National Standard 10
Preventing Falls and Harm from Falls

SELF DIRECTED
LEARNING GUIDE
& QUESTIONNAIRE

2 CNE Points
Continuing Nurse Education
Points as part of Royal College of
Nursing, Australia Lifelong
Learning Program (3LP)

*This activity has been endorsed
by APEC number 091021001 as
authorised by Royal College of
Nursing, Australia according to
approved criteria*.
Index

Aims and Objectives .................................................................................................................. 3
Target Group.............................................................................................................................. 3
Nominal Hours ........................................................................................................................... 3
Delivery Mode/Learning Material .............................................................................................. 3
Resources/Facilitation ................................................................................................................ 3
CNE Point Allocation .................................................................................................................. 4
Introduction ............................................................................................................................... 4
The Falls Story in Australia ........................................................................................................ 5
Falls Statistics for Mater Rockhampton ....................................................................................... 6
What is the Impact ..................................................................................................................... 6
Consequences of Falling ............................................................................................................ 6
Characteristics of Falls ............................................................................................................. 7
Risk Factors for Falls ................................................................................................................ 7
The Identification of Falls Risk .................................................................................................. 8
Implementation of Falls Risk Identification and Falls Prevention Strategies ........................... 8
Education .................................................................................................................................. 11
Discharge Planning ................................................................................................................... 11
Post Fall Procedure .................................................................................................................. 11
Guidelines for Post Fall Interventions and Rationale ............................................................... 12
Appendix A How to rise after a Fall ......................................................................................... 16
References .................................................................................................................................. 17
Aims and Objectives

OBJECTIVES of Learning Package are:
In our private hospital setting, the objectives of the Preventing Falls and Harm from Falls Learning Package are:

1. To promote staff assessing patients for risk of falls accurately and promptly;
2. To promote adherence to the current best practice of falls prevention strategies;
3. To assess shortfalls and enhance education around falls prevention;
4. To enhance the evidence-based policy.

AIMS and intentions of this Learning Package are to:

- Raise awareness and educate nursing staff and the multidisciplinary team of the importance of maintaining a safe environment for all patients;
- Assist with identifying patients who are high risk of fall;
- Provide the tools to educate families and carers of the potential risk of falls and outline strategies to develop individualized management plans of care to reduce risk for high risk patients;
- To understand and manage the risk factors associated with falls prevention and management;
- To understand how to perform an accurate falls risk assessment using the organisational falls risk assessment tool – MR55;
- To develop an understanding of the falls risk assessment and implementation of standardized and individualized falls prevention strategies;
- To gain knowledge on the appropriate management of the patient post fall;
- To understand the consequences and impact of a fall on the patient;
- To develop an understanding of the required organisational documentation and communication of falls risk and management strategies to ensure appropriate and individualized patient care;
- To develop an understanding of the importance of consumer participation in the prevention and management of falls.

Target Groups

This package applies to clinical staff and staff in high risk areas in the Mater Hospitals of Rockhampton and Gladstone.

Nominal Hours

Approximately 2 hours including reading of the package and completion of activity and subsequent completion of theoretical assessment.

Delivery Mode/Learning Material

This learning material is presented in a self-directed mode of learning with subsequent completion of competency based assessment.

Resources/Facilitation

There are many resources available to you in addition to this learning guide, and we encourage you to access these resources as required, including:

- Fall Prevention and Management CP5 5.05 (to be accessed and read in conjunction with this package);
- Textbook and Journal Articles;
- Reference documents (found at the completion of this package);
- Resource People such as:
  - Clinical Managers/After Hours Managers
  - Clinical Nurse Educator
  - Members of the Allied Health Team i.e. Physiotherapist, Dietician
  - Level 2 and Senior Staff Members
  - Medical Staff
CNE Points
Successful completion of this mandatory self-directed learning guide and subsequent competency achievement where applicable, will attract 2 CNE points as this program is endorsed by the RCNA (Royal College of Nurses Australia).

Introduction

The World Health Organisation defines a fall as "inadvertently coming to rest on the ground, floor or lower level, excluding intentional change in position to rest in furniture, wall or other objects". Falls in older people cover a wide range of events, including:
- trips on raised obstacles (e.g. loose rugs, cords, mats) or uneven surfaces (e.g. footpaths, roads)
- slipping on wet or highly polished surfaces
- tumbles and stumbles down steps or stairs
- falling off a ladder or stepladder
- falling over in a shopping centre or while using public transport.

