Clinical Excellence Commission
NSW Falls Prevention Program

The NSW Falls Prevention Program is focused on older people with an aim to:

- Reduce the incidence and severity of falls
- Reduce the social, psychological and economic impact of falls among older people, families and carers.

The NSW Falls Policy PD2011_029*: Prevention of Falls and Harm from Falls among Older People 2011 -2015***,** Policy Directive PD2011_029, was released in May 2011 by NSW Department of Health:
http://www.health.nsw.gov.au/policies/pd/2011/PD2011_029.html

The Clinical Excellence Commission (CEC) in collaboration with the NSW Ministry of Health and the Agency for Clinical Innovation (ACI) and Ambulance NSW will lead work in clinical settings to support Local Health Districts (LHDs) and Networks with the implementation of a uniform approach to the prevention of falls and harm form falls.

Guide for NSW Health Facilities
Purpose: To provide guidance to NSW Health facilities to ensure a uniform approach to the prevention of falls and harm from falls that is consistent with best practice. This document outlines the areas that need to be taken into consideration when identifying and managing people at risk of falling and the management of those people who have had a fall.

General Safety and Quality
All NSW Health Staff should be aware that there is an increasing number of older people admitted to hospital for a fall, and that patients in hospital are at risk of a fall. Our health services require systems to be in place to prevent patient falls and harm from falls.

Alignment with National Falls best practice guidelines and National Standards:
There are two national documents that are relevant to falls prevention in hospital.

1. The Australian Commission on Safety and Quality in Health Care (ACSQHC) 2009 falls best practice guidelines: *Preventing falls and harm from falls in hospitals, community care and residential aged care settings* provide the evidence base for falls interventions.

2. The ACSQHC National Safety and Quality Health Service Standards (NSQHSS), Standard 10: *Preventing falls and harm from falls.* This standard applies to all patients in hospital settings.

Health Staff have a responsibility to focus on patients individual falls risk factors and the risks imposed by the surrounding environments; develop multifactorial care plans to manage those risks and ensure continuity of care between settings. Interventions will

differ between community, residential care and hospital settings; and between individuals who are relatively well, frail or cognitively impaired.

All Local Health Districts are to ensure that falls programs are evidence based on the ACSQHC 2009 falls best practice guidelines: *Preventing falls and harm from falls in hospitals, community care and residential aged care settings*.

Education and training is to be available for all staff: nursing, medical, pharmacy, allied health, and ancillary staff about their role in identifying and reducing the risk of falls. This is achieved through:

- Falls risk screening - Ontario Modified Stratify (Sydney Scoring) Falls Risk Screen
- Falls risk assessment - Falls Risk Assessment and Management Plan (FRAMP)
- Implementation of interventions to reduce risk
- Post fall management – CEC Post Fall Guide
- Local systems in place to support staff with information and resources.

All LHDs and Network will utilise data and evidence to plan, measure, monitor and improve the effectiveness of systems of care and clinical practice for preventing falls and harm from falls.

Specific Outcomes

- To reduce falls and the severity of injury from falls in the acute and sub-acute facilities by; identifying, minimising, and managing the individual falls risk factors of patients.
- To ensure appropriate action is taken if a fall incident or injury occurs during hospital admission, to minimise harm to the patient and prevent further falls from occurring.
- Patients identified as at increased risk of falling are discharged with a plan for follow-up support and management in the community as appropriate.

Identifying Patients at risk of falling

Falls Risk Screen

The NSQHSS Standard 10 requires that all hospital patients are screened for falls risk. The tool recommended for NSW is the Ontario Modified Stratify (Sydney Scoring) Falls risk screen.

The falls risk screen is to be completed:

- At first point of contact
- At pre-admission - and flag falls risk for subsequent admission
- On admission to a ward or unit – within 24 hours
- Whenever the patient's condition changes e.g. medically or post-operatively
- Transfer of care to another ward, hospital or subacute unit
- After a fall has occurred

Note: using a screening tool does not replace experienced clinical judgement**.** Patients with a history of falls (including those admitted to hospital because of a fall) should always be considered at increased risk.

Falls Risk Assessment and Management Plan (FRAMP)
If falls risks are identified in falls screen, use the FRAMP to implement the appropriate interventions.

