

Document Management

Falls Injury Prevention and Management in SWAHS Hospitals

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Fall Injury Prevention and Management In SWAHS Hospitals

Revised : September 2008

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|--|----|
| 1. BACKGROUND..... | 3 |
| 2. PURPOSE..... | 3 |
| 3. SCOPE OF PRACTICE | 3 |
| 4. EXPECTED OUTCOMES..... | 3 |
| 5. RISKS OF POLICY NON-COMPLIANCE | 4 |
| 6. ROLES AND RESPONSIBILITIES | 4 |
| 7. DEFINITIONS..... | 5 |
| 8. PROCEDURES | 6 |
| 9. DISCHARGE PLANNING | 10 |
| 10. POST FALL PROTOCOL | 10 |
| 11. EMERGENCY DEPARTMENT PROCEDURES | 11 |
| 12. EQUIPMENT | 11 |
| 13. EDUCATION AND TRAINING | 12 |
| 14. MONITORING AND EVALUATION | 12 |
| 15. CAPITAL WORKS PLANNING | 12 |
| 16. REFERENCES and RELATED POLICIES..... | 13 |
| 17. Appendix 1 – CEC POST-FALL ASSESSMENT & MANAGEMENT CHART | 14 |

1. BACKGROUND

Fall injury is a major cause of preventable hospitalisation and loss of independence among people 65 years and over. As our population ages, the magnitude of this problem and its associated costs will continue to increase.

Falls remain the most common type of adverse incident occurring to patients in SWAHS Hospitals.

While the best approaches to falls injury prevention with older people (in particular, helping older people improve and maintain their muscle strength and balance) can only be achieved and implemented in the longer term (generally outside of the acute care setting), there is a growing body of evidence indicating that the number of falls occurring in hospitals can be reduced by implementation of a multi-factorial falls prevention program.

As a revision of the original Hospitals Falls Policy launched across SWAHS in early 2007, this Policy aims to sustain and further refine the multi-factorial falls prevention program in order to decrease fall injury amongst older patients in SWAHS Hospitals.

2. PURPOSE

1. To prevent fall injury among patients presenting to Sydney West Area Health Service (SWAHS) hospitals (acute and sub-acute facilities).
2. To guide hospital staff in the provision of optimal assessment, treatment and discharge planning services to older patients, especially those at increased risk of fall injury.
3. To identify, minimise and help manage patient's falls risk factors, thereby contributing to a reduction in fall injury among older people in the Sydney West population.
4. To ensure appropriate action is taken when a fall incident or injury occurs during hospital admission to minimise harm to the patient and prevent further falls from occurring.

3. SCOPE OF PRACTICE

1.1 Patient group

This Policy relates to all patients over the age of 65 (and patients over 50 years who are Aboriginal or Torres Strait Islanders) admitted to acute/subacute facilities within SWAHS (including Third Schedule hospitals).

The principles of falls prevention and management are generally the same for younger patients, but this Policy does not currently include additional information for special younger patient groups (eg. neurology, psychiatry, paediatrics).

1.2 Staff

As the most effective approach to preventing falls in hospital is multifactorial and requires support at all levels, implementing this Policy requires the involvement of all staff responsible for directing and delivering patient care in SWAHS hospitals.

4. EXPECTED OUTCOMES

- Reduction in fall injuries within acute and subacute facilities of SWAHS.
- All admitted patients are screened for their falls risk within 24 hours of admission. If the patient is identified as at increased risk of falls, an individual falls prevention plan is developed and implemented. This is integrated into the patient's overall care plan.

- Patients that present to ED following a fall **or** who are identified at increased risk of falls **or** who fall whilst they are in ED **and** return home without being admitted to hospital, **have a referral and ongoing assessment and management plan for falls prevention initiated by ED staff.**
- Each SWAHS hospital has an active multi-disciplinary falls working group that reviews local falls incidents, recommends and monitors further actions to prevent fall injuries and ensures that staff receive appropriate training in fall injury prevention.
- Staff are trained in and able to implement the falls risk screening tool and falls prevention strategies. Training will occur on commencement of employment and be ongoing, with a minimum of an annual update for all clinical staff.
- Patients (and their families/ carers) that are identified as at increased risk of falling will receive education regarding fall injury prevention.
- Patients identified as at increased risk of falling are discharged with follow-up support and assessment in the community.
- Patient falls are recorded in the electronic Incident Information Management System (IIMS) and always documented in the medical record.
- Service planning (new developments, structural design and changes to work practices) and purchasing of new equipment within SWAHS takes into consideration the impact that this has in preventing falls.

