



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

Contents

Introduction	3
Referencing system	3
Further information	3
Related websites	3
FRAMP Evidence Table 2014	4
Definition, Background Information and Key Messages	4
Falls Risk Screen	6
Screening and Assessment	8
Risk Assessment Identification and Individualised Intervention Section	8
Mobility Risks	9
Functional ability risks	10
Interventions	10
Medications / Medical Conditions Risks	11
Interventions	12
Cognitive State Risks	13
Interventions	14
Continence / Elimination Risks	16
Interventions	17
Minimum Interventions	17
Shift by Shift Check	21
Re-screen for Falls Risk	21
Other Individualised Interventions	22
Communication and Information to Patients and Carers	23
Important Practice Points	23
Supplementary Information Table - NSQHS standards	25
References	28

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 State-wide 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 Preventing Falls and Harm from Falls in Older People Best Practice Guidelines for Australian Hospitals (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
- 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)
<p>Definition, Background Information and Key Messages</p>	<p>10</p>	<p>A fall is an event which results in a person coming to rest inadvertently on the ground or other lower level. 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"> 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. <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 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"> • Previous fall • Postural instability, muscle weakness 	<p>ABPG ⁽¹⁾ 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)
		<ul style="list-style-type: none"> • Cognitive impairment, delirium, disturbed behaviour. • Urinary frequency, incontinence • Postural hypotension • Medications • Visual impairment <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"> • 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). <p>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.</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>ABPG p14</p> <p>ABPG pxvi</p> <p>ABPG 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>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 p15</p>	
Falls Risk Screen	10.5.1 1.8.1	<p>A best practice screening tool is used by the clinical workforce to identify the risk of falls.</p> <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>SQIG ⁽²⁾ p17</p> <p>SQIG p17</p> <p>NICE 161 ⁽³⁾ rec. 1.2.1.1</p> <p>NICE 161 rec. 1.2.1.2</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</p>



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		A falls risk screen should be undertaken when a change in health or functional status is evident or when the patient's environment changes.	ABPG p29	under 50 age group fall in hospital. (Consensus WA Falls Prevention Network CoP).
<i>Does the patient meet any of the following:</i>				
Had a fall in the past 12 months?		Documenting a history of recent falls is a good screening question for identifying people at higher risk of falls during their hospital stay. A previous fall is a risk factor for falling in hospital. Approximately 50% of falls are in patients who have already fallen.	ABPG p30 ABPG p15 ABPG p29	
Unsteady when walking / transferring or uses a walking aid?		Postural instability and muscle weakness are risk factors for falling in hospital.	ABPG p15	
Confused, known cognitive impairment or incorrectly answers any of the following Age, Date of birth, Current Year and Place?		Cognitive impairment (including agitation, delirium and dementia) is a major risk factor for falls. Identifying the presence of cognitive impairment should form part of the falls risk assessment process. The presence of confusion or disorientation has been independently associated with falls and fractures in hospital patients. 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.	ABPG p27 ABPG P37 ABPG P50 ABPG P50	



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)
		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.	Scofield et al 2010 ⁽⁴⁾	
Has urinary or faecal frequency / urgency or Nocturia?		Urinary frequency and incontinence are risk factors for falling in hospital. A high percentage of falls are associated with elimination and toileting.	ABPG p15 ABPG p14	
Screening and Assessment	10.7.1	The screen should be used to guide more detailed assessment and subsequent targeted interventions. When the threshold of a screening tool is: <ul style="list-style-type: none"> 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. 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.	ABPG p32 SQIG p22.	
Risk Assessment Identification and Individualised Intervention Section	10.6.1 10.7.1 1.8.2	Effective interventions to prevent falls are important as they will have significant health benefits. Interventions targeting multiple risk factors reduced falls in hospitals. Because falls are multifactorial and complex in nature,	Cochrane Review ⁽⁵⁾ SQIG p21	



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		<p>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>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 p36</p> <p>ABPG p29</p> <p>ABPG p29</p> <p>SQIG p21</p> <p>SQIG p22</p>	
Mobility Risks	10.6.1			
Require assistance with mobility/transfer?		Postural instability and muscle weakness are risk factors for falling in hospital.	ABPG p15	



