Falls Prevention and Management for People admitted to Acute and Subacute Care

Care of Adult Inpatients

Part 2: FRAMP & Post Fall Management

August 2018
Introduction

This procedure outlines the processes required to prevent & manage falls for people admitted to both acute & sub-acute facilities across the South Western Sydney Local Health District (SWS LHD).
What is the FRAMP!

The falls risk screening tool identifies the risk.

The FRAMP is the documentation of what you have done about the identified risk!
Falls Risk Assessment & Management Plan

- Adults who score greater \( \geq 9 \) (i.e. at high risk) or where the override button has been utilised, must have a FRAMP completed.

- Anyone who has an in-patient fall must be identified as ‘High Risk’ from that point onwards during their hospital stay.

- The FRAMP addresses the patient’s individual falls risk factors.

- The FRAMP is completed or reviewed;
  - On Admission (A)
  - Weekly -if there has been no change in condition (W)
  - When a patient’s condition changes (CC)
  - Post Fall (PF)
PLEASE NOTE:

Any identified risk on the falls risk assessment, regardless of the patient’s final score, should have a management plan (FRAMP) completed for that specific risk/s

i.e. Scoring 2 for incontinence but 0 for all other risk factors, the patient should have the FRAMP completed for the incontinence section to initiate strategies such as referral to continence nurse or timed toileting etc.
FRAMP

- Actions undertaken as part of the FRAMP must be signed & dated
- The FRAMP is evidence of a comprehensive assessment & management plan
- Duplication in the progress notes is not required
- The FRAMP is a multidisciplinary tool & all disciplines should participate in its development and respond to any referrals made
FRAMP – Case Study Mrs P

- 87 year old lady adm post fall at home.
- Went to the toilet at 12 am & fell on the floor.
- Found the next morning by a carer at 8am.
- She felt light headed prior to her fall.
- X-ray shows # R colles
- Pt R handed & holds a w/s in right hand.
- Hx 3 falls in the last month nil injuries & has always managed to get up.
- 2 falls occurred at night going to the toilet
- 1 fall getting up from the chair after dinner.
- Mrs P is alert & orientated but is afraid of falling again.
- She a very independent lady, husband died 10 yrs ago & states she doesn’t want any fuss.
FRAMP – Case Study Mrs P (continued)

- Whilst talking to her she is trying to unpack her bag.
- She has her wrist in a back slab and has been started on Targin with breakthrough Endone to help reduce her pain.
- She wears glasses for reading.
- She wear incontinent pads “just in case” as she can get urge incontinence.

A Falls Risk Assessment was completed on admission to the ward she scored:

- **Hx of Fall** = 6 (3 previous falls)
- **Mental Status** = 14 (fear of falling & impulsive)
- **Vision** = 0 (only has reading glasses)
- **Toileting** = 2 (has urge incontinence)
- **Mobility** = 0 (TS =1 MS = 1, Total =2)

**Total Score = 22 – High Risk**
NSW Health

Facility: INSERT

NAME

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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)

Risk factors and actions implemented

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:

1/6/18

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

Does the patient have postural hypotension?

Refer to Medical team for review


2. Mental Status

If this patient is confused, disoriented, agitated or depressed

ACTION:

Anxiously

1/6/18

Conduct or refer for a cognitive screen (e.g. MMSE, MoCA, RIKUTA)

Conduct 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/carer (e.g. Top 5)

Patient requires increased observation (avoid use of bed rails)

1/6/18

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

1/6/18

Locate patient near nurse’s station if possible or co-locate to high-risk room

1/6/18

Consider behavioral chart if patient’s behavior is disruptive/unsafe

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

1/6/18

Provide chair alarm (if available/appropriate)

2/1/18

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

2/1/18

Additional Comments: Referred to OT for OPAH; sensor mat ordered 1/6/18

3. Vision

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

ACTION:

1/6/18

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/applicable)

Additional Comments: Masks glasses - in reach - only for reading

4. Transferring/Mobility

If the patient has issues that affect balance/mobility/transfer that require assistance/equipment or safe footwear

ACTION:

Refer to Physiotherapist for mobility assessment and mobility plan (if available)

1/6/18

Refer to Occupational Therapist for functional assessment (if available)

1/6/18

Provide patient with equipment to assist mobility/transfer/self-care

1/6/18

Provide patient with assistance/supervision to mobilise to the bathroom

1/6/18

Provide patient with assistance for personal care

1/6/18

Provide patient with assistance/supervision in bathroom/toilet (not to be left alone)

1/6/18

Ensure patient has access to non-slip footwear (e.g. shoes, non-slip socks)

1/6/18

Additional Comments: No support desired, encouraged to walk when mobile

5. Medications

If the patient is taking antipsychotics, antidepressants, sedative/hypnotics, or opioid pain medication

ACTION: Refer to treating Medical Officer for medication review

1/6/18

Additional Comments:Morice Falls Sticker on Care Plan and patient health record to alert staff on documentation when transferring in hospital (e.g. x-ray, pathology, scans)

1/6/18

Flag and communicate falls risk status and interventions in place at each clinical handover
Nursing Considerations in Falls Management

- Consider 1:1 supervision for patients at high risk of falling.
- High Risk patients must be accompanied & remain supervised whilst in bathroom areas. Risks of being left unattended should be explained to patients / carers.
- Incontinence, urgency & urge incontinence can lead to patients having falls.
- Patients taking diuretic or laxative medication can have increased frequency & urgency. Consider regular toileting & other strategies to reduce risk of falling.
- Completing bathroom activities are complex tasks which requires balance, ability to dual task & endurance.
Restraints and Footwear

- Restraints are not to be used as a mechanism to prevent falls. Refer to SWSLHD_GL2016_003 Delirium.