5. RISKS OF POLICY NON-COMPLIANCE

Non-compliance with this Policy will result in high rates of patient fall injuries in SWAHS acute care facilities. Non-compliance will also result in re-admission of recently discharged patients who sustain fall injuries after returning home (hence the importance of comprehensive discharge planning and multidisciplinary intervention to address each patient's identified risk factors).

For the patient, a fall may result in pain, short or long term disability, psychological trauma, reduced independence and even premature death from the injury or its complications. For the hospital and Area Health Service, fall injuries increase costs of patient care due to increased lengths of stay, additional investigations and procedures and potential litigation.

6. ROLES AND RESPONSIBILITIES

SWAHS Executive

- Resource and support ongoing implementation and evaluation of the Falls Injury Prevention and Management Policy in SWAHS Hospitals.

Clinical Governance Unit

- Undertake ongoing monitoring of fall incident and injury data.
- Provide reports on fall incidents, injuries and implementation of the Falls Policy at Area level to the Health Care Quality Committee and all relevant levels of management - to inform decision-making and drive AHS policy/ procedure development.
- Audit compliance with the Policy at Area level and assess the effectiveness of the interventions implemented.
- Support and facilitate Area-wide activities to prevent fall injuries among hospital inpatients.
- Represent SWAHS hospitals on the SWAHS Falls Management Steering Committee.

Facility and Cluster Executives

- Facilitate, resource and support the ongoing implementation and evaluation of the SWAHS Hospitals Falls Policy at facility level.

- Discuss the findings of patient fall incidents and corrective actions to be taken as part of senior management meetings and/ or ensure that a facility Falls Working Party/ Committee is operational and has senior management (preferably Director of Nursing) representation.
- Ensure all staff (medical, nursing and allied health) are trained in and able implement the assessments and interventions required to prevent patient falls.
- Ensure that medical and nursing staff understand post-fall management protocols and adhere to them.
- Ensure all staff are aware of, understand and abide by the Policy.

Nurse Unit Managers

- Ensure nursing staff receive education (on commencement of employment and annual updates) re: patient assessment and interventions to prevent fall injury.
- Ensure that all patient falls incidents are fully investigated and appropriate action taken to prevent further fall injury.
- Ensure post-fall management protocols are followed for all patient falls incidents.
- Ensure that all patient falls and related injuries are reported in both IIMS and medical records, inclusive of findings of investigations and action taken to reduce the risk of further falls.
- Ensure environmental audits are conducted regularly and outstanding environmental issues impacting on fall safety are communicated to management and acted upon.
- Ensure falls prevention is an agenda item for ward meetings. This should include discussion of incidents, investigations and actions to be implemented to avoid further falls.
- Assist staff in developing and maintaining ward-based systems of evaluating and improving performance in falls injury prevention.

Facility Fall Prevention Committees/ Working Groups

- Support Area-wide fall prevention initiatives at the facility level.
- Provide a representative to attend the SWAHS Area Hospitals Falls Committee.
- Report on actions taken to address falls incidents and other fall prevention initiatives and activities to the Clinical Governance Unit (this is usually done by forwarding copies of Working Group meeting minutes to the CGU).
- Ensure all wards within the facility are aware of the SWAHS Falls Policy and are given opportunity to participate in facility-based activities to prevent fall injury among older inpatients.

All SWAHS staff

- Adhere to this Policy
- Undertake training in fall injury prevention, appropriate to role.
- Ensure all fall incidents are documented in the patients' medical record and a notification on IIMS is completed.
- Ensure that fall prevention is standard practice. This includes taking immediate action to minimize environmental hazards (such as reducing clutter at the bedside, ensuring a patient's mobility aid, food and water are within easy reach) and notifying managers of environmental hazards requiring attention.
- Be aware of a patient's falls risk and mobility status prior to assisting the patient to transfer or mobilise.

7. DEFINITIONS

Clinical Incident

Any incident, adverse event or near miss involving patient care.

Fall

A sudden, unintentional change in position causing an individual to land at a lower level, on an object, on the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Incident Information Management System (IIMS)

The state-wide electronic incident management system designed to support the NSW Safety Improvement Program and is a key component in the NSW Patient Safety and Quality Program. IIMS is used in SWAHS to document, manage and analyse clinical incidents and patient complaints.

