



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

# 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](#).

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](#), 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](#).

## Related websites

- Falls risk assessment and management plan:  
[http://ww2.health.wa.gov.au/Corporate/Articles/F\\_I/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)
<b>Definition, Background Information and Key Messages</b>	10	<p>A fall is an event which results in a person coming to rest inadvertently on the ground or other lower level.</p> <p>Many falls can be prevented.</p> <p>A multifactorial approach to preventing falls should be part of routine care for all older people in hospital settings.</p> <p>A best practice approach for preventing falls in hospitals includes:</p> <ol style="list-style-type: none"><li>1. the implementation of standard falls prevention strategies (minimum interventions)</li><li>2. identification of falls risk</li><li>3. implementation of individualised interventions to address risks which are regularly monitored and reviewed.</li></ol> <p>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.</p> <p>Risk factors can be intrinsic (factors that relate to a</p>	<p>ABPG <sup>(1)</sup> p4</p> <p>ABPG pxvi ABPG p21</p> <p>ABPG pxvi</p> <p>ABPG p15</p>	



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)
		<p>person’s behaviour or condition) and extrinsic (factors that relate to a person’s environment or their interaction with the environment).</p> <p>Intrinsic factors include:</p> <ul style="list-style-type: none"> <li>• Previous fall</li> <li>• Postural instability, muscle weakness</li> <li>• Cognitive impairment, delirium and disturbed behaviour</li> <li>• Urinary frequency and incontinence</li> <li>• Postural hypotension</li> <li>• Medications</li> <li>• Visual impairment</li> </ul> <p>Some risk factors (e.g. confusion, unsafe gait and antidepressant medications) are associated with an increased risk of multiple falls in hospital.</p> <p>Extrinsic factors include:</p> <ul style="list-style-type: none"> <li>• Environmental risk factors (most falls in hospital occur around the bedside and in the bedroom)</li> <li>• Time of day (falls commonly occur at times when observational capacity is low – i.e. shower time and meal times and outside visiting hours).</li> </ul> <p>A snapshot of studies that have reported fall data</p>	ABPG p14	



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)
		<p>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.</p> <p>Managing the risk for falls (e.g. delirium or balance problems) will have wider benefits beyond falls prevention.</p> <p>Engaging older people is an integral part of preventing falls and minimising harm from falls.</p> <p>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.</p> <p>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.</p>	<p>ABPG pxvi</p> <p>ABPG pxvi</p> <p>ABPG pxvi</p> <p>ABPG p15</p>	
<b>Falls Risk Screen</b>	10.5.1 10.8.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls.	SQIG <sup>(2)</sup> p17	



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)
		<p>You must ensure that the results of falls risk screening are recorded appropriately in the patient clinical record and action taken.</p> <p>Do not use falls risk prediction tools to predict inpatients risk of falling in hospital.</p> <p>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.</p> <p>A falls risk screen should be undertaken when a change in health or functional status is evident or when the patient’s environment changes.</p>	<p>SQIG p17</p> <p>NICE 161 <sup>(3)</sup> rec. 1.2.1.1</p> <p>NICE 161 rec. 1.2.1.2</p> <p>ABPG p29</p>	<p>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).</p> <p>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).</p>



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)
Does the patient meet any of the following:				
Had a fall in the past 12 months?		<p>Documenting a history of recent falls is a good screening question for identifying people at higher risk of falls during their hospital stay.</p> <p>A previous fall is a risk factor for falling in hospital.</p> <p>Approximately 50% of falls are in patients who have already fallen.</p>	<p>ABPG p30</p> <p>ABPG p15</p> <p>ABPG p29</p>	
Unsteady when walking / transferring or uses a walking aid?		<p>Postural instability and muscle weakness are risk factors for falling in hospital.</p>	<p>ABPG p15</p>	
Confused, known cognitive impairment or incorrectly answers any of the following: age, date of birth, current year or place?		<p>Cognitive impairment (including agitation, delirium and dementia) is a major risk factor for falls.</p> <p>Identifying the presence of cognitive impairment should form part of the falls risk assessment process.</p> <p>The presence of confusion or disorientation has been independently associated with falls and fractures in hospital patients.</p>	<p>ABPG p27</p> <p>ABPG P37</p> <p>ABPG P50</p>	