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)
Have poor coordination, balance, gait or uncorrected visual impairment?		Postural instability and muscle weakness are risk factors for falling in hospital. Use hospitalisation as an opportunity to screen systematically for visual problems that can have an effect both in the hospital setting and after discharge.	ABPG p15 ABPG p83	
Functional ability risks	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	
Interventions	10.7.1			
Assess, document and provide mobility aids and level of assistance required		Communicate to staff and the patient the limits of the patient's mobility status using written, verbal and visual communication. 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.	ABPG p23 ABPG p42	



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		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. A high percentage of falls are unwitnessed.	ABPG p15 ABPG p14	
Refer to Physiotherapist for a comprehensive mobility assessment		Organise routine physiotherapy review for patients with mobility difficulties, including transfers. 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.	ABPG p23 ABPG p21	
Refer to Occupational Therapist (OT) for functional assessment		Patients at higher risk of falling should be referred to an Occupational Therapist for needs and training specific to home environment and equipment.	ABPG p21	
Medications / Medical Conditions Risks	10.6.1			
Has the patient been prescribed:				
-Psychoactive medication e.g. benzodiazepines, antipsychotics, antidepressants?		A number of studies have shown an association between medication use and falls in older people. 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.	ABPG p78 ABPG p78	



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)
-New or old medication that may affect their blood pressure?		Certain classes of medication are more likely to increase the risk of falls. Taking more medications is associated with an increased risk of falls.	ABPG p78	
Does the patient take greater than 5 medications of any sort?			ABPG p78	
Does the patient report dizziness or presented following a fall/collapse?		Dizziness in the hospital setting remains a difficult diagnostic problem because it has many potential causes and may result from disease in multiple systems. Patients who report unexplained falls or episodes of collapse should be assessed for the underlying cause.	ABPG p72	
Interventions			10.7.1	
Liaise with Medical Officer (MO) or Pharmacist for review of medication associated with falls		Review medication, particularly high risk medications such as sedatives, antidepressants, antipsychotics and centrally acting pain relief. 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). Patients on psychoactive medication should have their medication reviewed and, where possible, discontinued gradually to minimise side effects and reduce their risk of falling.	SQIG p21. ABPG p77 ABPG p77	Also: see note under “Other Individualised Interventions” p22.



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)
If reporting dizziness, check lying/standing blood pressure. If a drop >20mmHg systolic or 10mmHg diastolic is present, discuss plan of care with MO		Monitor and record postural blood pressure. 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.	ABPG p69 ABPG p67	
Educate patient to stand up slowly and wait until dizziness resolves before mobilising. If dizziness persists, discuss plan of care with MO		Encourage patient to sit up slowly from lying, stand up slowly from sitting and wait a short time before walking. When patients describe being “dizzy”, “giddy” or “faint”, this may mean anything from anxiety or fear of falling, to postural disequilibrium, vertigo or presyncope. An important step in minimising the risk from falls associated with dizziness is to assess vestibular function.	ABPG p69 ABPG p72 ABPG p73	
Cognitive State Risks	10.6.1			
Previous delirium or known diagnosis of dementia?		Dementia has been associated with falls in hospital Patients with dementia are more susceptible to delirium. Older people with cognitive impairment have an increased risk of falls.	ABPG p50 ABPG p51 ABPG p50	
New or worsening memory impairment, confusion or disorientation?		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, pain) are crucial. The presence of confusion or disorientation has been independently associated with falls and fracture in	ABPG p51 ABPG p50	



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		<p>hospital patients.</p> <p>Any changes in the environment such as room change or ward change can increase confusion.</p>	ABPG p50	
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"> • 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. <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 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.</p>	<p>ABPG p15</p> <p>ABWTC ⁽⁶⁾ (clinicians) p4</p> <p>NICE 103 ⁽⁷⁾</p> <p>Kvelde et al. 2013 ⁽⁸⁾</p>	<p>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.</p> <p>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.</p>
Interventions	10.7.1			
Establish a baseline cognitive screen e.g. Abbreviated Mental Test		Identifying the presence of cognitive impairment should form part of the falls risk assessment process.	ABPG p37	



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(AMT) or as per local guidelines		Think of cognition as another vital sign that needs to be monitored.	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 so treatment can be provided to the reversible causes.	ABWTC ⁽⁹⁾ (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.
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		Use fall alarm devices to alert staff that patients are attempting to mobilise.	ABPG p52	



