WACHS Falls Prevention and Management - Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the prevention and management of falls throughout the WA Country Health Service (WACHS).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

The information should not replace the advice / instructions from senior clinicians as required, but serves to provide a minimum set of standards of care to be delivered.

This policy is to be used in conjunction with:

- WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018

For newborns and children refer to:

- Child and Adolescent Health Service (CAHS): Falls Risk Management Policy
- Women and Newborn Health Services (WHNS): Falls: Care of a newborn following a drop/fall

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency.

3. Procedural Information

Where care requires specific procedures that may vary in practice across regions staff are to seek senior clinician advice. Quick access to specific sections can be located via:

4. Considerations

- The minimum interventions for falls prevention listed on the MR521 Falls Risk Assessment and Management Plan (FRAMP) are adhered to at all times
- WACHS staff are to utilise the MR111 Nursing Admission, Screening and Assessment Tool to determine if a full FRAMP assessment is required.
- All interventions/strategies that are not on the MR521 Falls Risk Assessment and Management Plan (FRAMP) must be transcribed onto the patient care plan (only if they are not on the "other interventions section of the FRAMP)
- Falls and injury prevention needs to be addressed at the point of care and from a multidisciplinary perspective[1]
- Post Falls Management must adhere to WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018

5. General Information

Relatively minor falls in older people can lead to death and significant injury and/ or result in increased levels of anxiety and social withdrawal. Once a person has had a fall in hospital, they are at greater risk of having more falls[1]. A fall is not only an event that results in coming to rest on the ground or floor or other lower level but extends to the result of that fall (refer to Definitions).

6. Risk Factors

Falls can occur at any age however the frequency and severity of falls related injuries increase significantly with age[1,2]. At risk groups are (but not limited to):

- People aged 65 years and over (increased incidence)
- Aboriginal and Torres Strait Islanders (aged over 45 years and over)
- Younger people at increased risk of falling, such as those with:
  - history of falls
  - neurological conditions
  - cognitive impairment
  - depression
  - visual impairment
- Medical conditions leading to an alteration in functional ability[1,3]

Falls are associated with a number of predisposing risk factors that can be classified as intrinsic (personal) or extrinsic (environmental). A fall is usually the result of the complex interaction of risk factors:

Intrinsic (Personal) Factors[2,4,5]

- Impaired strength, flexibility, mobility, gait and balance instability
- Urinary incontinence or frequency, or need for assisted toileting
- Impaired cognition and confusion
- Impaired vision (acuity and depth)
- Deteriorating health (acute medical illness) and associated medical conditions
- Polypharmacy
- Drug and alcohol use
- Previous history of falls
- Inadequate nutrition and diet

Extrinsic (External) Factors[2,4,5]

- Unstable furniture
- Inadequate lighting
- Improper use of equipment
- Uneven and slippery surfaces
- Cluttered areas
- Use of Restraints
- Hospitalisation for 19 days or more
- Individual surveillance and observation - falls most commonly occur at times when observational capacity is low (by staff and/or visitors)

7. Falls Risk Screening and Assessment

Key principles – assessment

- Cultural, ethical and communication requirements of the patient
- Ensure choice of equipment is appropriate for the age, size and condition of the patient
- Review patient history and diagnosis for clinical conditions, medications and psychosocial factors that could increase falls risk
- Information provided by patient, family and/or carer about the risk of falling and safety concerns

Risk screening and assessment - inpatients

- All patients who are admitted should be screened for falls risk as soon as possible using the appropriate tool e.g. MR111 Nursing Admission, Screening and Assessment Tool (Adults), MR521 Falls Risk Assessment and Management Plan (FRAMP)[1], the MR521P Paediatric Falls Risk Assessment Tool (Paediatric Patients), the MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis, or the MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis.
- If the patient is identified as at risk for falls, complete a full risk assessment, identify and document individualised interventions using the FRAMP including:
    - Identification on the FRAMP if the patient requires falls prevention minimum interventions only or minimum and individualised interventions
    - Additional interventions specific to the patient that are not listed on the FRAMP must be documented on the 'other individualised interventions section' of the FRAMP

  - Documented evaluation of strategies and reason for change as appropriate in the patient's medical record

  - Shift by shift sign-off of interventions must be completed

    Exclusion: sign off is required at least daily for residents in aged care facilities/ stand-alone accommodation separate from the main multi-purpose service (MPS) e.g. lodges, and who are low risk of falls, however procedures must be in place outlining who, when and how this occurs (refer to Residential Aged Care section).
- Communication and information provided to patients/family/carers at risk should be documented on the appropriate section of the FRAMP
- Re-screening of falls risk should be performed and documented as soon as possible following:
  - Ward Transfer[1,5,6]
  - Post Fall (PF)
  - Post Medical / Surgical Condition Change

Risk screening and assessment - Maternity

Falls risk assessment and screening is performed via the MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis and MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis forms which are completed on admission, post birth and before discharge. If at any point a risk factor is identified, the FRAMP is commenced.