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)
		<p>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.</p> <p>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.</p>	<p>ABPG P50</p> <p>Scofield et al 2010<sup>(4)</sup></p>	
<p>Has urinary or faecal frequency / urgency or Nocturia?</p>		<p>Urinary frequency and incontinence are risk factors for falling in hospital.</p> <p>A high percentage of falls are associated with elimination and toileting.</p>	<p>ABPG p15</p> <p>ABPG p14</p>	
<p><b>Screening and Assessment</b></p>	<p>10.7.1</p>	<p>The screen should be used to guide more detailed assessment and subsequent targeted interventions. When the threshold of a screening tool is:</p> <ul style="list-style-type: none"> <li>• Exceeded: a falls risk assessment should be done as soon as practicable</li> <li>• not exceeded: the patient is considered to be at low risk of falling, and standard falls prevention strategies apply</li> </ul> <p>Falls prevention and harm minimisation plans that</p>	<p>ABPG p32</p> <p>SQIG p22</p>	



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)
		<p>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.</p>		
<p><b>Risk Assessment Identification and Individualised Intervention Section</b></p>	<p>10.6.1 10.7.1 1.8.2</p>	<p>Effective interventions to prevent falls are important as they will have significant health benefits. Interventions targeting multiple risk factors reduced falls in hospitals.</p> <p>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.</p> <p>The outcomes of the falls risk assessment, together with the recommended strategies to address identified risk factors, need to be documented.</p> <p>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.</p>	<p>Cochrane Review <sup>(5)</sup></p> <p>SQIG p21</p> <p>ABPG p36</p> <p>ABPG p36</p>	



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)
		<p>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.</p> <p>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.</p> <p>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.</p>	<p>ABPG p29</p> <p>SQIG p21</p> <p>SQIG p22</p>	
<b>Mobility Risks</b>	10.6.1			
Require assistance with mobility/transfer?		Postural instability and muscle weakness are risk factors for falling in hospital.	ABPG p15	
Have poor coordination, balance, gait or uncorrected visual impairment?		<p>Postural instability and muscle weakness are risk factors for falling in hospital.</p> <p>Use hospitalisation as an opportunity to screen</p>	<p>ABPG p15</p> <p>ABPG p83</p>	



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)
		systematically for visual problems that can have an effect both in the hospital setting and after discharge.		
<b>Functional ability risks</b>	10.6.1			
Is the patient unsteady, disorganised or require assistance when attending to Activities of Daily Living (ADLs)?		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).	ABPG p42	
<b>Interventions</b>	10.7.1			
Assess, document and provide mobility aids and level of assistance required		<p>Communicate to staff and the patient the limits of the patient’s mobility status using written, verbal and visual communication.</p> <p>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.</p>	<p>ABPG p23</p> <p>ABPG p42</p>	



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)
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		<p>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.</p> <p>A high percentage of falls are unwitnessed.</p>	<p>ABPG p15</p> <p>ABPG p14</p>	
Refer to Physiotherapist for a comprehensive mobility assessment		<p>Organise routine physiotherapy review for patients with mobility difficulties, including transfers.</p> <p>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.</p>	<p>ABPG p23</p> <p>ABPG p21</p>	
Refer to Occupational Therapist (OT) for functional assessment		<p>Patients at higher risk of falling should be referred to an Occupational Therapist for needs and training specific to home environment and equipment.</p>	<p>ABPG p21</p>	
<b>Medications/ Medical Conditions Risks</b>	10.6.1			
<b>Has the patient been prescribed:</b>				



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)
<p>Psychoactive medication e.g. benzodiazepines, antipsychotics or antidepressants?</p> <p>New or old medication that may affect their blood pressure?</p> <p>Does the patient take greater than 5 medications of any sort?</p>		<p>A number of studies have shown an association between medication use and falls in older people.</p> <p>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.</p> <p>Certain classes of medication are more likely to increase the risk of falls.</p> <p>Taking more medications is associated with an increased risk of falls.</p>	<p>ABPG p78</p> <p>ABPG p78</p> <p>ABPG p78</p> <p>ABPG p78</p>	
<p>Does the patient report dizziness or presented following a fall/collapse?</p>		<p>Dizziness in the hospital setting remains a difficult diagnostic problem because it has many potential causes and may result from disease in multiple systems.</p> <p>Patients who report unexplained falls or episodes of collapse should be assessed for the underlying cause.</p>	<p>ABPG p72</p> <p>ABPG p67</p>	
<p><b>Interventions</b></p>	<p>10.7.1</p>			
<p>Liaise with Medical Officer (MO) or</p>		<p>Review medication, particularly high risk medications such as sedatives, antidepressants,</p>	<p>SQIG p21.</p>	<p>See note under "Other Individualised Interventions" p22.</p>



