



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____		M.O.
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

Following completion of the Falls Risk Screen, implement the appropriate action/s for the identified falls risk factors

Complete on:	A <input type="checkbox"/>	PF <input type="checkbox"/>	PF <input type="checkbox"/>
Admission (A), Post Fall (PF), Change of Condition (CC), or When Appropriate (W)		CC <input type="checkbox"/>	CC <input type="checkbox"/>
		W <input type="checkbox"/>	W <input type="checkbox"/>

Risk factors and actions implemented	Date	Date	Date
Initial and date action if patient has any of these risk factors			

1. History of Falls

Obtain details about previous fall in the last 6 months (medical record, family/carer)

ACTION:

Patient describes: loss of consciousness, syncope, blackout, seizures, osteoporosis (bone health). Refer to Medical Team for review

Does the patient have postural hypotension?
Refer to Medical team for review

Additional Comments:

2. Mental Status

If this patient is confused, disoriented, agitated or depressed

ACTION:

Conduct or refer for a cognitive screen (e.g. AMTS, SIS, MMSE, RUDAS)

Consider delirium. Complete or refer for a Confusion Assessment Method (CAM)

Identify possible causes for delirium (e.g. sepsis, pain, constipation, urinary retention, medication related or infection). Refer to Medical Team for review

Implement a Delirium Care Pathway (as per LHD protocol)

Commence communication plan with family/carers (e.g. Top 5)

Patient requires increased observation (**avoid use of bed rails**)

Patient with confusion NOT to be left alone during planned toileting/showering

Locate patient near nurses' station if possible or co-locate to 'high risk' room

Consider behavioural chart if patient's behaviour is disruptive/unsafe

Provide bed at appropriate patient height and/or floor bed at lowest level
 lo-lo bed hi-lo bed

Provide bed/chair alarm (if available/appropriate)

Refer to Allied Health/Medical Team for review (if available/appropriate)

Additional Comments:

3. Vision

If the patient has visual impairment (e.g. cataract, glaucoma, macular degeneration)

ACTION:

Ensure easy access to bathroom and toilet

Direct patient to seek assistance when mobilising

Ensure adequate night lighting in ward (e.g leave toilet light on at night)

Refer to Allied Health/Medical Team for review (e.g. if appropriate/available)

Additional Comments:



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FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP) SMR060.912



FAMILY NAME

MRN

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MALE FEMALE

D.O.B. ____/____/____

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ADDRESS

Facility:

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Risk factors and actions implemented	Date	Date	Date
Initial and date action if patient has any of these risk factors			
4. Toileting If the patient has confusion, urinary or faecal frequency, incontinence, urgency, nocturia or other toileting issues ACTION:			
Provide patient with individualised (supervision/assistance) toileting plan (e.g. regular toileting, rounding) and document in care plan			
Patient to be always supervised when mobilising to the toilet/bathroom			
Patient to be supervised in toilet/bathroom			
Refer to Continence nurse and/or Allied Health review (if available)			
<i>Additional Comments:</i>			
5. Transfer/Mobility If the patient has issues that affect balance/mobility/transfer that require assistance/equipment or safe footwear ACTION:			
Referral to Physiotherapist for mobility assessment and mobility plan (if available)			
Referral to Occupational Therapist for functional assessment (if available)			
Provide patient with equipment to assist mobility/transfer/self care			
Provide patient with assistance/supervision to mobilise to the bathroom			
Provide patient with assistance for personal care			
Provide patient with assistance/supervision in bathroom/toilet (not to be left alone)			
Ensure patient has access to non-slip footwear (e.g. shoes, non-slip socks)			
<i>Additional Comments:</i>			
6. Medications If the patient is taking antipsychotics, antidepressants, sedatives/hypnotics, or opioids ACTION: Refer to treating Medical Officer for medication review			
<i>Additional Comments:</i>			
Place Falls Sticker on Care Plan and patient health record to alert staff and on documentation when transferring in hospital (e.g x-ray, pathology)			
All appropriate actions are identified and implemented			
Falls risk discussed and intervention developed in partnership with patient/family/carer & resource information provided <i>Comments:</i>			
Staff member attending to the assessment/action plan	Name: _____	Name: _____	Name: _____
Other Comments:	Designation: _____	Designation: _____	Designation: _____
	Signature: _____	Signature: _____	Signature: _____

Flag and communicate falls risk status and interventions in place at each clinical handover

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