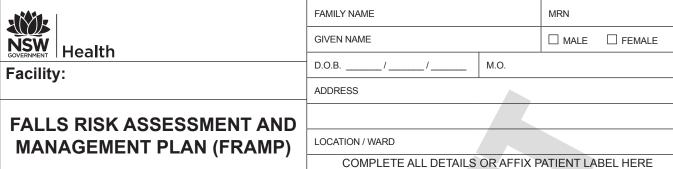
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RISK ASSESSMENT AND
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Following completion of the Falls Risk Screen, implement the appropriate action/s for the identified falls risk factors

Complete on:	Α□	PF □	PF 🗆
Admission (A), Post Fall (PF), Change of Condition (CC), or When Appropriate (W)		сс□	сс□
		w□	w□
Risk factors and actions implemented Initial and date action if patient has any of these risk factors	Date	Date	Date
Initial and date action if patient has any of these risk factors			
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:			

NO WRITING Page 1 of 2

NSW GOVERNMENT Health	GIVEN NAME		☐ MALE ☐ FEMALE		
Facility:	D.O.B// M.O.				
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					1
FALLS RISK ASSESSMENT AND					-
MANAGEMENT PLAN (FRAMP)					
· ,	COMPLETE ALL DETAILS (OR AFFIX PAT	IENT LABEL	HERE	
Risk factors and actions implemented		Date	Date	Date	
Initial and date action if patient has any of these risk factor	ors				4
4. Toileting If the patient has confusion, urinary or faecal frequency, inocturia or other toileting issues ACTION:	incontinence, urgency,				
Provide patient with individualised (supervision/assistant (e.g. regular toileting, rounding) and document in care p					
Patient to be always supervised when mobilising to the to	oilet/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/transequipment or safe footwear ACTION:					
Referral to Physiotherapist for mobility assessment and r					
Referral to Occupational Therapist for functional assessn					_ =
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/					6
Ensure patient has access to non-slip footwear (e.g. sho	es, non-slip socks)				_
Additional Comments:					
6. Medications If the patient is taking antipsychotics, antidepressants, ACTION: Refer to treating Medical Officer for medication		5			
Additional Comments:					
Place Falls Sticker on Care Plan and patient health red documentation when transferring in hospital (e.g x-ray, p					
All appropriate actions are identified and implemented					
Falls risk discussed and intervention developed in partial family/carer & resource information provided Comments:	rtnership with patient/				
					\mathbb{Z}
Staff member attending to the assessment/action plan		Name:	Name:	Name:	SMR060912
Other Comments:		Designation:	Designation:	Designation:	912
		Signature:	Signature:	Signature:	

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

FAMILY NAME

GIVEN NAME

MRN

Page 2 of 2 NO WRITING **BINDING MARGIN - NO WRITING** Holes Punched as per AS2828.1: 2012