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)
Pharmacist for review of medication associated with falls		<p>antipsychotics and centrally acting pain relief.</p> <p>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).</p> <p>Patients on psychoactive medication should have their medication reviewed and, where possible, discontinued gradually to minimise side effects and reduce their risk of falling.</p>	<p>ABPG p77</p> <p>ABPG p77</p>	
If reporting dizziness, check lying/standing blood pressure. If a drop >20mmHg systolic or 10mmHg diastolic is present, discuss plan of care with MO		<p>Monitor and record postural blood pressure.</p> <p>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.</p>	<p>ABPG p69</p> <p>ABPG p67</p>	
Educate patient to stand		Encourage patient to sit up slowly from lying, stand	ABPG p69	



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<p>up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO</p>		<p>up slowly from sitting and wait a short time before walking.</p> <p>When patients describe being “dizzy”, “giddy” or “faint”, this may mean anything from anxiety or fear of falling, to postural disequilibrium, vertigo or presyncope.</p> <p>An important step in minimising the risk from falls associated with dizziness is to assess vestibular function.</p>	<p>ABPG p72</p> <p>ABPG p73</p>	
<b>Cognitive State Risks</b>	10.6.1			
<p>Previous delirium or known diagnosis of dementia?</p>		<p>Dementia has been associated with falls in hospital.</p> <p>Patients with dementia are more susceptible to delirium.</p> <p>Older people with cognitive impairment have an increased risk of falls.</p>	<p>ABPG p50</p> <p>ABPG p51</p> <p>ABPG p50</p>	
<p>New or worsening memory impairment, confusion or</p>		<p>Repeatedly and regularly check for the presence of delirium. Rapid diagnosis and treatment of a delirium and its underlying cause (e.g. infection,</p>	<p>ABPG p51</p>	





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disorientation?		<p>dehydration, constipation, and pain) are crucial.</p> <p>The presence of confusion or disorientation has been independently associated with falls and fracture in hospital patients.</p> <p>Any changes in the environment such as room change or ward change can increase confusion.</p>	<p>ABPG p50</p> <p>ABPG p50</p>	
Drowsiness, is easily distracted, withdrawn or depressed?		<p>Cognitive impairment, delirium and disturbed behaviour are risk factors for falling in hospitals.</p> <p>The key signs to look for are that the patient:</p> <ul style="list-style-type: none"> <li>• cannot answer your questions</li> <li>• is inattentive or easily distracted</li> <li>• has disorganised thinking</li> <li>• has an altered level of consciousness</li> <li>• is agitated</li> <li>• is overly sleepy – this may be hypoactive delirium</li> </ul> <p>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.</p> <p>Depressive symptoms were found to be</p>	<p>ABPG p15</p> <p>ABWTC <sup>(6)</sup> (clinicians) p4</p> <p>NICE 103 <sup>(7)</sup></p> <p>Kvelde et al.</p>	<p><a href="#">A Better Way To Care</a> (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.</p> <p>Settings were community and rehabilitation. There was no</p>



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		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.	2013 <sup>(8)</sup>	difference between community samples and those with identified healthcare needs with respect to depressive symptoms being a risk factor for falls.
<b>Interventions</b>	10.7.1			
Establish a baseline cognitive screen. For example the abbreviated Mental Test (AMT) or as per local guidelines.		Identifying the presence of cognitive impairment should form part of the falls risk assessment process.  Think of cognition as another vital sign that needs to be monitored.	ABPG p37  ABWTC (clinicians) p5	
If result abnormal (e.g. AMT <8) refer to OT or MO for prompt review.		The screening tool is not expected to diagnose, but to detect cognitive impairment and to trigger further investigation and action.  Treat medical conditions that may contribute to an alteration in cognitive status.  Older patients with a progressive decline in cognition should undergo a detailed assessment	ABWTC <sup>(9)</sup> (Managers) p40  ABPG p51  ABPG p51	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.



