The Falls Assessment and Management Plan and Post Fall Clinical Pathway Revised Version
What is the Falls Assessment and Management Plan

The Falls Assessment and Management Plan (FAMP) is a state wide clinical form that has been designed to document initial and ongoing falls injury prevention strategies. It focuses on three key components:

✓ Risk Factors
✓ Actions
✓ Management strategies.
Why do we need it?

The National Safety and Quality Health Service (NSQHS) Standards not only provides guidelines to help deliver safe and quality care; but is also a key component of the accreditation process for all QH facilities. There are ten standards and **Standard 10** relates to *Preventing Falls and Harm from Falls*.

This tool has been developed and designed to help clinicians provide best practice care and meet requirements set out within the National Standards.
How was it developed?

• This tool was developed in 2010 in response to requests from clinicians for a purpose designed form to facilitate the implementation of best practice care for our patients in Queensland Health (QH) facilities.

• The Patient Safety Unit together with clinicians across the state have collaborated to develop this tool.

• Recently completed a review process that involved consultation with clinicians from around Queensland, human factors, graphic designer and form specialist’s.
So how do I fill in the form?

The next few slides will outline how to fill in the 3 components of the form:

Page 1
Risk Factors & Actions

Page 2
Management Plan
Risk Factors and Actions

The first area of the tool to complete is the Falls Risk Factors and Actions Date, Time and Signature block.

Note that time is now included.

This is a measured key performance indicator for all HHS facilities and therefore it is important to ensure that the time and date of admission are documented.
Reassessment of the patient is to occur

- at a minimum weekly,
- when there is a change in condition, medication, after a fall and on discharge.

It is important to remember that care outlined must be altered if not clinically appropriate for the individual patient.
Page 2 Falls Management Plan

Preventing and Managing falls requires a multifaceted planning approach and interventions will vary depending on the individual patient and their identified risk factors.

The Management Plan is divided into 5 sections:

- **Communication** between health care professional the patient and/or carer. Communication between health care professionals.

- **Environment /Equipment** needs required by the patient to reduce their risk of falling.

- **Observations** required.

- **Other Care** strategies that may be implemented by the multidisciplinary team.

- **Discharge Planning /Education** given to the patient.

Each strategy implemented requires a signature.

Finally, on the bottom of page 2 is a signature log for all staff who complete this form. This document becomes a record of care and there is no need to duplicate information in the patient progress notes.
Changes made to align with ieMR and in response to the Expert working Group

- Format changed to align with the ieMR format
- Time added
- Risk screen incorporated into risk factors
- Space for 3 separate assessment rather than once only assessment
- Signature at the top and tick appropriate actions
- Signature box removed from the bottom
Management Plan

- Form aligns with ieMR
- Time added
- Actions removed from management plan e.g. Dietician review has been added to the actions on page 1
- Space for 3 separate assessments rather than once only
Murray is a 73 year old male admitted for investigation of new onset confusion and decreased mobility. Murray has chronic back pain. He has been admitted from his assisted living unit.

**Background:**

- Recent history of falls (4 weeks ago)
- Mobilises with a 4 wheeled walker
- Visual impairment - wears glasses
- Has urinary frequency
- Usually very independent and walks to the local shop daily.
- Murray is reluctant to ask for extra help as he is worried that he will lose his independence
- Very supportive daughter
- Dispenses own medications which include an anti-hypertensive, PPI, anti depressant, paracetamol and oxycodone (Endone)
**Risk Factors and Actions**

**Queensland Stay On Your Feet**

**Case Study**

Murray is a 73 year old male admitted for investigation of confusion and decreased mobility. Murray has chronic back pain. He has been admitted from his assisted living unit.

- **Background:**
  - Recent history of falls (4 weeks ago)
  - Mobilises with a 4 wheeled walker
  - Visual impairment - wears glasses
  - Has urinary frequency
  - Usually very independent and walks to the local shop daily.
  - Murray is reluctant to ask for extra help as he is worried that he will lose his independence
  - Very supportive daughter
  - Dispenses own medications which include an anti-hypertensive, PPI, anti depressant, paracetamol and oxycodone

---

[Image of risk assessment form with multiple risk factors and actions listed]
# Queensland Stay On Your Feet®

## Management Plan

### Case Study

Murray is a 73 year old male admitted for investigation of confusion and decreased mobility. Murray has chronic back pain. He has been admitted from his assisted living unit.