Falls are one of the largest causes of harm in health care and are a national safety and quality priority. The Australian Commission on Safety and Quality in Health Care (the Commission) assists health services to reduce the number of falls, and the resulting patient harm, through a number of national initiatives.

Patient falls are common in hospital; however, most of these falls can be prevented. Evidence indicates that accurate and prompt falls risk assessment, and adherence to the best practice in falls prevention strategies can significantly reduce the incidence of falls.

Many falls in institutional and residential settings can be prevented. The key to best practice in fall and injury prevention includes the implementation of standard prevention strategies, identification of falls risk and implementation of targeted individualised strategies that are adequately resourced and regularly reviewed and monitored (Australian Council for Safety and Quality in Health Care 18 May 2015).

Stroke patients represent a very high risk of falling and having fall related injuries. One of the biggest predictors of future falls is that if someone who has fallen once has a 50 percent chance of a future fall. If a patient has already fallen once on the ward, emphasizes the need for a tailored fall reduction plan for each patient. Rather than filling in a form for administrative purposes. (Dr David Oliver, 2007 Preventing falls and fall injury in hospital: a major risk management challenge).

Key Points

1. Many falls can be prevented.
2. Fall and injury prevention needs to be addressed at both point of care and strategic levels.
3. Involvement of the older person and their carers is an integral element to successfully preventing falls and minimising harm from falls.
4. Best practice in fall and injury prevention includes implementation of standard strategies, identification of falls risk and implementation of targeted individualised strategies that are adequately resourced, regularly reviewed and monitored.
5. Staff in our facilities must be actively engaged in the organisations multifactorial fall-prevention program.

Falls prevention is primarily being aware that falls are a problem, acknowledging that many falls can be prevented and understanding the risk factors. It is through a team effort and shared responsibility of hospital staff, patient and their families that early identification of risks can occur. Identification of risks and early prevention commences from preadmission, with thorough patient assessment and history information, early orientation of patients to the clinical unit, early assessment for proactive care planning and providing a safe environment. With ongoing review of falls risk and using incident reporting as descriptive tools, problem solving can prevent recurrent falls from occurring.
The Falls Story in Australia

Fall-related hospitalisations by age group, 2011–12
Fall-related hospitalisation is particularly common among older people. In 2011–12, 96,385 people aged 65 and over were hospitalised for a fall-related injury—three and a half times as many cases as 45–64 year olds (Figure 1). Of these, 65,965 (68%) were women compared with 30,420 (32%) men.

Consistent with national data Rockhampton and Gladstone data identifies that the average fall age among our patients is 80 years.
Falls and their consequences are the leading cause of morbidity and mortality in older Australians. However, in Queensland, one in four people aged 65 years older reported having a fall in the last year. Of these, about one in three required medical attention, and one in 10 were admitted to hospital.
Everyday133 older Queenslanders have a fall requiring medical attention, even though falls are mostly preventable. (Qld Health ‘stay on your feet’ – 16th February 2016)
Of those who reported falling, 45 per cent reported having more than one fall. Falls are a serious issue for all Queenslanders aged 65 years and older because:
  - Each year there are approximately 120 deaths and 17,000 hospitalisations for falls, two thirds of those falls result from slipping, tripping or stumbling on the same level
    - 325 hospitalisations every week
    - 46 hospitalisations every day
    - two hospitalisations every hour
Female fallers outnumber males 2:1
- Falls account for 11.8% of occupied bed days for all conditions in this age group
- 30 – 40% of falls result in injury and of those 40% are fractures including 1 out of every 10 being a hip fracture
- The average length of stay for a fall related hospitalisation is 12 days
- Most importantly falls steal a person’s confidence and independence to live at home


FALLOSTATISTICS FOR MATER HOSPITAL ROCKHAMPTON
End of Financial Year 2014-2015

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>NUMBER OF FALLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM2</td>
<td>15</td>
</tr>
<tr>
<td>HDU</td>
<td>0</td>
</tr>
<tr>
<td>MB2</td>
<td>73</td>
</tr>
<tr>
<td>SCU</td>
<td>3</td>
</tr>
<tr>
<td>CM3</td>
<td>1</td>
</tr>
<tr>
<td>DSU/SAU</td>
<td>1</td>
</tr>
<tr>
<td>OPD</td>
<td>1</td>
</tr>
<tr>
<td>Total for 2014/15</td>
<td>143</td>
</tr>
</tbody>
</table>

What is the Impact?

The cost of injuries causes a significant economic burden on both hospitals and the community. Interestingly the consequences of falls resulting in minor or no injury are often neglected, but factors such as fear of falling and reduced activity level can profoundly affect the function and quality of life and increase the risk of seriously harmful falls.