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Re-orientate patient and ask family to assist in orientating and settling patient		Establish orientation programmes using environmental cues. Repeat orientation and safety instructions regularly. Encourage family members or carers to spend time sitting with the patient.	ABPG p53 ABPG p97	
Increase frequency of patient checks to proactively attend to patient needs		Place high-risk patients within view of, and close to, the nursing station. Falls commonly occur at times when observational capacity is low. 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.	SQIG p21 ABPG p15 ABPG p52	
Continence / Elimination Risks	10.6.1			
Require assistance with toileting?		Assess and address functional considerations, such as reduced dexterity or mobility, which can affect toileting. Numerous falls in hospital occur when people go to or return from the toilet.	ABPG p58 ABPG p57	
Have constipation, urinary or faecal frequency/urgency or nocturia?		Obtain a continence history from the patient. 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. Transient incontinence is present in 50% of older hospital patients.	ABPG p58 ABPG p56 ABPG p56	



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Interventions	10.7.1			
Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation.		Obtain a continence history from the patient, which may include a bladder chart. Check post void residuals in incontinent older patients. Consider risk factors for falling related to incontinence, along with the symptoms and signs of bladder and bowel dysfunction.	ABPG p58 ABPG p58 ABPG p58	
Review toileting needs with patient daily including frequency, patient's requirement for continence/ toileting aids and assistance required to access toilet facilities		Establish a plan of care for bowel and bladder function. Assess functional considerations such as mobility and accessibility of the toilet. As part of multifactorial intervention, toileting protocols and practices should be in place for patients at risk of falling. Managing problems with urinary tract function is effective as part of a multifactorial approach to care.	SQIG p21 ABPG p58 ABPG p55 ABPG p55	
Complete urinalysis. If abnormal, discuss with MO if MSU indicated		Organise routine screening urinalysis to identify urinary tract infections. Ward urinalysis should form part of routine assessment for older people with a risk of falling.	SQIG p21 ABPG p55	
Minimum Interventions	10.4			
Provide ongoing orientation for patient to bed area, toilet facilities and ward		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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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		Make sure that the patient’s personal belongings and equipment are easy and safe for them to access.	ABPG p91	
Encourage patient to use their aids such as glasses or hearing aids		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.	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 lead to falls		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).	ABPG p46	
Place IV pole and all other devices/attachments on exit side of bed		Make the environment safe. Check all aspects of the environment and modify as necessary to reduce the risk of falls.	SQIG p21 ABPG p91	



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)
Remove clutter and obstacles from room		Make the environment safe. Reduce clutter and other trip hazards in patients' wards and rooms.	SQIG p21 ABPG p92	
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		Poor nutrition and dehydration may affect 20-50% of older patients in the hospital setting and are associated with adverse outcomes. Precipitating factors for delirium include dehydration and under-nutrition. Dehydration and malnutrition are risk factors for harm in patients who have a cognitive impairment.	ACSQCH ⁽¹⁰⁾ p13 ABWTC (Managers) p14 &17	
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.		In addition to using standard falls risk assessments, screen patients for ill-fitting or inappropriate footwear on admission to hospital. Include an assessment of footwear and foot problems as part of an individualised, multifactorial intervention. Hospital staff should educate patients and provide information about footwear features that may reduce the risk of falls. 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. Walking barefoot or in socks is associated with a 10-13	ABPG p61 ABPG p61 ABPG p61 ABPG p 62	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. 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



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		<p>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>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. 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</p>	<p>ABPG p64</p> <p>Chari et al. 2009 ⁽¹¹⁾</p> <p>Yi-Ju Tsai, Sang-I Lin. 2013 ⁽¹²⁾</p> <p>Hatton et al. 2013 ⁽¹³⁾</p> <p>Hubscher et al. 2011 ⁽¹⁴⁾</p> <p>High risk foot MOC ⁽¹⁵⁾ p16 &p3</p>	<p>compression stockings.</p> <p>For the purposes of this model the High Risk Foot is defined as a foot with progressive deformity, ulceration,</p>