Interventions to address the identified risk factors that are outlined in the FRAMP are informed by the ACSQHC 2009 falls best practice guidelines: *Preventing falls and harm from falls in hospitals.*

Note: screening and flagging do not prevent falls – it is the care provided following the identification of risk that is important to prevent falls.

An individualised patient care plan is to be completed in consultation with the patient, family and carers who should also be provided with information about falls risks in hospital e.g. CEC Falls Prevention flyers.

Multidisciplinary Assessment.
All patients admitted following a fall, particularly those with mobility and transfer issues - consider referral to Physiotherapy and Occupational Therapy for a comprehensive assessment. Health Services will be required to have systems in place for multidisciplinary intervention. Where there is no ready access to allied health service, ward staff to be provided with education and support to ensure they can identify and care for people who have a falls risk, especially those with poor mobility and self-care issues.

Communication
Falls risk and care plan is to be documented and communicated at each clinical handover. The clinical team is to engage with patients, families and carers in the provision of care and special communication tools may be required, for example the communication questions as described in the CEC Top 5 Program.

Note: Health care interpreters can be used to provide information to patients who are unable to speak English proficiently.

Flag Patients Identified at Increased Risk of Falling
Patients identified at risk of falling are to be flagged as per local protocol e.g. using a patient sticker. This sticker can be ordered through Fuji Xerox, State Order No:
NH 600955

Toileting protocols or practices should be in place for all patients at identified with toileting issues. One of the most common causes of patient falls in hospital is related to their need to get to the toilet in a timely manner. Health services are to ensure that

patient have easy access to the bathroom and night lighting to assist people to get to the toilet.

Patients with toileting issues will benefit from prompted voiding and regular monitoring e.g. rounding. Where possible a continence assessment and plan should be in place. High risk patients, and in particular patients who are confused and not able to follow instructions should not be left unsupervised in the toilet.

Falls Equipment
Falls and fall injury prevention equipment is to be available for use by staff and patients and appropriate education and information is to be provided to staff patients and families about their use. Equipment may include items such as lo-lo beds, bed and chair alarms. Each LHD is to have an approved list of equipment for falls prevention.

Special Considerations
Patient with cognitive impairment
Patients in hospital are at increased risk of cognitive impairment associated with illness, increasing age and an unfamiliar environment. In older people dementia and delirium are the most common forms (may exist in all age groups due to acquired brain injury, mental health conditions and pre-existing conditions).

Examples of different behaviours that contribute to increased risk of falls in people with cognitive impairment include agitation, wandering, reduced awareness of environmental hazards, impaired ability to solve problems and impulsiveness. Patients may have impaired postural stability and altered gait patterns.

Some patients may require increased supervision, and more frequent observation to ensure timely and proactive assistance that facilitates safety in self care, mobility and transfers. This may also require providing constant supervision when attending to patient toileting and showering.

Staff are to ensure that there is referral to the appropriate clinician for investigation of causes and treatment. A cognition screen (e.g. AMTS, MMSE, SIS, RUDAS) should be attended, and a screen and management for Delirium is required (e.g. Confusion Assessment Method (CAM).

When a patient is cognitively impaired or has communication difficulties, if possible staff are to engage with family or carer about patient's usual mental status and care routines prior to admission. Staff to encourage carers/family/friends to be involved in the patients falls prevention strategies. Family/carers can often alert staff to changes in cognition and this does need to be investigated.

Note: Restraints (both mechanical and chemical), including bed rails, **are not recommended** as a first line precaution for the prevention of falls for patients with altered mental status.

Increased Supervision.

Patients at high risk of falling may require increased supervision and observation. Health Services will be required to have systems and process in place to increase the supervision and observation of patients who are considered high risk.

Possible interventions include:

- Moving a patient closer to the nurse's station for observation.
- Considering co-locating high risk patients with increased supervision.
- Reviewing staffing allocation practices to ensure that staff mix and patient/staff ratio is optimal to meet needs of patient needs and peak workload periods.
- Consideration of an Individual Patient Special (IPS) for patients at high risk of falls, particularly for those with altered mental status.
- If using volunteers sitters, their role should be clearly defined.
- Sitters/IPSs should have cover for meal/toilet breaks.
- Encouraging and supporting family/carers/sitters to provide increased supervision as appropriate.
- Consider use of bed/chair alarms to notify staff when an at risk patient attempts to mobilise.