In 2001, total hospital costs were $54 million, and costs are projected to quadruple in the next 40 to 50 years. Taking into account all costs including GP, nursing homes, specialists and pharmaceutical, projected costs are set to increase to $320 million by 2051.

The population is growing and getting older, with the number of people aged 65 years and older is expected to more than triple in the next 20 to 50 years.

In 2007, one in eight people are aged 65 years and over. By 2051, one in four people will be aged 65 years and over. Unless we prevent and protect people aged 65 years and over from falls, we can conservatively expect see a tripling in health services to meet population growth.

2009-10, the estimated number of hospitalised injury cases due to falls in older people was 83,800 - more than 5,100 extra cases than in 2008-09 - and about 70% of these falls happened in either the home or an aged care facility. One in every 10 days spent in hospital by a person aged 65 and older in 2009-10 was directly attributable to an injurious fall (1.3 million patient days over the year), and the average total length of stay per fall injury case was estimated to be 15.5 days.

Consequences of Falling

Other significant impacts include-
- Functional deterioration and physical injury which includes a decrease in independence and restriction of activity
- Psychological impact such as fear of falling and deterioration in confidence
- Social impact which includes the burden on family members and carers
- Increase length of stay in hospital
- Increase in diagnostic procedures and or surgery
- Potential litigation and a fear of litigation for clinical staff
- Increase in total hospital costs
Characteristics of Falls

Understanding the characteristics of falls as discovered through numerous studies may assist clinical staff to more readily identify “risky situations” and assist to strategically emphasize appropriate interventions.

- Falls are associated with a number of factors such as environmental obstacles, dementia, delirium, incontinence and medications.
- A snapshot of studies that have reported falls data has revealed the following consistent information:
  - the bedside is the most common place for falls
  - the bathroom is frequently identified in incident analysis
  - a high percentage of falls are associated with elimination and toileting
  - a high percentage of falls are unwitnessed

The pattern of falls depends on setting and case mix; for example, more mobile patients such as in rehabilitation settings are most likely to fall when walking from a bed or chair.

Risk Factors Associated with Falls

There are a number of risk factors for falling among older people both in and out of hospital settings, as a person’s risk of falling increases as their number of risk factors accumulates.

Risk factors may be divided into:
- Intrinsic risk factors – which are factors that relate to a person’s behaviour or condition
- Extrinsic risk factors – which are factors that relate to a person’s environment or their interaction with the environment.

Risk Factors for Falling in Hospitals

<table>
<thead>
<tr>
<th>Intrinsic Risk Factors</th>
<th>Extrinsic Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past history of falls</td>
<td>Hospitalisation for 19 days or more</td>
</tr>
<tr>
<td>Postural Instability, impaired balance muscle weakness</td>
<td>Environmental risk factors (i.e. most falls in hospital occur around the bedside and in the bedroom)</td>
</tr>
<tr>
<td>Cognitive impairment, delirium, disturbed behaviour</td>
<td>Time of day – i.e. when reduced observational capacity exists i.e. shower and meal times</td>
</tr>
<tr>
<td>Urinary Frequency, Incontinence</td>
<td>Clutter</td>
</tr>
<tr>
<td>Postural Hypotension/Syncope</td>
<td>Poor lighting</td>
</tr>
<tr>
<td>Depression</td>
<td>Uneven flooring</td>
</tr>
<tr>
<td>Medications/polypharmacy</td>
<td>Inappropriate footwear and clothing</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Use of poorly maintained equipment</td>
</tr>
<tr>
<td>Visual Impairment</td>
<td></td>
</tr>
<tr>
<td>Low level of physical activity</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis/other musculoskeletal disorders</td>
<td></td>
</tr>
<tr>
<td>Low body mass index/malnutrition</td>
<td></td>
</tr>
<tr>
<td>Fear of Falling</td>
<td></td>
</tr>
</tbody>
</table>

The Individual Environmental Checklist MR 57 must be completed for all patients who have fallen as a result of an extrinsic factor.

With the body of knowledge regarding the risks of falls and how to reduce these risks, is continually growing. One key message prevails that multifactorial multidisciplinary engagement is the optimal approach in the hospital setting in which the patient and their carers are active participants in any falls prevention program.
**The Identification of Falls Risk**

**Patient Assessment and Risk Identification**

“Patients are screened for risk of a fall and the potential to be harmed from falls using a best practice screening tool” NSQHS Standard 10

Patient assessment of falls risk using the Falls Risk Assessment Tool (MR55) Attachment A is to be completed

- On admission and reassessment at a minimum of weekly, when there is a change in condition, medication, after a fall and prior to discharge. Above all, clinical judgement should be used if the patient has a potential risk of a fall.