Older person

A person who is 65 years of age or over

Risk of falls

Probability of falling

Ontario STRATIFY risk assessment tool

Currently the best available tool for screening for falls risk in hospital settings.

SAC

Severity Assessment Code

8. PROCEDURES

8.1 Screen for falls risk

All patients must be screened for falls risk within 24 hours from admission, preferably at the first point of contact, using the Ontario STRATIFY tool located within the Patient Assessment Form.

The patient must be re-screened if:

- Their condition changes
- There is a transfer in care
- After a fall

8.2 Flag patients identified at increased risk of falling

Patients identified as at risk of falling must be flagged. A mechanism must be put in place at the bedside to identify patients at increased risk of falling. The patient medical record, care plan and medication chart must be flagged using the SWAHS green falls sticker. The sticker may be used on other items at staff discretion.

8.3 Communicate falls risk

- *Communicate to staff:*

In addition to flagging, patient’s increased risk status must be communicated to all personnel involved in patient care. This may include clinical staff, wardsmen, porters, radiology, allied health, pharmacy etc. Nursing “handovers” must include the patient’s risk and management strategies that are in place to prevent falls.

- *Communicate to the patient and carer:*

The patient’s risk of falling and intervention strategies to prevent falls must be discussed with the patient and their carer. Health interpreters should be used when appropriate.

8.4 Assess mobility

- Every patient’s mobility status must be established at time of admission. All patients identified at increased risk must be referred for physiotherapy review (to be attended as soon as possible).
- Prior to the physiotherapy review, patients at risk of falling must be instructed to ask for assistance when attempting to mobilise.
- If patient usually uses a mobility aid, staff should ask the family/ carer to bring it into the hospital.

8.5 Screen for unsafe footwear

At time of admission, footwear should be checked to ensure it is not ill-fitting or inappropriate.

- If the patient does not have safe (fitted, flat and non-slip) footwear, the family/ carer should be contacted and requested to bring in appropriate footwear
- If appropriate footwear is unavailable, the patient must be provided with non-slip socks.
- Walking in loose-fitting slippers, socks or surgical stockings must be strongly discouraged. Walking barefoot should also be discouraged.

8.6 Document in the medical record

All screening, assessments and interventions related to the patient's fall risk and risk factors must be documented in the patient's medical record and care plan (if kept separately).

8.7 Multidisciplinary assessment and intervention

Patients at increased risk of falling must receive comprehensive multidisciplinary assessment of and intervention for their fall risk factors.

Depending on the patient's underlying risk factors, referrals will be made to:

- Physiotherapy (needed for nearly all patients as problems with mobility, strength and balance are the most common risk factors for falls)
- Occupational therapy (needed for most patients who will be discharged to anything other than high level residential care)
- Dietitian
- Continence CNC/Nurse
- Geriatrician or Rehabilitation Physician
- Podiatrist
- Pharmacist

8.8 Provide increased supervision/ assistance

Patients identified at increased risk of falling need to receive increased supervision and/or assistance.

This may require:

- Moving the patient closer to the nurses station
- Co-locating patients at increased risk
- Reviewing staffing allocation to ensure that staff mix and patient/staff ratio is optimal to meet the needs of the patient/s.
- Encouraging and empowering family/ carer or volunteers to help with patient care and supervision where appropriate
- Use of nursing 'specials' when required

8.9 Manage altered mental status appropriately

Altered mental status, including cognitive impairment, is strongly linked to falls. Delirium (acute confusional state with underlying medical cause) is common among older people in hospital and is often overlooked. People with dementia, delirium, closed head injury, intoxication, and some mental illnesses are at the highest risk of falling.

If the patient is disorientated, confused, agitated:

- Increase supervision and provide reassurance to the patient
- Ensure patient is reviewed by the medical team
- Ensure environmental considerations (see below) are implemented
- Consider use of bed/chair alarms
- Consider use of hi/lo bed
- Encourage family /carers to be involved with fall prevention strategies where appropriate
- Consider referral to CNC Aged Care and Geriatrician

Restraints, both mechanical and chemical, including bed rails, are **NOT recommended** for the prevention of falls, particularly in people with altered mental status.

