

Transforming Falls Prevention with Digital FRAMP: A Collaborative Innovative partnership between SLHD/SWSLHD

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SLHD

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Safety Culture Coordinator
SWSLHD

2nd May 2025

Project Team

SWSLHD & SLHD:

- Digital Health Team (eMR clinical applications)
 - Clinical Governance
 - Falls Prevention Coordinators
 - Change Manager
 - Implementation Working Group (Nursing, Allied Health & Medical)
-

Background – why change ?



Recommendations
from HS1 and HS2
incidents



Poor compliance
Hybrid versions

- *pre-completed notes in eMR vs paper FRAMP*
- *causes confusion with staff re: source of truth*



Align with best
practice

- *Removal of Falls Scoring CEC White Paper and World Falls Guidelines*

Previous Practice



On admission to ward, falls management:

1. Adult Admission Assessment Checklist
2. Ontario Falls Risk Scoring
3. If Score >9, complete FRAMP (paper-based)
4. Document strategies in pre-completed notes
5. Strategies updated in Clinical Handover



Staff feedback:

- *Current process is repetitive*
- *The scoring does not reflect the actual risk of the patient*
- *Using the paper form does not ensure continuity of care with management strategies*
- *Clinicians were frustrated with how time-consuming the process is to complete risk scoring and paper FRAMP*