8. Residential Aged Care

Further information, refer to:

- Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Community Care 2009
- Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Residential Aged Care Facilities 2009
- Australian Aged Care Quality Standards
- Residential Aged Care – Pre-Admission Checklist - Conditions of Occupancy and Resident's Agreement
- User Rights Principles 2014 - Part 2.2.10 – outlines responsibilities of approved providers of residential care including restrictions on moving care recipient within residential care service

Within WACHS there are certain sites that house residential aged care consumers who require minimal supervision and interventions. Although these sites are affiliated with a multipurpose site they are not located on the same site as the main care facility and are known as stand-alone accommodation. Some do not have registered healthcare workers on site 24hours per day.

Residents in stand-alone aged accommodation e.g. lodges separate and off site from the main multi-purpose service (MPS) and who are low risk of falls still require a daily check and sign off of interventions on the FRAMP. This can be achieved by the nurse visiting daily and signing based on reports by unregulated health care workers.

Assessment

When residents are admitted into a residential care facility staff are to follow the Residential Aged Care - Admission to Residential Facility Flowchart to ensure all relevant assessments are completed in a timely manner ensuring relevant referrals to allied health for further assessments are completed where required.

Individualised interventions

All interventions relating to falls for residential aged care should be covered in the residential care (RC 5 & 7)) plans and assessments that inform the care plans, including external/internal factors and multidisciplinary services involved in the care of the individual. If staffing cannot be arranged to support residents of stand-alone aged accommodation who are assessed as a high falls risk and require increased surveillance and monitoring as per the FRAMP, transfer to a higher level of care e.g. the affiliated MPS needs to be considered. The process of transfer needs to adhere to the WA Health OD 0214/09 Security of Tenure for Residents of Aged Care Facilities.

Each resident upon admission is required to receive a Residential Aged Care – Pre-Admission Checklist - section 8 outlines the circumstances in which a resident may be asked to leave the residence.

If the resident has the appropriate decision making capabilities to understand the risks involved and they decline to be moved they have the right to remain in the current location. Discussions with the resident, family and carer are to be initiated and staff are required to inform the medical team, documenting this decision in the medical record. A new plan of care (RC6 Specific Care Plan) incorporating these decisions is to be clearly documented including frequency of reassessment and parameters for escalation.

9. Falls Prevention

Completion of a falls risk assessment is the first step in preventing falls. Accurate assessment and documentation will promote continuity of care and initiate effective falls prevention strategies[1,7]. Prevention of falls needs to take a holistic view of the patient; including their physical and mental health, mobility and environment. Further information can be found via the Falls Prevention Health Network relating to the Falls Prevention Model of Care.

Minimum interventions

All inpatients must have the minimum interventions listed on the relevant screening/ assessment tool e.g. MR521 Falls Risk Assessment and Management Plan (FRAMP)[1], MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis, MR80A.2 Postnatal Risk Assessment for VTE Prophylaxis, and must have the appropriate sign off section completed or documented on the FRAMP, individual care plan or pathway.

The following interventions are to be implemented for all general adult inpatients as appropriate:

- Provide ongoing orientation for patient to bed area, toilet facilities and ward.
- Demonstrate the use of call bell, ensure it is in reach and that they can use it effectively.
- Ensure frequently used items including mobility aids are within easy reach of patient.
- Encourage patient to use their aids such as glasses or hearing aids.
- Adjust bed and chair to appropriate height for patient.
- Minimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may lead to falls.
- Place IV pole and all other devices/attachments on the exit side of bed. (Consider the need for IV fluids and remove unless indicated).
- Remove clutter and obstacles from room.
- Provide adequate lighting according to patient activities/needs.
- Encourage patient to take adequate fluids and nutrition.
- Optimise footwear where possible- discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable.
- Inform the patient that all inpatients are at increased risk of falling due to injury / illness / medications

Individualised interventions

- Patients identified as being at risk of falls require individualised interventions depending on the needs of the patient.
- Additional interventions specific to the patient that are not listed on the FRAMP must be documented on the 'other individualised interventions section' of the FRAMP.
- Individual interventions and minimum interventions should be checked each shift and signed off (daily for residential aged care).

Communicating fall prevention information with Patients and/or Carers

- At each screen, updated information should be provided to the patient and/or carer regarding falls risks and identified prevention strategies.
- The appropriate section on the rear of the FRAMP MR521 should be signed as evidence of discussion and understanding.

Bed Rails

Practical and ethical considerations mean that bedrails are not usually appropriate for a patient:

- Who could be independently mobile without them
- With capacity who does not want them
- With severe confusion who is mobile enough to climb over them

Bedrails should never be a substitute for adequate levels of care and observation or used as a stand-alone method of falls prevention. Reducing the use of bedrails does not appear to change the total number of falls that occur in the hospital but can decrease the number of serious falls.
Minimise the use of restraints and bedrails. The use of bedrails requires careful and frequent assessment. When bed rails are in use the patient call bell, bedside table and fluids must be within reach at all times.

For patients without decision-making capacity, staff have a duty of care to act in the patients best interests underpinned by realistic assessment and regular review of the individual risks of bedrail use or non-use. This duty of care also applies in instances when the relative or carer of a patient without decision-making capacity requests staff use bed rails.