Falls assessment is not a standalone action in falls prevention. Falls risk assessment needs to be linked to the clinical pathway to address modifiable falls risk factors identified. Even where risk factors for falling cannot be reversed, alternative strategies can be implemented to minimize the risk of falling or preventing injury in collaboration with the health care team.

**Implementation of Falls Risk Identification and Falls Prevention Strategies**

“Prevention strategies are in place for patients at risk of falling. Developing and implementing a multifactorial falls prevention plan to address risks is identified in the assessment” NSQHS Standard 10

Although the risk of falls is well documented for the elderly, impaired mobility is also a major falls risk and it is not age defined. Therefore, preventative measures and/or strategies such as screening to reduce falls and the harm from falls should not be limited to older Australians. (National Safety and Quality Health Service Standard 10 Preventing Harm from Falls).

Strategies are patient specific and require ongoing evaluation and reassessment to monitor the effectiveness and accommodate changes as part of the patient’s planned care. When caring for the paediatric/neonate patient it is critical to ensure that cot rails/sides are raised, unless staff or carers are in direct attendance and that bed rails remain raised on the unattended child.

If the patient is identified as being an increased risk of a fall, an individual falls prevention plan is developed and implemented. This is integrated into the patient’s overall care plan, documented on the clinical pathway.

**a) Communication**

- Falls green magnet outside room
- “Falls Risk” stickers (MR17 Progress Notes, MR20 Clinical Pathway)
- Notify medical/nursing team of Falls Risk (Clinical Handover)
- Provide the patient and/or carer with information on falls prevention
- Document Fall Status/Fall Prevention strategies on Clinical Pathway

**b) Supervision**

- Sight observations every 30 or 60 mins
- Specialling/sitter program
- Wandering arm band/sensor device
- Consider referral to Physio

Individual observation and supervision are components of a multifactorial falls prevention program. Staff should be aware of the patient’s individual risk factors and reasons why improved supervision
may reduce the risk of falling. More than one approach should be considered, avoiding
dependence on a single approach.

**c) Environmental**

- Refer to and/or complete Individual Environmental Checklist (Section A) MR57

Environmental review and modification refers to checking the patient room or environment for
hazards that might cause patients to fall, and then modifying or rearranging the environment to
remove or minimize these hazards.

**d) Vision**

- Ensure adequate lighting
- Keep glasses within reach, ensure they are clean
- Document/communicate visual needs and limitations at handover

Visual dysfunction is associated with increased risk of falling and includes, reduced contrast
sensitivity, poor depth perception and reduced visual field size.

**e) Mobility/Transfers**

- Review method of mobilisation, transfers and mobility aids (refer to FMRA)
- Place mobility aids within reach, with breaks on where applicable
- Ensure patient understands correct use mobility aid i.e. height adjusted.
- Consider balance and strength exercises
- Reinforce with the patient the need to ask for assistance when mobilising
- Document change in mobility status
- Consider use of hip protectors
- Consider referral to Physio/Rehab Unit

Balance and mobility are often poorer when a patient is in hospital compared with their normal
level of mobility, and may further deteriorate during a the episode of care if the patient is less
active due to their medical condition or due to the environment. Exercise programs delivered as a
component of patient rehabilitation will reduce falls in the hospital setting and at home.

**f) Footwear/Clothing**

- Check footwear is non-slip properly fitting
- Check clothes are suitably fitted e.g. long pants /dressing gown
- Consider referral to podiatrist

Inappropriate footwear and clothing worn by older people is a contributing factor to falls and
fractures. Footwear should be reviewed considering soles and heels. The presence of foot problems
such as pain, toe deformities, muscle weakness and reduced ankle flexibility can impair balance
and functional ability. Clothing should be fitted, not floor length or loose requiring the patient to
hold up the garment while mobilizing.