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		so treatment can be provided to the reversible causes.		
Remain in attendance at all times when the patient is toileting or showering as this is a high risk activity for the patient.		A staff member should remain with patients with cognitive impairment and a high risk of falls while the patient is in the bathroom.	ABPG p97	
If agitated commence behaviour observation chart to assist behaviour management plan.		Identify causes of agitation, wandering and impulsive behaviour, and reduce or eliminate them.	ABPG p53	
Avoid use of bedrails due to climbing/ entrapment risk and consider low-low bed.		Minimise the use of restraint and bedside rails.  Avoid the use of physical restraints as they make delirium worse and increase the risk of falls.	SQIG p21  ABWTC (clinicians) p28	
Set an alarm system in place to alert when patient is trying to get up unaided.  Re-orientate patient and		Use fall alarm devices to alert staff that patients are attempting to mobilise.  Establish orientation programmes using	ABPG p52  ABPG p53	



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ask family to assist in orientating and settling patient.		<p>environmental cues. Repeat orientation and safety instructions regularly.</p> <p>Encourage family members or carers to spend time sitting with the patient.</p>	ABPG p97	
Increase frequency of patient checks to proactively attend to patient needs.		<p>Place high-risk patients within view of, and close to, the nursing station.</p> <p>Falls commonly occur at times when observational capacity is low.</p> <p>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.</p>	<p>SQIG p21</p> <p>ABPG p15</p> <p>ABPG p52</p>	
<b>Continence/ Elimination Risks</b>	10.6.1			
Require assistance with toileting?		<p>Assess and address functional considerations, such as reduced dexterity or mobility, which can affect toileting.</p> <p>Numerous falls in hospital occur when people go to or return from the toilet.</p>	<p>ABPG p58</p> <p>ABPG p57</p>	
Have constipation,		Obtain a continence history from the patient.	ABPG p58	



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)
urinary or faecal frequency/ urgency or nocturia?		<p>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.</p> <p>Transient incontinence is present in 50% of older hospital patients.</p>	<p>ABPG p56</p> <p>ABPG p56</p>	
<b>Interventions</b>	10.7.1			
Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation.		<p>Obtain a continence history from the patient, which may include a bladder chart.</p> <p>Check post void residuals in incontinent older patients.</p> <p>Consider risk factors for falling related to incontinence, along with the symptoms and signs of bladder and bowel dysfunction.</p>	<p>ABPG p58</p> <p>ABPG p58</p> <p>ABPG p58</p>	
Review toileting needs with patient daily		Establish a plan of care for bowel and bladder function.	SQIG p21	



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including frequency, patient's requirement for continence/ toileting aids and assistance required to access toilet facilities.		<p>Assess functional considerations such as mobility and accessibility of the toilet.</p> <p>As part of multifactorial intervention, toileting protocols and practices should be in place for patients at risk of falling.</p> <p>Managing problems with urinary tract function is effective as part of a multifactorial approach to care.</p>	<p>ABPG p58</p> <p>ABPG p55</p> <p>ABPG p55</p>	
Complete urinalysis. If abnormal, discuss with MO if MSU indicated.		<p>Organise routine screening urinalysis to identify urinary tract infections.</p> <p>Ward urinalysis should form part of routine assessment for older people with a risk of falling.</p>	<p>SQIG p21</p> <p>ABPG p55</p>	
<b>Minimum Interventions</b>	10.4	Environmental modifications should be included as part of a multifactorial intervention.	ABPG p91	
Provide ongoing orientation for patient to bed area, toilet facilities		Orient the patient to the bed area, room, ward or unit facilities. Some patients might need repeated orientation because of cognitive impairment.	ABPG p24	



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and ward.				
Demonstrate the use of call bell; ensure it is in reach and that they can use it effectively.		Tell patients how they can obtain help when they need it.	ABPG p24	
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.		Make sure that the patient’s personal belongings and equipment are easy and safe for them to access.  Ensure that patients have their usual spectacles and visual aid to hand.  Make sure that the patient’s personal belongings and equipment are easy and safe for them to access.	ABPG p91  SQIG p21  ABPG p91	
Adjust bed and chair to appropriate height for patient.		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).	ABPG p24	
Minimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may		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	ABPG p46	