Bedrails should only be considered for:

- Safety measures e.g.:
  - Patients being transported on a bed/trolley within the hospital. Bedrails are not considered a restraint when use is based on assessed safety needs of the patient
  - When the patient is incapable of making a voluntary or involuntary movement
  - For a sedated, comatosed or paralysed patient, or if a patient is fitting or thrashing around, a nurse may be required to stay with the patient
- The patient is able to express consent such as:
  - Wishes to use the bedrail as a mobility aid to assist in turning
  - Requests a bedrail as a reminder not to get up unaided.

Low-low beds

Note: the term low-low bed is used covering the different beds (e.g. ultra-low, floor line, lo-lo, Hillrom) that lower the mattress height to approximately 25 centimetres from floor level.

Some patients are at risk of falling from bed. Risk factors include dementia, delirium, agitation, disorientation, limited mobility and acute illness. These patients may, in the past, have been nursed on mattresses on the floor.

Where the use of bedrails is inappropriate, consideration must be given to the use of a low-low bed. However, they must not be seen as a universal falls prevention solution and provided inappropriately for mobile patients.

Low-low beds can reduce the risk of a fall from height, whilst allowing staff to attend to the patient, with consideration to back care. It is important to note that even when used correctly in the lowest position, some patients may still sustain serious injuries such as a fractured hip or intracranial injury. Refer to Appendix 3 Use of low-low beds in falls prevention.

10. Post Fall Management

Falls are a major cause of death, injury, functional decline, hospital admission, psychological trauma and institutionalisation in older people.[1,2,7] Consequences of falls resulting in minor or no injury are often neglected, but factors such as fear of falling and reduced activity level can affect function, quality of life, and increase the risk of serious falls[1,2] and impact on length of hospital stays.

Patient care and the review of fall prevention interventions after a patient falls is the responsibility of all clinical disciplines.

Following an inpatient fall Medical Officers are to be notified and a review requested. If significant physical injuries are identified Medical Officer review within 30 minutes (urgent if the patient meets MER criteria) is required which may be achieved via the Emergency Telehealth Service.

Recommended timeframes for the notification and review by Allied Health and Pharmaceutical clinicians following a fall described in the WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018 will vary depending on local service models.

The WA Health Clinical Incident Management Policy requires all inpatient falls to be notified within the DATIX Clinical Incident Management System (DATIX – CIMS).

Following a fall staff must escalate care and follow site processes for escalation per the WACHS Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy. Consideration should be given in relation to the need for pain relief and administration of analgesia as indicated

Staff should consider the potential risk of spinal or head injury prior to moving the patient:

- should a spinal injury be suspected and if mechanical aids to lifting are unavailable or inappropriate seek advice from senior clinician /medical officer prior to moving patient
- if staff are unable to find the required equipment in the local area, it is essential to the safety of the staff that they wait for the correct assistance and/or mechanical aids. Ensure the patient is kept warm and comfortable.

Post falls management in WACHS Hospitals is to follow the WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018 (the guidelines). The Guidelines include:

- Discipline specific guidance for Nurses and Midwives, Medical Officers, Occupational Therapists, Physiotherapists and Pharmacists.
- A Nursing Guideline and 48 Hour post fall process flowchart (included in this CPS as Appendix 1).

- Medical practice guidance addressing History, Examination, Investigation (including when to consider a CT head and/or cervical spine). Medical Practice Guidance is included in this CPS as Appendix 2.

11. Clinical Communication

Clinical Handover

Information exchange is to adhere to MP 0095/18 WA Health Clinical Handover Policy using the iSoBAR framework.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

- Outcomes of Falls Risk assessment to be reported at handover including prevention strategies
- Any fall that occurs is handed over to all staff involved in the care of the patient and includes ongoing monitoring, treatment and prevention requirements[11]

Documentation

An individualised management plan is to be documented in the patient's health records as soon as practicable, in regard to this CPS. Refer to the WACHS Documentation CPS.

The plan must consider:

- Falls risk screening, assessment and individualised interventions are recorded in the FRAMP as soon as is practicable
- Record additional individualised interventions/strategies that are specific to the patient on the appropriate section of the FRAMP.

Post fall documentation

- Document outcomes in patient health record as required including any medical review, specific observations required and transfer/ escalation parameters
- Amend the patients management plan, mobility chart and notes to make any necessary changes to reduce the risk of the patient falling again
- Falls risk stickers / stamps (as appropriate to site specific guidelines) are to be placed on the patients care plan to identify them as being at high risk for falls, initiate frequent faller programs as appropriate for sites to escalate review of certain individuals

Document a full assessment of the risk factors and relevant interventions to be documented in the appropriate section of the FRAMP including:

- mobility/functional Ability
- medications/medical conditions
- cognitive state
- continence/elimination needs

Patient/Carer information

There are a number of ways patients and carers can obtain specific information relating to hospital admissions, transfers and discharge from hospital.

Refer to:

- Health advice following a fall (PDF 63KB) or (Word 110KB)
- Stay On Your Feet®

12. Community / Rural Settings

For further information refer to:

- Stay On Your Feet®
- Preventing Falls for Older Farmers
- Move Improve Remove booklet for Aboriginal People (via the Stay on your feet resources page – A5 can be ordered and sent to people)

Once a consumer is discharged from hospital and requires follow-up with a physiotherapist the FRAMP no longer applies as they are not classified as inpatients. Different assessment tools and intervention strategies will be more appropriate as per specific individual requirements, resource availability and location within WACHS.