**g) Poly-pharmacy**

- Monitor effects of medication, be aware of medication interactions
- Reassess falls risk with significant change in medication
- Consider MO/Pharmacist review

The risk of falls can be increased by medication interaction and side effects such as dizziness or
sedation. The ageing process and disease can result in changes in pharmacokinetics and
pharmacodynamics. Appropriateness of medications should be reviewed on admission and
discharge in all hospitalized older patients.
h) **Activities of Daily Living (ADL’s)**

| Do not leave patient unattended on shower or toilet |
| Supervise all activity of daily living especially hygiene/grooming |

Clinical staff should stay with the patient who is a high falls risk to directly supervise showering and toileting activities.

i) **Nutrition**

| Provide assistance with eating to ensure optimal nutrition status |
| Ensure adequate nutritional intake (Vit D/Calcium Supplements) |
| Consider Dietician/Speech Therapist review |

Low vitamin D levels are associated with reduced bone mineral density, high bone turnover and increased risk of hip fracture. Vitamin D may prevent falls by improving muscle strength and psychomotor performance. Screening for osteoporosis will reduce fractures and improve bone health. Bisphosphonates allows bone rebuilding and increases bone density.

j) **Continence**

| Ensure continence plan documented on clinical pathway |
| Provide regular prompted toileting, including before sleeping or if restless |
| Locate patient near the bathroom |
| Consider commode or bottle at bedside |
| Leave light on in toilet at night, ensure pathway is obstacle free |

A ward urinalysis should be considered for all patients assessed as a falls risk. Incontinence, urinary incontinence and assisted toileting are identified as risk factors for falls in hospital. Patients will often make extraordinary efforts to avoid an incontinent episode, placing themselves at risk of falling as they may be reluctant or unable to discuss issues relating to urinary and fecal incontinence. Toileting is a practical approach to maintaining continence for many patients eg. timed voiding, habit retraining and prompted voiding.

k) **Cognitive/Memory Problems** (Dementia; Alzheimer’s; Agitation; Impulsive behaviour; Memory loss; Poor concentration; Confusion (constant or intermittent))

| Work to instil feelings of trust, confidence and respect – approach patient slowly, calmly from the front; respecting personal space; addressing by name, introducing oneself; using eye contact/speaking clearly/simply |
| Use gentle touch and gestures; auditory, pictorial and visual cues |
| Consider using symbols (photos) |
| Minimise number of bed location movements |
| Place close to nurses station for increased observation |
| Encourage family/carer to sit with patient |
| Encourage the supply and use of familiar personal items |
| Reassure and re-orientate patient to surroundings |
| Identify triggers to agitation behaviour and reduce or eliminate these |
| Consider MO/Speech Therapist review |
| Consider use of restraint in accordance with restraint policy [CPS 5.03] |

Cognitive impairment is common among hospital patients. Although cognitive impairment is most commonly associated with increasing age, it is a complex problem that may exist in all age groups due to acquired brain injury, mental health conditions and other pre-existing conditions. Cognitive impairment implies a deficit in one or more cognitive domains, such as memory, visuospatial skills or function. Dementia and delirium are the two most common forms of cognitive impairment in older people.
**Education**

“Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan” NSQHS Standard 10

Involvement of the older person and carer is an integral element to successfully prevent falls and minimize harm from falls. Patients and carers require education to assist them to understand their falls risk factors (acute and chronic) and actions required to address them. Patient education begins immediately after the risk assessment tool has been completed and the patient has been identified as high risk. Education should emphasise what patients can do to be healthy, active and independent rather than focusing on “falls prevention”.

Education to patients and their carers will be provided by all members of the multidisciplinary team relevant to the provision of care for the patient. Education will also enhance the patient’s confidence and reduce their fear of falling.

Education should be given to the patient/family/carer about the following -
• the risk of falling, safety issues and activity limitations
• how to minimize fall risks, for example, use of appropriate footwear and clothing during the patients admission
• teaching patients to make position changes slowly
• orientating patients to the bed area, ward facilities and how to get assistance
• information on what would happen if they were to have a fall
• support services available
• falls information pamphlets and videos in all patient care areas (available own language as appropriate)

**Discharge Planning**

“Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process” NSQHS Standard 10

Interventions to reduce the risk of falls and harm from falls should be included in discharge planning. Appropriate referrals should be made to primary health providers and community services. Communication with the patient and carer will assist understanding that the benefits of fall prevention and management in discharge planning is understood and that plans are followed.

**Post Fall Procedure**

The circumstances surrounding a fall are a critical part of care, because a fall may be the first and main indication of another underlying problem. It is important for staff to follow established guidelines in response to a fall please refer to CP5 5.05 Fall Prevention and Management (policy can be located on the Intranet and printed off)

Additionally, to guide our staff in the appropriate management of a fall and to ensure the continuity of care for our patient and family it is essential that a Post Fall Checklist (MR 59) be completed and remains in the patient’s bed chart. After immediate follow-up, determine how and why the fall may have occurred and implement remedial/preventative actions accordingly as analysing the fall is the key way to prevent future falls.