Individual Patient Specials (IPS)

The provision of an IPS can increase the cost of the overall provision of staffing costs on a ward. Careful consideration is to be given to the implementation of an IPS. Care of a patient that is confused and disorientated, agitated or behaviourally disturbed is challenging. Staff require skills to undertake processes for screening, assessment and management of a confused older person, and knowledge about referral processes for further intervention and employing an IPS. Medical staff are an important part of the care team and they need to be informed and trained in appropriate interventions, including the use of psychotropic medication.

Staff who undertake the role of an IPS require special skills to be effective. This not only includes education about confusion (delirium, dementia, behavioural disturbance), but also care skills in the provision of safe mobilisation, personal care (toileting and showering), nutrition (food and fluids), communication and diversional activities.

Bone Health (Osteoporosis)

Osteoporosis diagnosis and management is an important consideration in the minimisation of fall injury and fracture prevention. If an older person or post-menopausal woman is admitted with a fracture or history of recurrent falls, staff are to follow-up with the patients treating doctor re investigations for osteoporosis, and if present, commenced on a management plan of appropriate evidence-based treatments**.** Treatments may include commencing calcium, Vitamin D and anti-resorptive drugs. Mobilisation of the patient at risk is to be encouraged and supported by staff.

Recommendations re osteoporosis assessment and treatment should be conveyed to the patient's general practitioner as part of the discharge process.

Management of Patients who have fallen

If a patient falls in hospital, staff are to implement immediate care and management, in accord with the CEC Post Fall guide.

Health Services are to ensure that staff are provided with education on post fall assessment and management. Staff are to ensure that there is accurate and complete documentation of the fall event, in the health care record and in the Incident Information Management System (IIMS) and that the family/carer are notified. Patients/families/carers are to be provided with information/strategies to prevent further falls in hospital

A re-assessment using the FRAMP is to be completed (in consultation with patient/family/carer if possible) identifying interventions to reduce further risk of falls. This information is to be documented in the care plan and communicated to the care team. A post fall huddle is recommended following a fall so the care team can discuss what happened, how the fall happened and how to reduce the risk of this happening again.

Following a serious fall or a repeat fall, the care team should undertake a review of the falls incident. For SAC1 a Root Cause Analysis (RCA) will be completed. For serious falls events (SAC2, or repeat faller) an analysis of the falls event will provide feedback as to what improvements could be made. The CEC SAC2 Fall Incident Investigation Form may assist in this review process.

Improvements in care and safety should result in recommendations for:

- Changes in care to reduce the likelihood of further falls
- Ward/facility/Health Services wide practice change, and reports made to the appropriate quality and safety executive committee
- Comprehensive incident data capture.

Discharge

Prior to discharge from hospital patients with identified/ongoing falls risks to be referred to appropriate community services. Information is to be provided to the patients GP about fall risk and referrals that have been made. The discharge summary is to include information about medications including whether bone health treatments have been commenced or to be commenced by the GP.

If a patient has had a fall in hospital, patients/families/carers to be provided with the CEC post fall discharge information flyer on discharge.

Emergency Departments

Patients who present to Emergency Departments (ED) will be screened for fall risk. Younger people will be screened if they present as a result of a fall, or combination with unsteadiness or a recent history of fall (more than 2 in the past 6 months) or a condition that is associated with increased risk such as osteoporosis, neurological conditions and disability or chronic conditions.

Patients admitted to hospital will be screened for falls risk, using the **Ontario Modified Stratify (Sydney Scoring) tool.** This tool is provided in the Adult Emergency Department Observation Chart and on ED First Net.

Some patients will require follow-up in the community services after discharge, where possible staff to ensure the referral is made. The discharge summary to GPs is to include:

- Information about falls risk identified
- History of a fall
- Any referrals made to community services.

Residential

All patients admitted to NSW Health long stay facilities, including Multipurpose Services will be assessed for falls risk and suitable interventions are to be in place.

Capital Works Planning

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 all new facilities / renovations should take into consideration:

- That 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
- Fall resistant floor surfaces and coverings
- The design of toilets and showers to enable easy access
- Building layout to that ensures safe design features for older people.