 13: Any final comments on changes you would like to see made to the FRMT to help make management of falls easier?

Appendix 4: 2014 Falls Risk Assessment and Management Plan (FRAMP) trial survey questions

Question 1: What site did you use the FRAMP at?

- Bentley Hospital Ward 1
- Bentley Hospital Ward 3
- Bentley Hospital Ward 4
- Fremantle Hospital Ward B7 South
- Fremantle Hospital Ward B9 South
- Fremantle Hospital Amity Ward
- Sir Charles Gairdner Hospital GRU
- Sir Charles Gairdner Hospital Ward G74
- Sir Charles Gairdner Hospital Ward G61
- Royal Perth Hospital Ward 5H
- Royal Perth Hospital Ward 9C
- Royal Perth Hospital Ward SPC1

Question 2: Did you receive specific education on how to utilise the FRAMP to help manage patients risk of falling?

- Yes or No

Question 3: Generally speaking, when did you find yourself referring to a patient's FRAMP? Answer all that apply to your practice.

- At the beginning of the shift
- On admission to the ward
- When there was a change in the patients status
- After a fall
- When signing the FRAMP for the shift
- No specific time
- You're supposed to refer to it?
- Other (please specify)

Question 4: To what extent do you believe the FRAMP is useful for:

- Providing an intuitive process to follow for screening, assessment and management of falls
- Prompting staff when to perform a re-screen of a patient's falls risk
- Providing appropriate intervention options
- Monitoring the implementation of falls interventions

Rate each statement on the scale of: Extremely useful/ Very useful/ Moderately useful/ Slightly useful/ Not at all/ Useful

Question 5: Compared to the FRMT, risk screening on page 1 of the FRAMP was:

- Much Easier/ Easier/ About the same/ More difficult/ Much more difficult

Question 6: Compared to the FRMT, Risk Assessment and Individualised Interventions on page 2 of the FRAMP were:

- Much easier to understand/ Easier to understand/ About the same/ More difficult to understand/ Much more difficult to Understand

Question 7: I found the space on page 3 for other disciplines to collaborate and document interventions:

- Was very helpful/ Was helpful/ Made no difference/ Was unhelpful/ Was very unhelpful

Question 8: I found signing the FRAMP shift by shift made me look at the FRAMP:

- More than I did with the FRMT About the same that I did with the FRMT
- Less than I did with the FRMT

Question 9: I found having a place to record communication to patients/carers:

- Prompted me to discuss falls planning more often with them
- Did not prompt me to discuss falls planning with them

Question 10: Overall compared to the FRMT, using the FRAMP was:

- Much Easier/ Easier/ About the same/ More difficult/ Much more difficult

Question 11: Is there anything particular about the FRAMP that makes you feel that way?

Question 12: Are there any changes to the FRAMP that you think would improve the management of patient falls?

This document can be made available in alternative formats on request for a person with a disability.