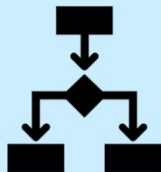
Aim



- To have a Falls Risk Assessment and Management Plan (FRAMP) in eMR

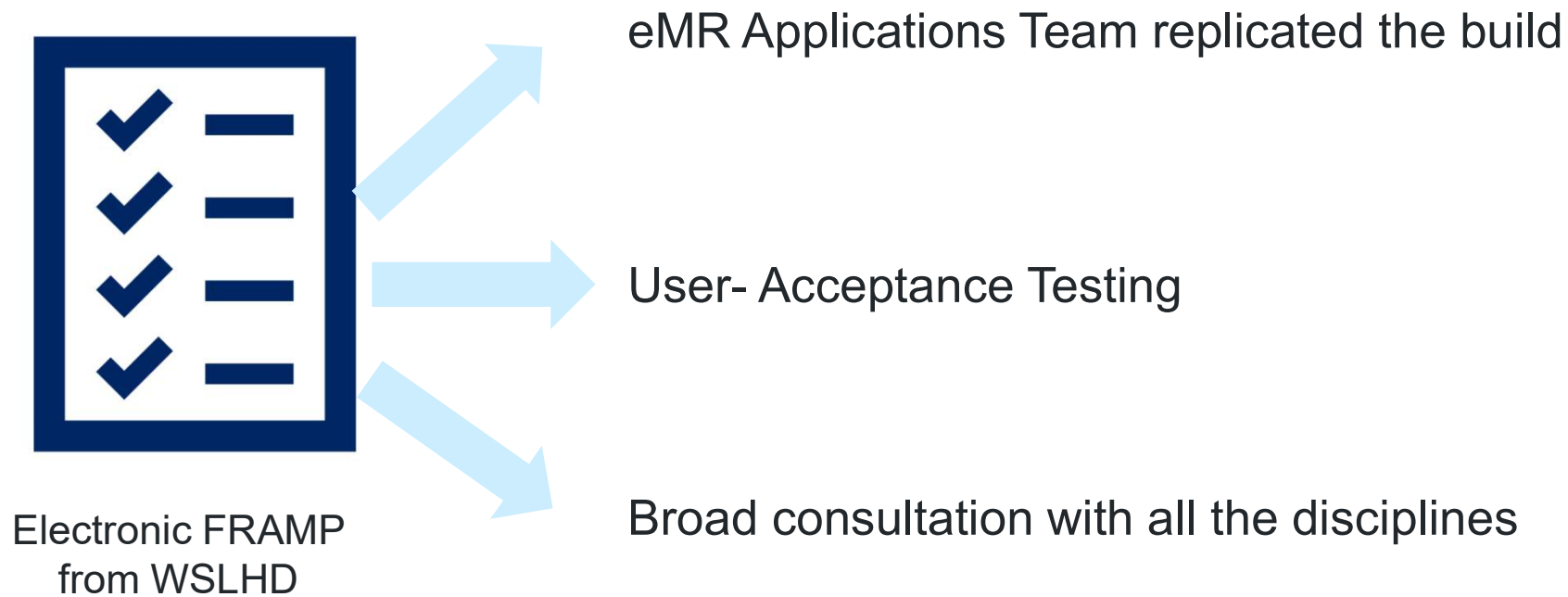


- To support clinicians with identifying falls risk factors and implement an individualised management plan for falls prevention



- To simplify current process and enhance critical thinking

Methodology



User-Acceptance Testing (UAT) and Clinicians Input



80 clinicians

- From both LHDs to validate workflow and functionality
- Allied health, medical and nursing



Scenario-based testing to:

- Validate documentation or actions are clear, intuitive and complete
- Evaluate form workflow supports consistency, continuity, supports or hinders safe and efficient care

FRAMP Demo



Falls Risk Assessment & Management Plan (FRAMP) - FRAMP, Test2

*Performed on: 30/04/2025 17:16 AEST By: Gacayan, Shereen Ivy Balbin (Clinical Nurse Educator)

Falls Risk Assessment and Management Plan (FRAMP)

Framp, Test2 MRN: 179-43-41 DOB: 02/01/1950 AGE: 75 Years MC: 9999 99999 9 9
2 Hospital Street LIVERPOOL 2170 SEX: F LOC: CTC Admissions; A; 001
ABORIGINALITY: Neither

i - Indicates Reference Text exists for this field. To access, right click in the field and select Reference Text.

Implement the appropriate action/s for the identified falls risk factors

FRAMP Completed On ☐ Admission ☐ Change of Condition ☐ Post Fall ☐ When Appropriate

History of Falls

Has the patient had a fall in the last 12 months? ☐ Yes ☐ No

The patient has medical condition(s) that may contribute to a fall. ☐ Yes ☐ No

The patient has issues that affect balance/mobility/transfer that require supervision, assistance and/or mobility aids. ☐ Yes ☐ No

Actions for History of Falls, for example:
- document mechanism of previous fall, need for orthostatic BP, etc.

Segoe UI 9

Sensory - Vision & Hearing

The patient has visual impairment (e.g. cataract, glaucoma, macular degeneration, uses eye glasses). ☐ Yes ☐ No

The patient has hearing impairment (e.g. loss, cochlear implant, uses hearing aids). ☐ Yes ☐ No

Actions for Vision and Hearing, for example:
- document sensory aids and any specific individualised care.

Segoe UI 9

In Progress

FRAMP Demo



FRAMP, Test2 - 179-43-41 Opened by Gacayan, Shereen Ivy Balbin (Clinical Nurse Educator)

Task Edit View Patient Chart Links Notifications Options Help

Tear Off Change Intranet SLHD CareCompass Patient Access List Patient List Multi-Patient Task List Scheduling Cardiovascular Message Center Patient Dashboard Task Manager Community Client List Results: 0

FRAMP, Test2

MRN:179-43-41 02/01/1950 Female 75 Years

No Alerts Recorded

LIVERPOOLH Inpatient CTC Admissions;A;001 Adm: 24/02/2025 ServCat:Acute

Menu

- Patient Summary
- Results
- ContinuousDoc
- Clinical Notes
- Form Browser
- Documentation
- I-View
- Advance Care Documents
- BTF Observation Chart
- Orders
- Patient/Encounter Information
- Perioperative Communication
- Diagnoses, Alerts & Ongoing Prob...
- Histories
- Allergies & Adverse Reactions (AD...
- Medication List + Add
- Medication Alert History
- Medication Request Summary
- MAR
- MAR Summary
- High Risk Medications
- Pregnancy Summary Report
- Patient Schedule
- CHIE - NSW Shared Record View
- HealthNet