8.10 Review medications

Medications are linked with falls and must be reviewed for all patients at increased risk of falling. Medications particularly linked to increased risk of falls are:

- Benzodiazepines
- Psychotropic agents - including antipsychotic, sedatives/anxiolytics and antidepressants
- Cardiovascular agents (antihypertensives, diuretics, vasodilators)
- Analgesics/opioids.

The use of multiple medications is an independent predictor for falls. Any patient over the age of 65 years on 4 or more medications will have these reviewed during admission by the treating medical team, with the aim of prescribing the minimum number of medications at the minimum required dose for clinical effect.

Pharmacists and Geriatricians can assist in determining the relative risks of multiple medications in older patients.

Benzodiazepines are not recommended for the treatment of insomnia and should not be commenced in older patients who have not used them previously. Non-pharmacological interventions to promote sleep (including limiting caffeinated drinks in the afternoon/ evening) should be trialled.

8.11 Make the patient environment as safe as possible

Standard fall prevention strategies in hospital wards/units include:

- All patient areas kept free from clutter, trip hazards and spills
- Floor surfaces kept clean and dry. Wet floor signage is used where appropriate
- All clinical areas use appropriate lighting, including the use of night lights.
- Patients are orientated to the bed area, room and ward facilities. This will include how to use the call bell and any other equipment. Personal belongings will be placed within reach
- Furniture will be positioned and adjusted to allow ease of access and safe use:
 - Bed height at lowest
 - Chair height to optimise ease of transfers (usually so patient's hips are at 90-100 degrees).
- Brakes must be applied on all equipment when stationary.
- Walking aids will be located on the side of the bed that the person will exit from.
- Bed rails will NOT be used as a standard falls prevention strategy.

Monthly environmental audits of patient areas will be undertaken as part of regular occupational health and safety audits, to identify any potential contributing factors to falls.

8.12 Manage continence and toileting problems

Many patient falls are related to the need for toileting.

Strategies must be put in place to manage patients who are incontinent or require frequent toileting.

This may include the following:

- Locate patient close to toilet facilities
- Use a urinal or bedside commode at night
- Planned frequent toileting- eg. every 3 hours (except overnight) and immediately prior to nurse "handover"
- Consider reducing caffeine intake, while maintaining adequate hydration

High risk patients should not be left unsupervised in the toilet or bathroom

Referral to Continence CNC should be made to assist in planning for post-discharge care.

8.13 Identify and treat Osteoporosis

Osteoporosis is an essential consideration in the prevention of fall injury. Osteoporosis is very common in Australia: one in two women and one in three men will have an osteoporotic fracture in their lifetime.

If an older person or post-menopausal woman is admitted with a fracture or history of falls, they must be investigated for osteoporosis and commenced on a management plan of improved diet and adequate sunlight exposure, supplements, bisphosphonates or similar or combinations of these.

Vitamin D and Calcium supplementation should be considered as a routine management strategy for all older people to significantly reduce the risk of fall injury.

8.14 Provide education to the patient and family/carer

Involvement of the older person and their carers is an integral element to successfully preventing falls and minimizing harm from falls. Many older people find it difficult to talk about falls because they are frightened of the potential threat to their independence and don't understand that fall injuries can be largely prevented.

- Patients and their carer/s need to understand their falls risk factors and the actions they need to take to address them.
- Regardless of age, physical activity to improve and maintain strength and balance is the most important thing an older person can do to reduce their risk of falls. The physiotherapist will advise re: appropriate exercises.
- **Education should emphasize what people can do to be healthy, active and independent**, rather than focussing on "preventing falls", which may be seen as negative and de-motivating.
- Education to patients and their carers will be provided by members of the multidisciplinary team involved in caring for the patient.
- The 'Don't fall for it. Falls can be prevented!' booklet is the standard education resource provided to patients and their families, especially for those identified at risk. People who do not read English will be provided with information in their own language (if available). An audio CD of this booklet is available for people who are visually impaired or have difficulty reading.
- Other forms of education such as group education sessions, inpatient TV will be considered where appropriate.

8.15 Identify and address vision problems

Visual impairment is a risk factor for falls.

Ward lighting must be optimal to reduce the risk of falls.

On admission, patients should be asked about their vision. If the patient does not have their usual glasses with them, their relatives/ carers will be contacted and asked to bring them for the patient to use in hospital.