Assessment

Physiotherapy assessment tools that are used in the community may include (but are not limited to):

- Falls Risk Assessment Tool (FRAT) – this does not require shift by shift sign off which is more applicable to outpatient settings
- De Morton Mobility Index (DEMMI)
- Short Form Falls Efficacy Scale -1 (to measure fear of falling)
- Timed up and go (TUG)
- The Berg Balance Scale (BBS)

Interventions are tailored specifically to the individual needs and may include further assessment from other allied health professionals including (but not limited to):

- Physiotherapy assessment of mobility/balance and then either 1:1, group or TA therapy program as indicated
- OT assessment of home environment, cognition and ADLs and IADLs
- Referral to Pharmacy for medication review, especially if polypharmacy; Dietitian referral if at risk of malnutrition
- Referral to Day Therapy Unit (DTU) On Your Feet Workshops (Falls Prevention education; Falls Action Plan; Practical session for practicing getting on and off the floor) as appropriate or consider referral to physiotherapy and/or occupational therapy for falls prevention education, to develop a falls action plan and where appropriate provide practical sessions for getting on and off the floor
- Referral to Podiatrist if indicated
- Referral to optician if has not had review for over one year.

13. Staffing Requirements

Workforce training must be available for staff on falls screening, prevention, inclusive of risk identification and mitigation strategies and post-fall management

Falls risk assessment tools are available to staff at the point of patient presentation

14. Compliance Monitoring

WACHS regions are to use a risk based approach to determine the frequency of monitoring clinical practice against the Falls Prevention and Management Clinical Practice Standard.

The following resources have been endorsed for use by WACHS:

- The WACHS Combined Bedside Risk Assessment Audit for acute and subacute adult inpatients(CoBRA Country intranet link)
- WA FRAMP audit tool (external link to Survey Monkey)
- WA FRAMP Audit tool (pdf)
- WA FRAMP Audit Analysis tool (excel spreadsheet) for use with the FRAMP Audit tool online
- WA FRAMP Intervention, Implementation and Appropriateness Audit Tool (external link to Survey Monkey)
- WA FRAMP Intervention, Implementation and Appropriateness Audit Tool (pdf)

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

15. Records Management

WACHS Health Record Management Policy

16. Relevant Legislation

(Accessible via: Western Australian Legislation or ComLaw sites)

- *Aged Care Act 1997*
- *Carers Recognition Act 2004*
- *Disability Services Act 1993*
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Occupational Safety and Health Act 1984*
- Occupational Safety and Health Regulations 1996
- *Medicines and Poisons Act 2014*
- Medicines and Poisons Regulations 2016

- *Privacy Act 1988*
- *State Records Act 2000*

17. Relevant Standards

National Safety and Quality Health Service Standards
Comprehensive Care Standard: 5.24, 5.25. 5.26
Recognising and Responding to Acute Deterioration Standard: 8.4, 8.6, 8.10

Australian Aged Care Quality Standards
Standard 2a, 2e,3b,3d and 3f

18. Related WA Health Policies

MP 0053/17 Clinical Alert (Med Alert) Policy
MP 0095 Clinical Handover Policy
MP 0122/19 Clinical Incident Management Policy 2019
MP 0086/18 Recognising and Responding to Acute Deterioration Policy
OD 0214/09 Security of Tenure for Residents of Aged Care Facilities
OD 0657/16 WA Health Consent to Treatment Policy
OD 0592/15 WA Open Disclosure Policy
WA Health Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018

19. Relevant WACHS Policy Documents and Forms

Aged Care Accreditation Standard 2.14 Mobility and Dexterity Flowchart
Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy
Documentation Clinical Practice Standard
MR111 Admission, Screening and Assessment Tool
MR521 WACHS Falls Risk Assessment Management Plan (FRAMP)
MR60.1.5 WACHS Malnutrition Screening Tool
MR60.1.8 WACHS Mini Nutrition Assessment - Short Form (MNA-SF)
MR80A.1 WACHS Antenatal Risk Assessment for VTE Prophylaxis
MR80A.2 WACHS Postnatal Risk Assessment for VTE Prophylaxis
RC5 WACHS Resident Admission Assessment
RC6 WACHS Specific Care Plan
RC7 WACHS Resident Care Plan
Residential Aged Care - Admission to Residential Facility Flowchart
Residential Aged Care – Pre-Admission Checklist

20. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

21. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Clinical Practice Standard, and the Royal Perth Bentley Group guidance on the use of ultra-low beds.