Form Browser

24 February 2025 AEDT - 01 May 2025 AEST(Admission - Current)

Sort by: Date

All Forms

- Thursday 01 May 2025 AEST
 - 09:36 AEST Falls Risk Assessment & Management Plan (FRAMP) (Auth (Verified)) - Gacayan, Shereen Ivy Balbin (Clinical Nurse Educator)
 - 09:30 AEST Falls Risk Assessment & Management Plan (FRAMP) (Auth (Verified)) - Gacayan, Shereen Ivy Balbin (Clinical Nurse Educator)
- Wednesday 30 April 2025 AEST
 - 17:41 AEST Falls Risk Assessment & Management Plan (FRAMP) (Modified) - Gacayan, Shereen Ivy Balbin (Clinical Nurse Educator)

ASCRT 60026270 01 May 2025 09:38 AEST

Go-live FRAMP 11th March 2025



Falls Prevention and Management Procedure



Very successful Engagement and awareness through:

- Roadshows across SLHD and SWSLHD
- Memo
- Countdown banner on the intranet



Training and Education Prior to Go-live

- Mixed modes: face to face and webinar sessions
- Train the trainer
- Quick Reference Guide, My Health Learning Training Module, FAQs, training video

What are our clinicians telling us



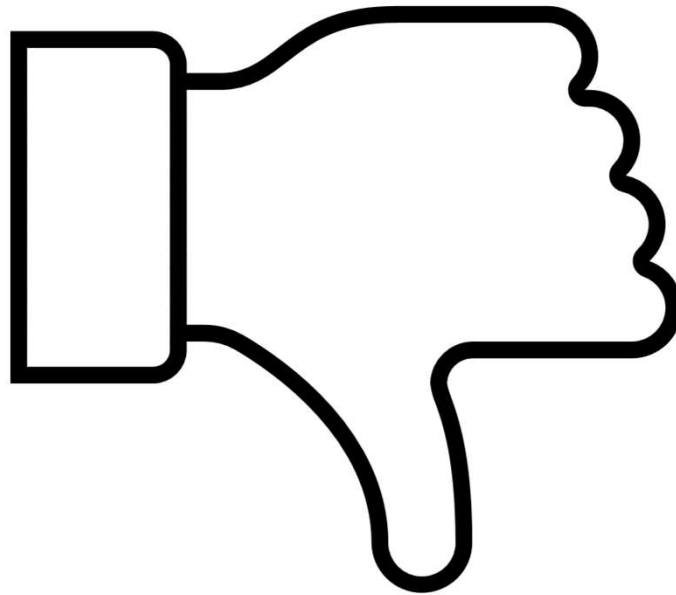
*“fosters collaboration between MDTs”
“love the reference guide”*

*“very
comprehensive”*

*“The form is more clear and useful
to fill in correct information about
the patient’s risk factors of falling”*

*“I like that you do not lose the
information previously provided
once you re-launch the form for re-
assessment”*

Did we miss the Falls Risk Scoring?



Comprehensive Care Plan

FRAMP

Input from FRAMP is automatically populated into Comprehensive Care Plan:

- *Mobility*
- *Medication safety*
- *Cognition*
- *Communication and sensory needs*
- *Personal Care*



Reduces duplication, documentation fatigue and promotes continuation of care

Comprehensive Care Plan

Comprehensive Care Plan

Name: ACCREDITATION, Balmain

MRN: 359023

DOB: 01/01/1945

Age: 80 Years

Ward: J/BEAS

Bed: 00

Aboriginality: Declined to respond

NDIS: Reason for Admission: Fall

Diagnosis: Interpreter Required: No

Last Signed by: Nurse, Balmain

Some information in this document is automated from other areas of eMR. If any automated information needs updating, go to the source document (such as the FRAMP) and update the information there. It will then transcribe across correctly.