When assisting the patient back to a position of comfort following a fall, it is important that staff observe the principles of safe workplace practice and utilise appropriate lifting devices and manual handling techniques as required (See Attachment A - How to Rise After a Fall)
Guidelines for Post Fall Interventions and Rationale

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scan immediate environment</strong></td>
<td>Determine if there is immediate danger to yourself/patient</td>
</tr>
<tr>
<td><strong>Do not immediately move patient</strong> – observe the position of the patient where they fell</td>
<td>Many injuries can be sustained during a fall and may not be initially apparent. Further movement may increase injury to the patient.</td>
</tr>
<tr>
<td><strong>Call for assistance</strong> (nurse assist/code blue as appropriate)</td>
<td>Safe lifting technique must be undertaken</td>
</tr>
</tbody>
</table>

**Clinical Assessment of patient condition/potential injuries**

- Reassure and comfort the patient
- Determine the patient’s conscious state
- Ensure the patient’s airway is clear, monitor breathing

Check for signs of injury including abrasion, contusion, laceration and skin tears

- Apply firm pressure to any sites of obvious bleeding

Observe the patient for signs of a fractured neck of femur (#NOF) including shortening of leg or external rotation of leg.

If these signs are present, assume the patient has a #NOF and contact medical officer.

Check for signs potential head injury (for witnessed/unwitnessed falls):
  - Visually inspect head for signs of injury
  - Question patient/witness if patient states they have sustained a head injury
  - Assess patient for signs or symptoms of head injury

**Suspected Head Injury**

- Contact Medical Officer and request review of patient (for witnessed/unwitnessed falls with suspected head injury)

Close monitoring of neurological and vital signs are required due to increased risk of bleeding/haematoma or intracranial haemorrhage

**Patients on Anticoagulant Therapy**

- Assess patients who have fallen who are taking anticoagulants – document neurological and vital signs.

- Request urgent INR post fall – to assess blood monitoring and baseline for INR level

Close monitoring of neurological and vital signs are required due to increased risk of bleeding/haematoma or intracranial haemorrhage for patient on anticoagulant therapy
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consider CT scan (Medical Officer)</strong></td>
<td>Intracranial bleeding as a result of a fall can occur at any age, however in older adults (&gt;65 years) this may occur even with minor head injury due to the cerebral changes associated with aging. Older patients are more likely to develop chronic subdural haematoma (SDH) and experience secondary injury than younger patients.</td>
</tr>
<tr>
<td>Patients on regular anticoagulants with a suspected head injury should be strongly considered for a cerebral CT scan.</td>
<td>As a result of age associated brain atrophy a haematoma can collect over time without obvious changes in neurological status until the size is sufficient to produce a mass effect. The patient may have experienced a fall in the recent past, resulting in the slow development of a SDH which in turn has caused a further incidence of falling.</td>
</tr>
<tr>
<td>Patients not on anticoagulants with a suspected head injury and increased confusion and/or persistent abnormal mental status manifested by drowsiness, abnormal behaviour or cognitive impairment is an indication for cerebral CT scanning.</td>
<td></td>
</tr>
</tbody>
</table>

| **Initial observations for all falls occurring at any time day or night / witnessed or unwitnessed fall** | A fall is an adverse event and the patient’s condition needs to be observed closely. Baseline recording of vital signs and level of consciousness provide information on the patient condition and any further deterioration against these can be more readily assessed. Low blood sugar level (BSL) may have precipitated the fall and needs to be treated immediately. [Refer to CP3 3.33 Diabetic Patient Clinical Guidelines] |
| Document neurological observations (Glasgow Coma Scale) including; BP, heart rate, respiratory rate, temperature, oxygen saturation | |
| • ½ hourly for 2 hours; hourly for 4 hours and 4 hourly for 24 hours | |
| • BSL | |
| • Consider ECG | |
| • Observe for change in behaviour/ headache | |