22. References

1. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people: Best practice guidelines for Australian hospitals. Sydney: ACSQHC; 2009
2. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide standard 10: Preventing falls and harm from falls. Sydney: 3 ACSQHC; 2012
3. Haines, TM, Hill, AD, Hill, KD et al. Patient education to prevent falls among older hospital inpatients: a randomised controlled trial. *Arch Intern Med*. 2011; 171: 516-24.
4. Australian Commission for Safety and Quality in Health Care. National safety and quality health service standards. Sydney, NSW: Australian Commission for Safety and Quality in Health Care; 2011
5. Degelau J BM, Bungum L, Flavin PL, Harper C, Leys K, Lundquist L, Webb B, Institute for Clinical Systems Improvement (ICSI). Prevention of falls (acute care). Health care protocol. Bloomington, MN: Agency for Healthcare Research and Quality (AHRQ); 2012
6. Department of Health WA. The falls policy for older Western Australians. Perth, WA: Department of Health; 2004
7. Department of Health WA. Falls prevention model of care for the older person in Western Australia. Perth, WA: Health Networks Branch, Department of Health; 2008.
8. Pamaiahgari P. Falls (older adults): Preventative interventions. Adelaide, SA: The Joanna Briggs Institute; 2011. Accessed 6 December 2012.
9. Teasdale G, Jennett B,. Assessment of coma and impaired consciousness. A practical scale. Lancet 1974;2(7872):81-4.
10. Cohen DB, Rinker C, Wilberger JE. Traumatic brain injury in anticoagulated patients. The Journal of trauma 2006;60(3):553-7.
11. Jones S, Kafetz K. A prospective study of chronic subdural haematomas in elderly patients. Age Ageing 1999;28(6):519-21.
12. Clemson L, Finch CF, Hill KD, Lewin G. Fall prevention in Australia: policies and activities. *Clinics in Geriatric Medicine.* 2010;26(4):733-749.
13. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards Version 2: Consultation draft. Sydney: ACSQHC, 2015.

23. Definitions

Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, a medical condition (including a terminal or chronic illness) or a mental illness, or are frail and/or aged
Fall	The World Health Organization defines a *fall* as ‘an event that results in a person coming to rest inadvertently on the ground or floor or

	other lower level'[1] and 'an *injurious fall* is a fall that results in a physical injury, including bruising, laceration, dislocation, fracture, loss of consciousness, or if the patient reports persistent pain[13].
Patient	A person who is receiving care in a health service organisation
Residential Care Record	The compilation of information for an aged care resident's health history, past and present, organised in such a manner that critical information concerning a patient is immediately accessible

24. Appendices

Appendix 1 Nursing Guideline and 48 Hour Post Fall Process

Appendix 2 Medical Guidance

Appendix 3 Use of low-low beds in falls prevention

This document can be made available in alternative formats on request for a person with a disability

Contact:	WACHS Project Officer, Clinical Practice Standards (R. Phillips)		
Directorate:	Medical Services	**EDRMS Record #**	ED-CO-18-76629
Version:	3.01	**Date Published:**	15 October 2024

Appendix 1: Nursing Guideline and 48 Hour Post Fall Process

Source: Western Australian Department of Health. Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018. Perth: Post Fall Working Group Western Australia; 2018

NURSING GUIDELINE AND 48 HOUR POST FALL PROCESS

Stop and Consider: Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy (e.g. alcohol dependent persons) are at an increased risk of intracranial, intrathoracic, intra-abdominal haemorrhage

DATE AND TIME OF FALL:

IMMEDIATE POST FALL PROCEDURE

DRSABCDE

- Provide patient reassurance and comfort and call for assistance
- Patient not to be moved if any physical injuries identified (unless airway is compromised)
- Activate Medical Emergency Team (or local process) if patient meets criteria
- If significant physical injuries identified, fast track Medical Officer review within 30 minutes
- Immobilise cervical spine if patient is unconscious or reports head or neck pain
- Patient movement to be guided by local policy and clinical assessment
- Commence neurological and baseline physical observations
- Minimum investigations include blood glucose level, ECG cognitive impairment screening using the AMT4/4AT/CAM (as per local policy). Identify immediate pre-fall symptoms e.g., dizzy, feeling unsteady, etc. and consider other investigations as indicated by the pre-fall symptoms, contributing factors to the fall and the patient's condition
- Notify Medical Officer of patient fall and request review. (If no apparent injury, this can occur within 4 hours or as per local policy)
- Notify Ward/Area/ Facility/ Senior Registered Nurse (SRN)/After Hours Clinical Nurse Specialist

TYPE OF FALL AND ONGOING OBSERVATIONS AND CARE DELIVERY

WITNESSED FALL – DID NOT HIT HEAD	PATIENTS ON ANTICOAGULANTS/ANTIPLATELETS AND/OR WITNESSED FALL – HIT HEAD, UNWITNESSED FALL
• Medical/SRN's clinical judgment for observations. • Documentation of rationale required. Continue with instructions below.	Neurological observations: • Half-hourly for a minimum of 2 hours until GCS of 15 or patient considered back to their normal level of cognition achieved. • Continue if GCS remains < 15 or patient not considered at normal level of cognition. Report to MO and continue as per instructions. If patient has GCS of 15 or patient considered back to their normal level of cognition then continue: • Hourly for 4 hours. • Two-hourly 4 hours. • Four-hourly for 40 hours (to make total of 48 hours from time of fall). • If clinically assessed as stable, no deterioration, return to observations pre-fall.