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		insensate foot leading to skin breakdown. The resultant wound is prone to soft tissue sepsis, secondary osteomyelitis, and ultimately amputation.		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 , p3.
Educate that all inpatients are at increased risk of falling due to injury / illness/ medications		The physical environment takes on greater significance for people with diminished physical, sensory or cognitive capacity.	ABPG p94	
Shift by Shift Check	10.5.3	<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>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>APBG pxvi</p> <p>EAPBG ⁽¹⁶⁾ p25</p> <p>FRAMP education PowerPoint</p>	
Re-screen for Falls Risk after a fall, ward transfer or improvement or deterioration in medical condition	10.5	<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</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)
		<p>already fallen.</p> <p>Any changes in the environment, including transfers within or between rooms can increase confusion and agitation, and may also increase risk of falls.</p>	ABPG p50	
Other Individualised Interventions	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 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.</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)
Communication and Information to Patients and Carers	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>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>	SQIG p27 SQIG p27 SQIG p27 ABPG p17 ABPG p17 ABPG p17 FRAMP education PowerPoint	Outputs may include: patient clinical record audit and care plan audit undertaking to ensure patient and carer input in falls prevention plans.
Important Practice Points		<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</p>	WA PFMG ⁽¹⁷⁾ p10 WA OMC ⁽¹⁸⁾ P48	



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)
		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. Consider vitamin D supplementation as a routine management strategy for mobile older patients.	SQIG p21	



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"> • falls prevention requirements • falls screening and assessment • management of falls risks including <ul style="list-style-type: none"> ○ 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 	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.
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.

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*. Sydney : ACSQHC, 2009.
2. Australian Commission on Safety and Quality in Health. *Safety and Quality Improvement Guide Standard 10: Preventing Falls and harm from Falls*. Sydney : ACSQHC, 2012.
3. National Institute for Health and Care Excellence. *NICE Clinical Guideline 161. Falls: Assessment and Prevention of falls in Older People*. Manchester : NICE, 2013.
4. Schofield I, Stott DJ, Tolson D, McFadyen A, Monaghan J, Nelson D. Screening for cognitive impairment in older people attending accident and emergency using the 4-item Abbreviated Mental Test. *European Journal of Emergency Medicine*. 2010, 17(6): 340-342
5. Cameron ID, Gillespie LD, Robertson MC, Murray GR, Hill KD, Cumming RG, Kerse N. *Interventions for preventing falls in older people in care facilities and hospitals (Review)*. London : The Cochrane Collaboration, 2013.
6. Australian Commission on Safety and Quality in Health. *A better way to care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital - Actions for Clinicians*. Sydney : ACSQHC, 2014.
7. National Institute for Health and Care Excellence. *NICE Guideline 103. Delirium: Diagnosis, prevention and management. Quick reference guide*. London : NICE, 2010.
8. Kvelde T, McVeigh C, Toson B, Greenaway M, Lord SR, Delbaere K, Close JCT. Depressive Symptomatology as a Risk Factor for Falls in Older People: Systematic Review and Meta-Analysis. *JAGS*. 2013, Vol. 61, (5): 694–706.
9. Australian Commission on Safety and Quality in Health. *A better way to care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital - Actions for health service managers*. Sydney : ACSQHC, 2014.
10. Australian Commission on Safety and Quality in Health Care. *Evidence for the safety and quality issues associated with the care of patients with cognitive impairment in acute care settings: a rapid review*. Sydney : ACSQHC, 2013.
11. Chari S, Haines T, Varghese P, Economidis A. Are non-slip socks really 'non-slip'? An analysis of slip resistance. *BMC Geriatrics*. 2009, Vol. 9, 39.
12. Yi-Ju Tsai, Sang-I Lin. Older adults adopted more cautious gait patterns when walking in socks than Barefoot. *Gait & Posture* . 2013, 37.
13. Hatton A, Sturnieks DL, Lord SR, Lo JCM, Menz HB, Menant JC. Preventing Falls in Older People: The Role of Footwear and Lower-Extremity Interventions. *J Am Podiatr Med Assoc*. 2013, Vol. 103, (6): 471-479.
14. Hubscher M, Thiel C, Schmidt J, Bach M, Banzer W, Vogt L. Slip resistance of non-slip socks – An accelerometer-based approach. *Gait & Posture*. 2011, (33): 740–742.
15. Department of Health, Western Australia. *High Risk Foot Model of Care*. Perth : Health Networks Branch, Department of Health, Western Australia, 2010.
16. The Centre of Research Excellence in Patient Safety, School of Public Health and Preventive Medicine, Monash University. *An evaluation of the preventing falls and harm from falls in older people best practice guidelines for Australian hospitals*. Melbourne : 2012.

17. Department of Health, Western Australia. *Post-Fall Management Guidelines in WA Acute Healthcare Settings*. Perth : Health Networks Branch, Department of Health, Western Australia, 2013.
18. Department of Health, Western Australia. *Osteoporosis Model of Care*. Perth : Health Networks Branch, Department of Health, Western Australia, 2011.



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