- Bed rails should never be used with patients with confusion. Refer to SWSLHD_PD2014_031 Safe and Effective Use of Bedrails.

- Correctly fitting, supportive shoes can reduce the risk of a fall in hospital.

- Mobilising in ill-fitting slippers, socks or surgical stockings (without non-slip soles) should be strongly discouraged.
Equipment

- Equipment & devices should be available to implement prevention strategies for patients at risk of falling

- Equipment may include: alarm devices, lo-lo beds, transfer belts, non-slip socks, protective headwear & hip protectors

- Equipment log should be kept at unit level. It should identify; available equipment, whether equipment is meeting the unit’s needs & monitor maintenance processes
Post Fall Management

- Management of fall incidents must be in line with the CEC Post Fall Guide. Check for sepsis, delirium & head injury.
- Immediate response must assess the need for Basic Life Support.
- Undertake a rapid assessment to check for; pain, bleeding, injury, possible fracture.
- Ask for assistance. If the patient is able to be moved, help the patient back to a chair / bed using manual handling techniques.
Post Fall Management

- Take baseline **vital signs** (BP, HR, RR, O2 Sats, Temp, BSL & pain score). Repeat **hourly for first 4 hours & then 4 hourly for 24 hours**, or as clinically indicated.

- **Neuro Ob’s** are mandatory post fall, regardless of whether the patient hit their head. Ob’s should be undertaken **hourly for first 4 hours & then 4 hourly for 24 hours**, or as clinically indicated.

- The above observations applies to **ALL PATIENTS** including those with a current NFR, not for CRC or not for Observations order.

- **All patients must be referred for a medical review after the incident.**
Intracranial bleeding can occur even in the absence of a direct injury to the head

Indication for a CT scan:

- GCS <15 at 2 hours post injury (for patients who were a GCS of 15 pre fall)
- Deterioration in GCS
- Focal neurological deficit
- Age >65 years
- Clinical suspicion of skull fracture
- Vomiting (especially if recurrent)
- Dangerous mechanism of fall
- Seizure
Indications for CT Scan cont.

- Patient on anticoagulants, anti-platelets or has a known coagulopathy / bleeding disorder (e.g. haematological disease or chronic renal failure)
- Prolonged loss of consciousness (>5mins)
- Persistent post traumatic amnesia (A-WPTAS <18/18 at 4 hours post injury)
- Persistent abnormal alertness / behaviour / cognition
- Persistent severe headache
- Large scalp haematoma or laceration
- Known neurosurgery / neurological impairment.
- Multi-system trauma
Post Fall Management (Continued)

- As soon as possible inform the patient’s family/carers
- Complete the post fall form on eMR (or the post fall sticker for those units still using paper notes)
- Repeat the falls risk assessment
- Document the risk status, flagging high falls risk on the journey board
- The FRAMP must be completed / revised post fall incident
- Clinical handover must include; risk status, prevention strategies, description of incident & post fall management
Post Fall Management (Continued)

- A multidisciplinary approach should be taken to identify strategies to prevent falls & protect the patient’s safety

- MDT post-fall huddle at the patient’s bedside should occur as a mechanism to review the incident, ensure optimal post fall management & prevent further falls

- Record fall incident in IIMS

- Inform the Nursing Unit Manager or After Hours Nurse Manager
Clinical Handover when Transferring High Risk Patients

Clinical Handover must occur:

- Before transfer between units to assist in appropriate bed & staffing allocation
- When transferring temporarily to other departments (e.g. Radiology or OT) to ensure appropriate supervision is provided

- Inform ward orderlies or technical aids of the level of assistance required during transit
- Ensure the correct level of supervision is provided based on their falls risk & clinical status
Discharge Planning & Management

- The patient & carer should be advised of their high falls risk during hospitalisation, & should consult with their GP on D/C

- Falls Risk minimisation discussions should also be highlighted in the patients’ “My Passport of Care” document

- Communicate inpatient fall incidents and any ongoing falls risk factors to the patient’s GP, & refer to appropriate services (e.g. Able & Stable, Stepping On)
Conclusion

Falls Prevention is Everyone’s Business

This procedure provides best practice guidelines & tools for falls prevention. It describes the governance structures & processes required to deliver a proactive approach to reduce the frequency, severity of falls & injuries resulting from falls.
References

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References


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11. NSW Agency for Clinical Innovation Care of Confused Hospitalised Older Persons.

12. SESLHD Falls Prevention Procedure (Procedure No. SESLHDPR/380) [Internet]. 2016 [cited 2014 Dec].