<p>| <strong>Transfer/mobility assistance for patient post fall</strong> | Assess whether it is safe to move the person from their position and any special considerations in moving them. A staff member should not try to pick up the fallen person on their own, rather, use lifting devices if necessary and follow appropriate manual handling procedures. [See Attachment G How to Rise After a Fall] |
| Assist the patient to a comfortable position. If the patient is not injured and able to do so, with 2 staff encourage patient to roll onto side, then onto all fours then kneeling position, using chair as a prop, assist the patient up onto the chair. | |
| For unconscious/heavily dependent patient use a lifting machine to lift the patient – do not attempt to lift the patient off the floor. | |
| Ensure the comfort of the patient and provide counselling as required | |
| <strong>Contact Medical Officer for review</strong> | The fall may have occurred secondary to a cardiac or cerebro-vascular event which needs to be determined. |
| Report all falls to a medical officer, even if injuries are not apparent. | |
| A medical review should be undertaken as soon as possible to medically assess the patient and initiate further investigations. | |
| Consideration needs to be given regarding the urgency of the contact. Investigations such as x-rays must not be delayed. | |
| Consider medication review. | |</p>
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Escalate and communicate</strong>&lt;br&gt; Notify Senior Registered Nurse/Clinical Nurse Consultant/Afterhours Nurse Manager/Nursing Team&lt;br&gt; Clinical Handover of fall information and post fall management</td>
<td>Escalate patient fall clinical information to senior staff&lt;br&gt; Include patient fall clinical information at clinical bedside handover to ensure continuity of care and escalation of concerns</td>
</tr>
<tr>
<td><strong>Continued observations</strong>&lt;br&gt; Escalate notification to medical officer and senior nursing staff if any deterioration.</td>
<td>Highlight trends that may indicate deterioration in the patient which will dictate further actions and escalate notification to medical officer and senior nursing staff</td>
</tr>
<tr>
<td><strong>Notify next of kin (NOK)</strong>&lt;br&gt; The patient’s NOK must be notified of any unplanned event resulting in injury at the earliest possible convenience. Notification should be documented in the patient medical record chart.</td>
<td>Communicate to all relevant staff, family and carers that the person has fallen and may be at increased risk of falling again.</td>
</tr>
<tr>
<td><strong>Riskman Risk entry</strong>&lt;br&gt; Log fall incident on Riskman risk management system&lt;br&gt; Include details about the fall and any injuries sustained, suspected contributing factors and what, if any, fall prevention strategies were in use at the time</td>
<td>All staff are responsible for the mandatory reporting of all fall incidents&lt;br&gt; Clinical incident reporting provides a means to monitor incidents so that system improvement opportunities are readily identified and acted on regardless of whether the person is injured</td>
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<td><strong>Review level of falls risk and risk prevention strategies</strong>&lt;br&gt; Review the environment immediately following a patient fall and complete the Individual Environmental Checklist MR57&lt;br&gt; Investigate possible cause of fall&lt;br&gt; Review and document an individualised plan of care incorporating the Fall Prevention Strategies&lt;br&gt; Referral to Dietitian for review&lt;br&gt; Discuss physiotherapy review with Medical Officer&lt;br&gt; Consider the use of injury prevention interventions, discuss hip protectors with patient/family/carer&lt;br&gt; Consider investigations for osteoporosis in the presence of low-trauma fractures</td>
<td>Falls risk is not a static process and requires ongoing assessment. Exposure to acute care treatment and procedures can increase risk of falling with changes in patient clinical condition and / or increasing problems with perception and mobility.&lt;br&gt; After the immediate sequelae of a fall, determine how and why a fall may have occurred to reduce the risk of another fall.&lt;br&gt; Multifactorial interventions should be carried out as appropriate and may include, but are not limited to gait, balance/exercise programs, medication modification, hypotension management, environmental hazard modification and cardiovascular disorder treatment e.g. referral to other members of the health care team.</td>
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| **Documentation and communication**<br> Document fall incident details in patient’s medical record, including clinical assessment, evidence of injury, location of the fall, notification of medical officer/NOK/CNC or AHNM or Senior Nurse, and actions taken.<br> • Clinical Pathway<br> • Progress Notes<br> • Individual Environmental Checklist MR57 | Ensure effective communication of assessment and management recommendations to all involved.<br> Documentation in the medical record chart is to occur at the time of, or as soon as practicable following the provision of care, observation, assessment, diagnosis, review of results, management / treatment,
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>• Medication Chart MR22</td>
<td>professional advice, and documentation of incidents relating to the patient.</td>
</tr>
<tr>
<td>• Neurological Observation Chart MR39</td>
<td>Clinical notes provide a legal record of the patient’s episode of care and act as a form of record and communication to members of the treating team.</td>
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<tr>
<td>Clinical Handover (ISOBAR)</td>
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<td>• Medical Officer</td>
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<td>• Nursing Staff</td>
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<td>Education</td>
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<td>Debrief the patient regarding their fall and address their fear of falling</td>
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<tr>
<td>Provide information for the patient and carer to prevent further falls</td>
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<tr>
<td>Discharge Planning</td>
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<tr>
<td>Document and communicate patient falls risk status and strategies</td>
<td>Interventions to reduce the risk of falls and harm from falls should be included in discharge planning. Appropriate referrals should be made to primary health providers and community services. Communication with the patient and carer will assist understanding that the benefits of fall prevention and management in discharge planning is understood and that plans are followed</td>
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<tr>
<td>• MR5 Acute/Community Extended Care Transfer Referral Summary</td>
<td></td>
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<tr>
<td>• MR 4B Patient Discharge</td>
<td></td>
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<tr>
<td>• MR99 Discharge Medication Record</td>
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</table>
Attachment A – How to Rise After a Fall