RECOMMENDED ACTIONS WITHIN 4 HOURS OF THE FALL

- Next of Kin (NOK) notification
- Physical, behavioural, and cognitive injury care as indicated
- Continue to identify and report clinical deterioration
- Rescreen using FRAMP (or local endorsed falls risk assessment tool) and implement interventions
- Medical review (if not fast tracked)
- Documentation and reporting of the fall
- For an injurious fall that may be considered a SAC 1 injury – complete notification as per local clinical incident management policy

Nursing Guideline and 48 Hour Post Fall Process cont…

RECOMMENDED ACTIONS WITHIN 6 HOURS: CONTINUE OBSERVATIONS AS INDICATE BY FALL TYPE

- Continue to monitor for physical, behavioural, cognitive clinical deterioration. Report to MO if this occurs.
- Notification of fall to Occupational Therapist or Physiotherapist.
- Notify the Pharmacist when possible.
- Referral to other health professionals as per clinical assessment (and as per local policy).

RECOMMENDED ACTIONS WITHIN 24 HOURS: CONTINUE OBSERVATIONS AS INDICATED BY TYPE OF FALL

- Patient and family/carer to receive information and education. Ongoing falls management care developed in partnership with patient and family/carer.
- Review of results of bloods, imaging, microbiology, and observations has occurred and been actioned.
- The multidisciplinary team members have collaboratively discussed the fall and identified any further risks and interventions required.
- Consider a structured multidisciplinary Post Fall Safety Discussion.

RECOMMENDED ACTIONS AT 48 HOURS:

- Review of observations and if no clinical deterioration, return to appropriate observations.
- Completion of all actions within the guidelines.
- Comprehensive care plan review.
- Document and communicate to the appropriate person any outstanding actions and date/time completion required.

COMMUNICATION:

- Ensure patient consents to discussion of care with family/carer (where clinically appropriate).
- Interpreter is always to be utilised where appropriate (and as per local policy).
- Primary nurse to ensure documentation in patient's health care record and local reporting database.
- Medical and allied health reviews documented in the patient's health care record.
- Patient and family/carer to receive information/education about the fall and ongoing instructions if discharged within 48 hours of the fall.
- All disciplines involved are to partner with the patient and family and share decisions to develop ongoing plan of care.
- Communication may require different approaches depending on disability/cultural requirements.
- Documentation of the fall to occur on nursing, medical, allied health handover sheets, and all transfer and discharge documentation.
- Inclusion of the fall in verbal handovers: nursing, medical, allied health.
- All staff involved in the care of the patient to be informed of incident outcome and revised care plan.
- Visual flagging that the patient is at high risk of falls (and as per local policy).
- Contact Ward/Area/Facility/SRN/After Hours Clinical Nurse Specialist (and as per local policy)

ALLIED HEALTH ASSESSMENT: OT, PHYSIOTHERAPY, PHARMACY

- Complete assessments as per specific discipline guidelines within 2 working days of the fall (and as per local policy).
- Work collaboratively with the wider multidisciplinary team.

Appendix 2: Medical Guidance

Source: Western Australian Department of Health, Post Fall Multidisciplinary Management Guidelines for WA Health Care Settings 2018. Perth: Post Fall Working Group Western Australia; 2018

Medical practice guidelines (inpatient falls)

Introduction – the facts

- Once a patient has had one fall in hospital, they are at risk of having more falls.
- All falls are to be treated seriously by staff as often a fall is an indication of an underlying problem that can be treated.
- 'Even relatively minor falls in older people can lead to death or significant injury'.

Protocol

- Every patient experiencing a fall in hospital requires a timely medical review (urgent if deteriorating, within 30 minutes if injured, and within 4 hours for most other falls).
- Services without resident medical staff should follow local escalation processes including use of the Emergency Telehealth Service (ETS).
- Responding to the fall incident requires the provision of immediate first aid, longer-term care, and active addressing of falls risk factors to prevent future falls.

History

- Talk to the patient about the fall and symptoms arising from the fall.
- Review medical entries in the patient's health care record and medication chart to identify factors that may put the person at risk of falling, or of having an injury from the fall.
- Establish the patient's baseline mobility and cognitive state and determine whether it has changed post fall.
- Specifically, document whether the person is on Warfarin, Enoxaparin (Clexane), Heparin, Apixaban (Eliquis), Rivaroxaban (Xarelto), Dabigatran (Pradaxa), Prasugrel (Effient) and Ticagrelor (Brilinta), Aspirin, Clopidogrel, Aspirin and Diprydamole (Asasantin®) or other anticoagulant/antiplatelet medication.
- Patients with chronic liver disease or haematological disorders may also be coagulopathic.

Examination

- Examination should always take place, even if you must wake the patient.
- The examination should identify any injury sustained. When examining a patient, be aware that they may not draw attention to all their injuries (particularly if cognitively impaired).
- Do not allow the patient to be moved until head, cervical spine and hip injuries have been ruled out. Spinal precautions must be used if the patient has GCS <13 or a neck injury is suspected.
- The examination should also seek to identify the immediate underlying causes of the fall (infection, arrhythmia, stroke, hypotension, other acute illness).
- The examination should include:
  - Check pulse and blood pressure (when appropriate check postural drop).
  - Assess level of consciousness and document Glasgow Coma Scale.
  - Talk to the patient – assess for confusion (delirium or dementia). Document AMT4 (age, DOB, current year, place).
  - Examine the head, neck, spine, hips, and limbs to identify sites of tenderness/swelling/deformity (for example a shortened, externally rotated leg may indicate a hip fracture).
  - Neurological examination including speech, pupil size, eye movements, facial asymmetry, power, sensation, and plantar responses.