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lead to falls.		mobile by increasing the amount of incidental activity (e.g. walking to the toilet with appropriate supervision).		
Place IV pole and all other devices/ attachments on exit side of bed.		<p>Make the environment safe.</p> <p>Check all aspects of the environment and modify as necessary to reduce the risk of falls.</p>	<p>SQIG p21</p> <p>ABPG p91</p>	
Remove clutter and obstacles from room.		<p>Make the environment safe.</p> <p>Reduce clutter and other trip hazards in patients' wards and rooms.</p>	<p>SQIG p21</p> <p>ABPG p92</p>	
Provide adequate lighting according to patient activities/needs.		Ensure adequate lightning is supplied based on the patient's needs, particularly at night.	ABPG p24	
Encourage patient to adequate fluids and nutrition.		<p>Poor nutrition and dehydration may affect 20-50% of older patients in the hospital setting and are associated with adverse outcomes.</p> <p>Precipitating factors for delirium include dehydration and under-nutrition.</p> <p>Dehydration and malnutrition are risk factors for harm in patients who have a cognitive impairment.</p>	<p>ACSQCH<sup>(10)</sup> p13</p> <p>ABWTC (Managers) p14 &amp;17</p>	





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)
<p>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.</p>		<p>In addition to using standard falls risk assessments, screen patients for ill-fitting or inappropriate footwear on admission to hospital.</p> <p>Include an assessment of footwear and foot problems as part of an individualised, multifactorial intervention.</p> <p>Hospital staff should educate patients and provide information about footwear features that may reduce the risk of falls.</p> <p>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.</p>	<p>ABPG p61</p> <p>ABPG p61</p> <p>ABPG p61</p> <p>ABPG p61</p>	<p>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.</p> <p>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.</p>



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)
		<p>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.</p> <p>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.</p> <p>Bare feet provide better slip resistance than non-slip socks and therefore might represent a safer foot condition.</p> <p>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.</p> <p>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.</p>	<p>ABPG p62</p> <p>ABPG p64</p> <p>Chari et al. 2009<sup>(11)</sup></p> <p>Yi-Ju Tsai, Sang-I Lin. 2013<sup>(12)</sup></p> <p>Hatton et al. 2013<sup>(13)</sup></p>	



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)
		<p>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.</p> <p>Patients with a high risk foot should not walk bare foot.</p> <p>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.</p>	<p>Hubscher et al. 2011 <sup>(14)</sup></p> <p>High risk foot MOC <sup>(15)</sup> p16 &amp;p3</p>	<p>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. <a href="#">High Risk Foot model of care</a>, p3.</p>
<p>Educate that all inpatients are at increased risk of falling due to injury / illness/ medications.</p>		<p>The physical environment takes on greater significance for people with diminished physical, sensory or cognitive capacity.</p>	<p>ABPG p94</p>	
<p><b>Shift by Shift Check</b></p>	<p>10.5.3</p>	<p>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.</p>	<p>APBG pxvi</p>	



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)
		<p>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.</p> <p>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.</p>	<p>EAPBG <sup>(16)</sup> p25</p> <p><a href="#">FRAMP education PowerPoint</a></p>	
<p><b>Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition</b></p>	<p>10.5</p>	<p>A falls risk assessment should be done as soon as practicable after admission.</p> <p>A falls risk screen should be undertaken when a change in health or functional status is evident or when the patient's environment changes.</p> <p>A previous fall is a risk factor for falling in hospital.</p> <p>Approximately 50% of falls are in patients who have already fallen.</p>	<p>ABPG p33</p> <p>ABPG p29</p> <p>ABPG p15</p> <p>ABPG p29</p>	



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)
		Any changes in the environment, including transfers within or between rooms can increase confusion and agitation, and may also increase risk of falls.	ABPG p50	
<b>Other Individualised Interventions</b>	10.7.1	<p>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.</p> <p>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.</p>	<p>ABPG p22</p> <p>ABPG pxvi</p>	<p>This section is provided to record interventions that may be required in addition to the options listed on page 2 of the FRAMP.</p> <p>This section facilitates multidisciplinary input and the recording of falls prevention interventions in one medical record document.</p> <p>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</p>