With the aid of: Mechanical Lifter; Assisted Belt Lifter; Hoverjack/matt; Supervision;

MECHANICAL LIFTER
Make yourself familiar with the manufacturer’s instructions for your specific lifter.

Preparation:
- Before moving a patient from the floor, an RN/staff member must check for injuries.
- Before using the lifter, check that it is working properly.
- Check that the environment is safe to use the lifter. You may need to use a slide sheet/Albac mat to move the patient to a bigger area, or you may need to move furniture to give you more room.
- Lock the brakes on any furniture that you are moving the patient to.

The Lift:
- Reassure the patient.
- Raise the patient a few centimetres and recheck attachments.
- Never leave a patient suspended in a lifter. Someone should always stay with the patient.
- Ensure 2 x staff are in attendance at all times when using a lifter.
- Always lower the boom when transferring patients/residents.
- Always remove the straps from hoist, before removing the patient.

Post Lift:
- If you find something wrong with the lifter, mark it ‘out of order’ and report to maintenance.

ASSISTED BELT LIFT

Preparation:
- Before attempting to assist the patient to get up, an RN/staff member must check the patient for injuries and assess if the patient is capable to use this method.
- Reassure the patient and allow the patient time to regain composure before attempting to get up.

The Lift:
- When the patient is ready, roll the patient from side to side to place the belt under the patient’s/resident’s waist.
- Ask the patient to roll onto their stronger side.
- The patient should then push themselves up onto all fours, with the assistance of a staff member holding onto the belt.
- Get another staff member to place and hold a chair securely, so that the patient can use it to pull themselves up. The staff member holding onto the belt should provide guidance to the patient as they stand up.
- When the patient is standing, they can be turned around and seated in the chair.

HOVERJACK

Ensure you are familiar with the use of the Hover jack. (Detailed instructions are included with the item of equipment)

(Hoverjack/matt is located in the equipment storeroom on Rehab/MB3)

Preparation:
- Before moving a patient from the floor, an RN/staff member must check for injuries.
- Before using the hoverjack, check that it is working properly.
- Check that the environment is safe to use the hoverjack. You may need to use a slide sheet/Albac mat to move the patient to a bigger area, or you may need to move furniture to give you more room.
- Lock the brakes on any furniture that you are moving the patient to.
The Lift:
- Reassure the patient.
- Raise the patient a few centimetres by inflating the first air chamber and recheck attachments.
- Continue to raise the remaining chambers until fully inflated.
- Someone should always stay with the patient.
- Ensure 2 x staff are in attendance at all times when using the hoverjack/mat.
- Use a slide sheet/patslide or hovermat to transfer the patient from the hoverjack/mat to required place of rest.
- Always remove the straps from hoverjack/mat, before removing the patient.

Post Lift:
- The hover jack can easily be deflated when finished by opening the air chambers and folding up and placing back on storage trolley.
- Ensure the hoverjack is wiped clean after use.

SUPERVISION

Preparation:
- Before moving a patient from the floor, a RN/staff member must check the patient for injuries.
- Reassure the patient and allow the patient time to regain composure before attempting to get up.

Rising:
- When the patient is ready, ask them to roll onto their stronger side.
- Ask the patient to push themselves up onto all fours.
- Hold a chair firmly in front of the patient, so they can pull themselves up and then turn and sit on the chair.

References

Preventing Falls and Harm from Falls in Older People – Best Practice Guidelines for Australian Hospitals 2009. Australian commission on Safety and Quality in Health Care

National Safety and Quality Health Service Standards September 2011

National Safety and Quality Health Service Standards September 2011
- Guidebook for Preventing Falls and Harm from Falls in Older People
- Implementation Guide for Preventing Falls and Harm from Falls in Older People for Hospitals and Residential Aged Care Facilities
- Falls Fact Sheets
- Register of Falls Prevention Guidelines Issues and Errata

Falls risk assessment and falls prevention strategies in private oncology and neurosurgical setting: a best practice implementation project. Vol 12, No 10 (2014)