Annual eye examinations are recommended for older people, with treatment of identified problems undertaken. If this is required and not possible during admission, this must be documented in the discharge paperwork to the general practitioner.

Patients who have had falls involving environmental obstacles (such as stairs and curbs) should be advised (preferably by a medical officer) to consider using single-lens spectacles rather than bifocal or multifocal spectacles when walking.

8.16 Identify and address inadequate nutrition

Inadequate nutrition is a risk factor for falls injury. Inadequate intake of protein, vitamins, minerals and calories can lead to decreased muscle strength, poor bone health and impaired vision. Patients that are identified as having inadequate nutrition must be referred to the dietitian for review whilst an inpatient.

8.17 Identify, investigate and manage postural hypotension and syncope

About 5% of falls in older people are related to syncope (temporary loss of consciousness) or presyncope. Postural hypotension should be considered as a potential cause of unexplained falls.

Patients found to have postural hypotension, or who complain of dizziness, light-headedness or "blackouts" must:

- Have a medical review (including review of medications)
- Be supervised when changing position and encouraged to sit and stand up slowly from lying or sitting and to wait a short time before walking
- Be encouraged to report episodes of the above symptoms.

8.18 Encourage safe mobility and self care

- Encourage safe and early mobilisation and patient participation in self care.
- Activities of daily living should be structured to minimise injury risk

- High risk patients (particularly those with altered mental status) must be supervised during self care activities.
- Encourage use of appropriate self care equipment for the patient's particular fall risk (OT can advise with this)
- Ensure all personal self care items are placed within reach

8.19 Hip protectors

Hip protectors may reduce the risk of hip fractures. Hip protectors should be considered for certain patients. Indicators for use:

- The patient already uses hip protectors
- Over 80 years + prolonged hospital stay + history of falls
- Over 80 years + prolonged hospital stay + osteoporosis
- Over 70 years and a recurrent faller

Practical implications such as cost, appropriateness, laundering, continence and proper fixation after toileting need to be considered when deciding to use hip protectors.

9. DISCHARGE PLANNING

Discharge planning should begin early in the patient's admission.

- All patients identified at increased risk of falling (and not automatically returning to high level residential care) should be referred to Occupational Therapy early in the admission to determine environmental/equipment training needs and to allow adequate time for discharge planning.
- Ensure the patient and carer have been informed of the patient's current fall risk and have received information (see section 8.14) on how to reduce ongoing risk of fall injury.
- Ensure the discharge summary includes the patients falls risk status, interventions used while in hospital and recommendations for further assessments/ interventions in the community.
- The patient's residential care facility and/or relevant service provider/s will be informed of the patient's risk status, interventions used while in hospital and their ongoing care needs.

10. POST FALL PROTOCOL

Any fall (or near miss) must be seen as a clinical priority.

Unseen damage may be sustained from a fall, including fractures, head injuries, soft tissue injury.

Refer to the CEC post-fall assessment and management chart in appendix 1.

10.1 First aid

- Ensure the patient is safe from further danger.
- Ask for assistance
- Do not move the patient initially unless in an unsafe environment

10.2 Nursing assessment

- Assess baseline vital signs immediately.
- **Neurological observations are mandatory** for unwitnessed falls or falls where head has been hit.
- Undertake a full body assessment to identify potential injuries eg fracture, soft tissue, skin tears.
- Inform the medical team immediately following patient assessment. Details of assessment, medical condition and co-morbidities must be communicated.
- Establish the details of the fall (witnessed or unwitnessed).

10.3 Medical review

A medical review and investigations should be undertaken immediately to assess the patient and determine the cause of the fall.

- The review and any changes made in medical management of the patient must be documented in the medical record.
- **Patients who fall and hit their head or sustain an unwitnessed fall, and are on anticoagulant and/or antiplatelet therapy, must have a head CT scan performed.**
- If a patient sustains a SAC 1, 2 or 3 incident requiring medical intervention, the medical team must notify the family/ carer immediately after review and document this communication.
- The Consultant must be informed

10.4 Additional tasks

- If no serious injury (SAC 3 or 4) has occurred, the family/ carer are to be informed of the incident within 24 hours and this communication documented.
- Falls risk assessment and prevention strategies are to be reviewed and documented
- Communicate fall and change in falls risk status and interventions during subsequent nursing handovers

10.5 Documentation

- Document the fall and details of assessment in the medical record
- Online recording of the incident must be made in the IIMS reporting system. Ensure all injury details and potential causal factors are included in the report.