7

- If there are no obvious features of hip fracture, ensure hip range of movement is pain free, and as soon as is practicable ensure weight bearing is also pain free.
- Assess post-fall mobility.

Investigations

- Order relevant investigations and ensure the results are checked and documented in the patient's health care record.
- Exclude intracranial haemorrhage and fractures.

Is a CT head scan required?

i. If the patient has hit their head?[6]

This decision should be individualised and based on their risk of injury. There is no specific research determining the optimal pathway for inpatients. The National Institute for Health Care and Excellence (NICE) guidelines developed for Emergency Departments provide useful criteria for clinicians to assist decision-making. These are reproduced below in Figures 1 and 2.

Sites without available CT scanning should utilize local pathways and consultation services. Deterioration in neurological observations undertaken by nursing staff is a trigger for CT scanning.

Fig 1. ***When to perform a CT head scan within 1 hour[6]***

For adults who have sustained a head injury and have any of the following risk factors, perform a CT head scan within one hour of the risk factor being identified:

- *GCS less than 13 on initial assessment.*
- *GCS less than 15 at 2 hours after the injury on assessment.*
- *Suspected open or depressed skull fracture.*
- *Any sign of basal skull fracture (haemotympanum, 'panda eyes', cerebrospinal fluid leakage from the ear or nose, Battle's sign).*
- *Post-traumatic seizure.*
- *Focal neurological deficit.*
- *More than one episode of vomiting.*

Fig 2. ***When to perform a CT head scan within 8 hours[6]***

For adults with any of the following risk factors who have experienced some loss of consciousness or amnesia since the injury, perform a CT head scan within 8 hours of the head injury:

- *Age 65 years or older.*
- *Any history of bleeding or clotting disorders.*
- *Current anticoagulation treatment.*
- *Dangerous mechanism of injury (a pedestrian or cyclist struck by a motor vehicle, an occupant ejected from a motor vehicle or a fall from a height of greater than one metre or five stairs).*
- *More than 30 minutes' retrograde amnesia of events immediately before the head injury.*

ii. If patient had a witnessed fall and did NOT hit their head and they do NOT need a CT head scan?

- Unless signs of neurological impairment develop.

iii. Unwitnessed fall with no signs of head injury?

Consider CT head scan within 8 hours if:

- Cognitively impaired.
- Neurological deterioration on nursing observations.
- On current anticoagulant treatment.

Whether a CT head scan will alter patient management and patient/carer preferences should be considered; for example, would the patient be considered appropriate for neurosurgical intervention? This dialogue should be documented in the patient's health care record and discussed with the treating specialist.

Is a CT cervical spine scan required?[6]

i. For patients with a head injury:

NICE guidelines[6] make the following recommendations in relation to cervical CT requests:

Fig 3. Risk factors indicating CT cervical spine within 1 hour[6]

- *A cervical spine CT should be arranged within one hour for all adults who have sustained a head injury and have any of the following risk factors:*
  - *GCS less than 13 on initial assessment.*
  - *The patient has been intubated.*
  - *Plain X-rays are technically inadequate (for example the desired view is unavailable).*
  - *Plain X-rays are suspicious or abnormal.*
  - *A definitive diagnosis of cervical spine injury is needed urgently (for example before surgery).*
  - *The patient is having other body areas scanned for head injury or multi-region trauma.*
  - *The patient is alert and stable, there is clinical suspicion of cervical spine injury and any of the following apply:*
    - *Age 65 years or older.*
    - *Dangerous mechanism of injury (fall from a height of greater than 1 metre or 5 stairs).*
    - *Focal peripheral neurological deficit.*
    - *Paraesthesia in the upper or lower limbs.*

Fig 4. Assessing range of neck movement safely[6]

For adults who have sustained a head injury and have neck pain or tenderness but no indications for a CT cervical spine scan, perform three-view cervical spine X-rays within one hour if either of these risk factors are identified:

- *It is not considered safe to assess the range of movement in the neck.*
- *Safe assessment of range of neck movement shows that the patient cannot actively rotate their neck to 45 degrees to the left and right.*

Be aware that in adults who have sustained a head injury and in whom there is clinical suspicion of cervical spine injury, range of movement in the neck can be assessed safely before imaging only if there are no high-risk factors and at least one of the following low-risk features apply. The patient:

- *Was involved in a simple rear-end motor vehicle collision.*
- *Is comfortable in a sitting position.*
- *Has been ambulatory at any time since injury.*

Treatment

- Implement treatment as appropriate (for example resuscitation, immobilisation, pain relief).
- If patient has sustained significant injuries, inform the patient's consultant (or on call consultant after hours). If intracranial haemorrhage is confirmed, also urgently consult the neurosurgical registrar or consultant on call.
- If patient is unstable, return often to review.
- Implement appropriate actions to prevent a recurrence of a fall and communicate these to relevant staff.
- Review for high-risk medications. If clinical evidence for head injury, withhold anticoagulants until CT head scan is available.
- Inform the relevant medical team for follow-up.
- In the case of significant injuries, the doctor should inform the Next of Kin (NOK) if patient consents. Nursing staff will inform NOK about less serious falls.