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)
				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.
<b>Communication and Information to Patients and Carers</b>	10.9.1 & 10.10.1	<p>Patient information on falls and prevention strategies is provided to patients and their carers' in a format that is understood and meaningful.</p> <p>Falls prevention plans are developed in partnership with patients and carers.</p> <p>You should document that the patient is aware of the assessment findings and has participated in the care planning.</p> <p>Provide relevant and useful information to allow patients and their carers to take part in discussions and decisions about preventing falls.</p> <p>Find out what changes a patient is willing to make to prevent falls, so that appropriate and acceptable recommendations can be made.</p>	<p>SQIG p27</p> <p>SQIG p27</p> <p>SQIG p27</p> <p>SQIG p27</p> <p>ABPG p17</p>	Outputs may include: patient clinical record audit and care plan audit undertaking to ensure patient and carer input in falls prevention plans.



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)
		<p>Ask a family member to assist in falls prevention strategies.</p> <p>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.</p>	<p>ABPG p17</p> <p><a href="#">FRAMP education PowerPoint</a></p>	
<b>Important Practice Points</b>		<p>Patients who are on anti-coagulant, antiplatelet therapy and/or patients with a known coagulopathy are at increased risk of intracranial haemorrhage from falls.</p> <p>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.</p> <p>Consider vitamin D supplementation as a routine management strategy for mobile older patients.</p>	<p>WA PFMG <sup>(17)</sup> p10</p> <p>WA OMC <sup>(18)</sup> P48</p> <p>SQIG p21</p>	



## Supplementary Information Table - NSQHS standards

National Standard	Requirement	Reference	Achieved via:
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.	SQIG Standard 1 p30	Design elements of the FRAMP prompt for and record standard 10 requirements as much as possible.
10.1.1	<p>Policies should include areas such as:</p> <ul style="list-style-type: none"> <li>• falls prevention requirements</li> <li>• falls screening and assessment</li> <li>• management of falls risks including: <ul style="list-style-type: none"> <li>○ balance and mobility</li> <li>○ cognitive impairment</li> <li>○ continence</li> <li>○ feet and footwear</li> <li>○ syncope</li> <li>○ dizziness and vertigo</li> <li>○ medication</li> <li>○ vision</li> <li>○ environmental considerations</li> <li>○ individual surveillance and observation</li> <li>○ restraint</li> <li>○ requirement for minimising injury</li> <li>○ protective equipment</li> <li>○ adequacy of calcium and vitamin D</li> </ul> </li> <li>• management of falls</li> </ul>	SQIG p10	<p>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.</p> <p>It also provides prompts for issues such as calcium and vitamin D adequacy and post fall management.</p>





National Standard	Requirement	Reference	Achieved via:
10.1.2	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.	SQIG p11	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.
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.	SQIG Standard 1 p30	Design elements of the FRAMP prompt for and record standard 10 requirements as much as possible.
10.4.1	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.		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.
10.5.1	You must ensure that the results of the falls risk screening are recorded appropriately in patient clinical record and the action taken.	SQIGp17	The FRAMP provides both a prompt for appropriate screening and facilitates efficient documentation of same.
10.5.2	Use of the [best practice] screening tool is monitored to identify the proportion of at-risk patients that were screened for falls.	SQIG p17	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.
10.6.1	You should ensure that the results of falls risk assessments are recorded and used to formulate the patient care plan.	SQIQ p19	The FRAMP provides both the prompt for appropriate assessment and facilitates efficient documentation of same.
10.6.2	Use of the [best practice] assessment tool is	SQIG p19	The FRAMP is an easily audited clinical record, providing the



National Standard	Requirement	Reference	Achieved via:
	monitored to identify the proportion of at-risk patients with a completed falls assessment.		most efficient means for each clinical area/ward/unit to provide evidence to meet these standards.
10.7.1	Use of the best practice multifactorial falls prevention and harm minimisation plan is documented in the patient clinical record.	SQIG p22	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.
1.181.	Patients and carers are partners in the planning for their treatment	SQIG Standard 1 p46	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.
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SQIG Standard 1 p46	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.
10.9.1	Patient information on falls and prevention strategies is provided to patients and their carers in a format that is understood and meaningful.	SQIG p27	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.
10.10.1	Falls prevention plans are developed in partnership with patients and carers.	SQIG p27	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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