11. EMERGENCY DEPARTMENT PROCEDURES

The research evidence is clear that older people who fall once are more likely to sustain future fall injuries. For this reason, it is vital that these people receive further assessment and interventions to help them reduce their risk of fall injury.

Patients that present to ED following a fall
 or who are identified at increased risk of falls
 or who fall whilst they are in ED

and return home without being admitted to hospital, must have a referral and ongoing assessment and management plan for falls prevention initiated by ED staff.

- The person's primary care provider (usually GP) must be informed of the identified risk and subsequent referrals (such as to Aged Care Assessment Teams, Community Health providers).
- Each Emergency Department must have a clear referral pathway for people found to be at increased risk or with modifiable falls risk factors.
- ED staff must communicate clearly to patients and carers about the patient's falls risk and the rationale for referrals for follow-up assessment and intervention. Patients/ carers should be provided with information about how they can prevent falls. See section 8.14 of this Policy for further information about education.
- Emergency Departments should review the completion of falls risk screening and referral as part of their routine audit and quality improvement processes.

12. EQUIPMENT

- When acquiring new equipment (e.g. seating, shower chairs) falls risk needs to be considered.
- Health professionals providing patient care must be involved in equipment purchasing decisions.
- All equipment must be purchased as per the SWAHS General Procurement Policy – Goods and Services.
- A list of standard falls prevention equipment is available on the intranet (under Clinical Information Systems - falls prevention page).

13. EDUCATION AND TRAINING

All hospital staff will receive training in falls prevention and management on commencement of employment with at least annual updates. Training will cover the following areas:

- Risk factors for falls
- Risk screening
- Falls flagging procedure
- Falls prevention strategies
- Documentation
- IIMS reporting
- Referral processes
- Patient and carer education strategies

The Falls Policy education package is available on the intranet.

14. MONITORING AND EVALUATION

Individual facilities (ie. managers at all levels and facility Falls Prevention Working Groups) will regularly review falls incidents and take appropriate action to reduce the risk of further fall incidents.

- Recommendations following review of incidents and IIMS reports will be communicated to all relevant staff.
- 6 monthly audits on compliance with falls risk screening and fall prevention strategies will be undertaken at a facility level.
- Individual falls working groups will report monthly minutes to the Area Falls Committee Meeting and the Cluster Director. Minutes will be sent to Clinical Governance.
- The Clinical Governance Unit will provide monthly IIMS reports for each facility which will be presented at the Area Health Care Quality Committee and other appropriate forums.

15. CAPITAL WORKS PLANNING

The NSW Health, Health Facility Guidelines (2005) has as one of its aims to 'promote the design of Health Care Facilities with due regards for the safety, privacy and dignity of patients, staff and visitors'. The risk of falls must be a consideration in the planning of any new facilities or renovations to older buildings.

The planning and design of new facilities or renovations should take into consideration the following principles:

- Safety and practicality are more important than aesthetics
- All stakeholders should be included, including health professionals (especially those who will be working in the new area) facility managers and older people
- Provision of adequate storage space for equipment is essential to reduce clutter
- Lighting and observation/ surveillance of people
- Floor surfaces and coverings
- Access to, site and design of toilets and showers
- Wheelchair access
- Building layout

16. REFERENCES and RELATED POLICIES

- NSW Department of Health, *NSW Health Management Policy to Reduce Fall Injury Among Older People (2003-2007)*, 2003 (PD2005_353).
- Australian Council for Safety and Quality in Health Care. *Preventing falls and harm from falls in older people. Best practice guidelines for Australian hospitals and residential aged care facilities*, 2005.
- Clinical Excellence Commission – NSW Falls Prevention Program 2008: *Post Fall Assessment and Management* chart
- The National Ageing Research Institute, *Falls Prevention Guidelines for the Emergency Department*, 2007.
- Northern Sydney Central Coast Area Health Service, *Falls Prevention and Management Policy- NSCCH*, 2008 (PO2008_001).
- NSW Health Incident Management Policy (PD2007_61)
- SWAHS Healthcare Services Plan 2005-2010, April 2006

