NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

SMR060912

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

Complete on: **Admission (A), Post Fall (PF), Change of Condition (CC), or When Appropriate (W)**	A ☐	PF ☐ CC ☐ W ☐	PF ☐ CC ☐ W ☐
Risk factors and actions implemented Initial and date action if patient has any of these risk factors	**Date**	**Date**	**Date**
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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Risk factors and actions implemented Initial and date action if patient has any of these risk factors	**Date**	**Date**	**Date**
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)			
Additional Comments:			
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)			
Additional Comments:			
6. Medications If the patient is taking **antipsychotics, antidepressants, sedatives/hypnotics, or opioids** **ACTION:** Refer to treating Medical Officer for medication review			
Additional Comments:			
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 *Comments:*			
Staff member attending to the assessment/action plan Other Comments:	Name: _____ Designation: _____ Signature: _____	Name: _____ Designation: _____ Signature: _____	Name: _____ Designation: _____ Signature: _____

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