Stop and consider

- Have head, cervical spine and hip injuries been adequately ruled out? Do not allow patient to be moved until you have done so.
- Spinal precautions need to be used if the patient has GCS <13 or a neck injury is suspected.
- Has a new medical problem, for example sepsis, been adequately ruled out or treated?
- Does the patient have delirium or dementia, and is management in accordance with best practice?

Document and handover

- Documentation in the patient's health care record is vital. Sites may use a separate medical post-fall document, which should be used according to local policy.
- Communicate with relevant staff.

- If you have any doubts about appropriate investigations and management, contact the appropriate senior medical person and after hours, the afterhours registrar or medical officer on call.
- The patient's medical team members are encouraged to collaborate with the multidisciplinary team to identify all the patient's falls risk factors and formulate an individualised management plan to address these.
- The fall should be documented in the discharge summary, along with the falls prevention management plan.

***Note that a fall resulting in death must be reported to the Coroner.**

Appendix 3: Use of low-low beds in falls prevention

Falls risk assessment and management planning

1. Use the FRAMP to identify if patient is a falls risk.
2. Implement minimum interventions for all patients AND for those with specific risk factors use the FRAMP to assist in identifying strategies that may address these risk factors.
3. Consider if there are other strategies that may not be on the FRAMP that could be implemented.
4. Consider if a low-low bed might be of use and suitable for your patient. If used it should be placed flush against the wall with no gaps so that if the patient should roll they cannot become entrapped between the bed and the wall. When the patient is unattended the bed should be lowered to its lower level. When delivering care the bed should be raised to a height that suits the staff member delivering that care, and then returned to the lower level when that care has been completed or if the patient is left unattended at any point.

Patient criteria for the use of a low-low bed

There is no single criterion that indicates that a patient requires a low-low bed. However consideration needs to be given to the following list which is neither exhaustive nor exclusive.

- Inability to get up off the floor
- Assessed as being at risk of falls using the FRAMP
- Impaired mobility (requires assistance or standby with mobility) – this needs to be balanced with a low-bed impacting on the patients independence
- Impaired cognition / confusion e.g. Dementia, delirium, AMT4 is less than 4
- Impulsive and attempting to climb out of bed
- Has sustained a fall during this admission or on previous admissions to hospital

Other considerations

- Physical illness – some interventions may be difficult or impractical when using a low-low bed
- Psychological illness or distress – the unusual position of the bed may trigger distress, agitation or increased confusion
- Previous accidents or injuries from falls may indicate if a low-low bed will reduce the patients risk of falling
- Pressure injury - be aware that patients at risk of falls may also be at risk of pressure injury. Not all pressure mattresses are compatible with the hospital beds available at a site. Sometimes when a pressure mattress is placed on a low-low bed the bed is not then able to be lowered properly to the floor as would happen without a pressure mattress. This negates the potential benefit of using these beds to reduce the risk of injury for patients who roll out of bed. . The mattress may also hang over the edge of the bed itself, the pump can be caught under the bed and the cord too short to lower the bed fully. It may be that a patient with a high risk of pressure injury would be better managed on a normal bed positioned at its lowest height. Staff are encouraged to use risk

assessment and clinical judgement as well as seek guidance from a senior staff member in this situation.
- Ensure that there are no objects that can fall onto the patient to cause injury and that equipment at floor level does not pose a risk to the patient.

Discuss with the patient and/or their carer the patients risk of falls, provide education regarding falls prevention and how the patient and/or their carer can work with the ward team to prevent a fall. If a low low bed is used then explain the reason it is being used to the patient and/or carer and any visitors.

Document the strategies in the FRAMP and ensure that the Patient Care Plan reflects the strategies. Include the patients risk and strategies that are in use / working in the patient handover.

On each shift refer to the FRAMP to ensure that falls prevention strategies are actually in place and review the effectiveness of those strategies. If the patient moves location, changes in condition or has a fall then recomplete the FRAMP including identification of risk factors which may have changed, effectiveness of existing falls prevention strategies and any additional strategies that may be warranted. If existing strategies are effective then continue to put these in place. If strategies are ineffective consider other strategies. It is recommended that you discuss with a senior staff member and/or other members of the multidisciplinary team the falls prevention plan for the patient as there may be other strategies that have not been considered.

Where a low-low bed is used it is important that this is reviewed each shift as part of daily care - as a patients' condition may change quickly the bed may become unsuitable as a strategy to prevent falls for the patient.

Other aspects to consider when a patient is being cared for on a low-low bed.
- Hoists may not easily fit under the bed
- The low-low bed is not to be used for patient transport. Patients have to be transferred to a standard bed for transport.
- Ensure that the weight limit of the bed is appropriate for the patient.