| FALLS AND HITS HEAD | FALLS AND DOES NOT HIT HEAD | UNWITNESSED FALL |
|--|--|--|
| <p>SPECIAL CONSIDERATION – Patients on anticoagulant and/or antiplatelet therapy and patients with a known coagulopathy are at an increased risk of intracranial haemorrhage. Anticoagulants include: Warfarin, Heparin, Enoxaparin (Clexane), Dalteparin (Fragmin). Antiplatelet drugs include: Aspirin, Clopidogrel, Aspirin+Dipyridamole (Asasantin). Alcoholic patients are considered coagulopathic.</p> | | |
| <ul style="list-style-type: none"> Do not move initially Call for assistance Immobilise Cervical Spine and examine for injuries Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, Blood Sugar Level (BSL)) Neurological Observations - initial Glasgow Coma Scale (GCS) Observe for change in the level of consciousness, headache, amnesia or vomiting Clean and dress any wounds <p>↓</p> <p>Contact Medical Officer for review</p> <p>↓</p> <p>Consider need for analgesia</p> <p>↓</p> <p>Liaise for appropriate test (consider CT Scan if patient has any high risk factors, see Section 6 of <i>NSW Health PD2008_0081 Head Injury</i>)</p> <p>↓</p> <p>Notify registrar / consultant (if required)</p> <p>↓</p> <p>Observations</p> <ul style="list-style-type: none"> Record vital signs and neurological observations hourly for 4 hours then review Continue observations at least 4 hourly for 24 hours or as required Notify MO immediately if any change in observations <p>↓</p> <p>Notify family</p> <p>↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p>↓</p> <p>IIMS report</p> <p>↓</p> <p>Post Fall review</p> <p>Document in medical record strategies implemented</p> | <p>Potential Injuries: fracture, soft tissue injury or no observable injury.</p> <ul style="list-style-type: none"> Do not move initially Call for assistance Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) Clean and dress any wounds <p>↓</p> <p>Contact Medical Officer for review</p> <p>↓</p> <p>Consider need for analgesia</p> <p>↓</p> <p>Liaise for appropriate test (eg X rays)</p> <p>↓</p> <p>Notify registrar / consultant (if required)</p> <p>↓</p> <p>Observations</p> <p>Monitor vital signs for 24 hours</p> <p>↓</p> <p>Notify family</p> <p>↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p>↓</p> <p>IIMS report</p> <p>↓</p> <p>Post Fall Review</p> <p>Document in medical record strategies implemented</p> | <p>Potential Injuries: Head or neck injury, fracture, soft tissue injury or no observable injury.</p> <ul style="list-style-type: none"> Do not move initially Call for assistance Immobilise Cervical Spine and examine for injuries Baseline Vital signs (BP, heart rate, respiratory rate, oxygen saturation, BSL) Neurological Observations - initial Glasgow Coma Scale (GCS) Observe for change in the level of consciousness, headache, amnesia or vomiting Clean and dress any wounds <p>↓</p> <p>Contact Medical Officer for review</p> <p>↓</p> <p>Consider need for analgesia</p> <p>↓</p> <p>Liaise for appropriate test (eg CT Scan if patient has any high risk factors, see Section 6 of <i>NSW Health PD2008_0081 Head Injury</i>)</p> <p>↓</p> <p>Notify registrar / consultant (if required)</p> <p>↓</p> <p>Observations</p> <ul style="list-style-type: none"> Record vital signs and neurological observations hourly for 4 hours then review Continue observations at least 4 hourly for 24 hours or as required Notify MO immediately if any change in observations <p>↓</p> <p>Notify family</p> <p>↓</p> <p>If not already flagged as high risk of fall injury, flag as per hospital protocol</p> <p>↓</p> <p>IIMS report</p> <p>↓</p> <p>Post Fall review</p> <p>Document in medical record strategies implemented</p> |
| <p>Reassess Falls Risk Status – Refer to relevant staff to review, update care plan and implement Falls prevention strategies</p> | | |
| <p>Communication – All staff involved in the care of the patient to be informed of incident outcome and revised care plan</p> | | |

ACKNOWLEDGMENTS:

- Adapted From RNS and RHS Policy Per RNS2005/46
- Hook, ML., Winchel, S (2006) Fall Related Injuries in Acute Care: Reducing the Risk of Harm, MEDSURG Nursing, Vol 15/No.6
- NSW Department of Health, Policy Directive: *Initial Management of Closed Health Injury in Adults, PD2008_0081 Head Injury*, 2008.
- NSW Institute of Trauma and Injury Management www.itim.nsw.gov.au