Text in Italics is from the previously signed Comprehensive Care Plan and can be updated if clinically appropriate and the care plan has changed.

i Indicates Reference Text exists for this field. To access, right-click in the field and select "Reference Text".

Reason for Admission

If required, provide more information on reason for admission below. If reason for admission has changed, please follow your ward process to update this information in the patient registration system (PAS).

Segue UI

9

80 yo F admitted w/ 5/7 history of increased confusion resulting in 2x falls at home.

Partners in Care

Carer Information

Carer: Not Applicable

Relationship to Patient: Self

Full Name: ACCREDITATION, Balmain

Address: 123 Sydney Rd BALMAIN NSW 2041 AUSTRALIA

Provide carer details please update if changed

Segue UI

9

Patient does not have a carer

Introduction

What matters to me (Top 5):

Segue UI

9

Patient responses are not rational to the questions. Family engaged to assist with patients what matters to me.

1. Patient wants to remain as independent as possible.

Fundamentals of Care

Full Name: ACCREDITATION, Balmain

Address: 123 Sydney Rd BALMAIN NSW 2041 AUSTRALIA

Introduction

What matters to me (Top 5):

Segue UI

9

Patient responses are not rational to the questions. Family engaged to assist with patients what matters to me.

1. Patient wants to remain as independent as possible.

Fundamentals of Care

Communication and Sensory Needs:

Does the patient have visual impairment (e.g. cataract, glaucoma, macular degeneration, uses eye glasses)? Yes

Does the patient have hearing impairment (e.g. loss, cochlear implant, uses hearing aids)? No

Actions for Vision and Hearing, for example: document sensory aids and any specific actions for vision and hearing.

Personal Care:

Toileting level of assistance required: Full Care

Continence : Urinary incontinence

Actions for individualised toileting plan: Toilet frequency: 2 hourly during the day and 3 hourly at night.

Incontinence pads in situ as patient has not been asking nurses to take them to the

Behaviour Support:

Last charted 4AT score and score date: 12, 24/02/2025

4AT Result: Possible delirium +/- cognitive impairment (Score =>4)

Does the patient present with confusion, disorientation, agitation, depression or has dementia or delirium? Yes

Is there a change in 'usual' behaviour or new onset of confusion?(ask the carer/family if possible)? Yes

Mobility:

Date of FRAMP completed: 24/02/2025

Has the patient had a fall in the last 12 months? Yes

Does the patient have medical condition(s) that may contribute to a fall? Yes

Does the patient have issues that affect balance/mobility/transfer that require supervision, assistance and/or mobility aids? Yes

Other: (e.g. medication safety, pressure injury prevention, minimising restrictive practices, etc.)

Is the patient taking any high-risk medications and/or taking 4 or more medications (polypharmacy)? Yes

Actions for high-risk medications and/or polypharmacy.Consider a Pharmacist and/or Medical review?

Pharmacist review has been requested for medication.

Nutrition Provision:

Segue UI

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Full diet with Sustain

Goals of Care

Communication and:

Segue UI

9

Patient responds to communication

Personal Care - Add:

Segue UI

9

Previous baseline is

Goals of Care - This Admission:

Segue UI

9

Identify and treat cause of new delirium, Provide education about falls management to family.

Plan: (Changes in health or circumstances, next steps in the care plan)

Segue UI

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Await medical and AH reviews.

Goals for Discharge and Transitions of

Segue UI

9

Await further assessment. Patient's go

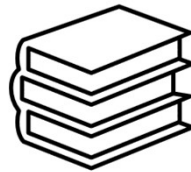
What's next?



Formal evaluation



Impact on patient care and safety



Research on risk management vs. risk scoring

Acknowledgment



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Tamsin McVeigh
Wendy Tilden

Find out more!