- **Background:**
  - Recent history of falls (4 weeks ago)
  - Mobilises with a 4 wheeled walker
  - Visual impairment - wears glasses
  - Has urinary frequency
  - Usually very independent and walks to the local shop daily.
  - Murray is reluctant to ask for extra help as he is worried that he will lose his independence
  - Very supportive daughter
  - Dispenses own medications which include anti-hypertensive, PPI, anti depressant, paracetamol and oxycontin

---

### Queensland Government

#### In-patient Falls Assessment and Management Plan

- **Name:** Murray
- **Address:** 123 Example Street, Example Suburb
- **Date of birth:** 01/01/1942

<table>
<thead>
<tr>
<th>Category</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>In partnership with patient and carer, discuss falls risk factors and develop falls prevention plan</td>
<td></td>
</tr>
<tr>
<td>Provide written falls prevention information (e.g. Stay On Your Feet® Fact Sheet)</td>
<td></td>
</tr>
<tr>
<td>Communicate patient's 'at risk' status at bedside handover</td>
<td></td>
</tr>
<tr>
<td>Instruct patient to call for assistance when getting out of bed (if mobilising)</td>
<td></td>
</tr>
<tr>
<td>Environment / Equipment</td>
<td></td>
</tr>
<tr>
<td>Orientate patient to surroundings, routine and location of bathroom and toilet</td>
<td></td>
</tr>
<tr>
<td>Ensure clutter free and safe environment (e.g. night-time lighting)</td>
<td></td>
</tr>
<tr>
<td>Ensure the bed height and position are suitable for the patient's needs</td>
<td></td>
</tr>
<tr>
<td>Apply bed-belts correctly</td>
<td></td>
</tr>
<tr>
<td>Ensure bed rails are at appropriate height for patient's needs</td>
<td></td>
</tr>
<tr>
<td>Keep buzzer in reach, visible to patient on buzzer usage</td>
<td></td>
</tr>
<tr>
<td>Keep patient's routine belongings within reach</td>
<td></td>
</tr>
<tr>
<td>Keep patient's mobility aid to reach if applicable</td>
<td></td>
</tr>
<tr>
<td>Ensure patient footwear and / or footwear</td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td></td>
</tr>
<tr>
<td>Ensure frequent monitoring and surveillance</td>
<td></td>
</tr>
<tr>
<td>Conduct supervision during bed making / positioning</td>
<td></td>
</tr>
<tr>
<td>Ensure suitable toileting protocols are in place</td>
<td></td>
</tr>
</tbody>
</table>

### Other Care Needs

- Provide information on falls risk factors and prevention strategies
- Refer to OT for AID and home assessment
- Complete nursing discharge summary and facilitate referrals

### Signature Log

- **Date:** 01/01/2023
- **Nurse:** Example Name

---

*Stay On Your Feet® is used with permission from the Department of Health Western Australia.*
Helpful Links

When a patient falls there must be an immediate and urgent response to ensure the clinical wellbeing of the patient.

The Post Fall Clinical Pathway assists in the implementation of a consistent and thorough response to a fall.
The recommended immediate response to a fall is highlighted in the red bordered box.

Details of the fall and the patients vital signs are recorded on the PFCP and observation chart as soon as possible.
It is a recommendation that a medical officer be notified of the fall within 15 mins. It is important to record who was notified and at what time.

Medical Assessment is used to record the results of the assessment, initial diagnosis and recommendations.
• **Investigations/observations** guide the care plan for the patient over the next 8 hours, depending on the seriousness of the falls related injury.

• Observations are recommended for a suspected head injury or unwitnessed fall and for no head injury. These observation will be recorded in the patient observation chart.
- **Management Plan** within 24 hours prompts the clinician to undertake ongoing tasks as the result of the fall

- Every person documenting in the clinical pathway must supply their details and signature in the signature log
Summary

There is consistent evidence that falls are preventable. Identification of risk factors specific to individual patients targeting individual risk factors reduces the rate of falls, because patient specific care plans can be put in place. These state-wide tools are suitable for use in any QH hospital, subacute, rehabilitation, residential aged care or community facility.

These tools do not replace clinical judgement and are a guide to clinical assessment.

These tools has been developed and reviewed in consultation with stakeholders from across the state and has been developed to assist HHS’s:

- ✓ provide best available care for our patients
- ✓ provide for timely and accurate documentation
- ✓ comply with the recommendations outlined within Standard 10 of the NSQHS Standards