# Falls Prevention and Management

# Policy and Guide Residential Care

Whiddon

## Document Control

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## Document Review

| Date | Description of review | Initiated by | Version |
|---|---|---|---|
| **24 /7/2019** | New template - - Changes to reporting titles - Inclusion of unwitnessed falls - Inclusion of My Life Care Model - Inclusion of Head Injuries - Changes to flow chart - Inclusion of Glasgow Coma Scale | GMCG | 1.2 |
| **18/10/2019** | Minor changes: Removal of flow chart – Assistant nurse when there is an RN on shift Changes to head injury management | GMCG | 1.2 |
| **12/09/2022** | Minor Changes Reformatting, grammatic and error correction throughout - Falls prevention equipment supplied by services included - Governance Statement - FRAT completion/update after falls -<br>Falls definition included, specifically detailing rolls from bed and slides from chairs or beds are considered a fall - Consideration of risk associated with Anticoagulant usage - Falls should be reported each month via a Clinical Indicator report. This report is helpful to systematically identify patterns of fall injury and address the causes<br>Follow up post fall, “four hourly thereafter for a minimum of 48 hours or until assessed as being”, added. | GM QCC | 1.3 |
| **Feb 2024** | Moderate changes Update risk factor identification<br>Update risk factor management actions Update clinical pathways to align with recent best practice guidelines Update recording and documentation | GM QCC | 2.0 |
| **Nov 24** | NDIS Inclusions. Consumers will receive acute care if post fall assessment indicates Updated to reflect governance [1] Australian Commission on Safety and Quality in Health Care Standard 10 Preventing Falls and Harm from Falls | GMCR&C | 2.1 |

# Contents

# Introduction and Whiddon Context

Falls are recognised as a major health problem, worldwide, and the prevention of falls has emerged as an international priority.[1] Falls are now the leading cause of injury-related deaths, across all age groups, in Australia[2] however advanced age is one of the key risk factors. This is most likely associated with the physical, sensory, and cognitive changes associated with ageing, in combination with environments that may not be appropriately adapted for an ageing population.[3] Falls affect at least one-third of community- dwelling older adults every year [4] but the rate of falls in care homes is up to 2.6 times higher. [5] For those in residential care, the profile of risk factors differs to that of community dwellers and different approaches are required to address these factors. Falls risk also increases for younger people who present with reduced or altered balance, gait, and mobility as a result of illness, injury, or disability.

Whiddon's Care Home Residents are also affected by falls. Falls are recorded and reviewed each month and show that, despite our best efforts, fall events are difficult to manage or predict. There is some uncertainty around what causes the fall levels to fluctuate across some services and a lack of consistency around how we manage and prevent falls. Preventing falls was identified as a key direction for Quality Care in our 2023 Strategic Plan. Resident and family feedback from Engagement Sessions identified the importance of supporting maximal independence and mobility while reducing falls. The number of residents who fall per quarter is also reportable to the Department of Health under the National Quality Indicator Program.

Research has demonstrated that falls are not purely random events – they can be predicted by assessing a number of risk factors. Globally there has been a surge of new work conducted to increase knowledge on best practice interventions for remediating these known risk factors. The World Health Organization now states that "most falls can be prevented with appropriate action" and there is an emerging body of evidence for effective and promising interventions.

This Falls Prevention Policy has been designed to reduce fall incidents across all Whiddon Care Homes, while optimising our residents' independence and mobility. The Policy has been created to support Whiddon's purpose of enriching people's lives by developing a range of evidence- based approaches to be trained and implemented across our organisation. We will translate best practice falls prevention research into practice and position Whiddon as a leader in falls prevention.

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[1] Falls prevention in older people and the role of nursing British Journal of Community NursingVol. 29, No. 7Clinical

[2] Australian Institute of Health & welfare Injury in Australia Falls July 6, 2023

[3] American Geriatrics Society and National Institute on Aging Bench-to-Bedside Conference: Sensory Impairment and Cognitive Decline in Older Adults

[4] Australia and New Zealand Falls Prevention Society

[5] Australian Institute of Health and Welfare Falls in older Australians 2019 – 20: hospitalisations & deaths among people aged 65 and over

# Policy

This policy applies to consumers in Residential Care and Community Care funded by the Department of Health and Aged Care and the National Disability Insurance Scheme (NDIS) .

To maintain clarity and consistency throughout the policy, the terms "consumers," "residents," "clients," "elders," and "NDIS participants" will collectively be referred to as "consumers," all such references encompass these groups equally.

- Our strategy in the minimisation of falls is that all residents admitted into a Whiddon residential care home must undergo a comprehensive falls risk assessment.
- Falls prevention interventions should include appropriate strategies that are trialed, assessed, monitored, and reviewed (these must be clearly documented and communicated in a timely manner in the appropriate sections of the care system e.g., Autumn Care and during team members case conferences and handovers).
- The process of assessment must be multidisciplinary and include the requirements of residents and or their representatives.
- The decision to use walking aides or support devices must be a clinical decision in consultation with the resident and with input by appropriate allied health professionals.
- Falls prevention equipment will be supplied by the service to support residents' mobility and independence.
- Every resident will undergo an individualised assessment to identify falls risk factors.
- An individualised Falls Risk Reduction Action list will be generated for:
    - Every new admission
    - Every resident's scheduled clinical review
    - Following a fall
- All falls are managed in accordance with the fall's management protocols within this document.
- In the event of a fall (witnessed or unwitnessed) a thorough investigation must also be conducted to identify root cause/s.
- Consumers will receive acute care if post fall assessment indicates

## How this Strategy fits within our MyLife Model of Care

This Policy is designed to align with the following wellbeing outcomes from our MyLife Model of Care:


**Health and wellness** Our approach will involve proactively responding to health needs and proactively promoting wellness.

**Independence** Our programs will enable control and increase capability for all of our care recipients.

**Safe and secure** Our approach will improve confidence and therefore promote personal, physical, and emotional safety and security.

## Relationship based care (RBC)

RBC is how we deliver care at Whiddon, it underpins our My Life model of care and enables all team members to deliver a more personalised level of care. We will use a partnership approach with residents, their representatives, and our teams, to develop person-centred falls prevention approaches.

This Policy should be read in conjunction with the Falls Process Guide and is applicable to all residents.

The most effective approach to falls prevention is likely to be one that includes all team members and residents

who are engaged in a fall's prevention program, falls are everyone's business.

## Purpose

The intention of this document is to reduce the incidence of resident falls and to minimise harm from falls. The aim is to recognise risks of falls promptly, and to ensure appropriate action is taken to remediate these risks.

The policy outlines standardised procedures and best practices for identifying individuals at risk for falls, assessing these risks, and implementing appropriate interventions. This helps staff to consistently address falls

The Falls Prevention and Management Policy aims to ensure a holistic, evidence-based approach to preventing falls, providing clear guidance for employees, and improving the safety and well-being of individuals at risk.

## Continuous Improvement:

The policy incorporates regular monitoring and review processes to assess the effectiveness of fall prevention strategies and make improvements over time.

## Implementing Systems[6]

| Criteria to achieve the Prevention of Falls and Harm from Falls Standard: | |
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| **Governance and systems for preventing falls** | **The governing body is responsible for providing leadership and fostering a culture of safe and quality clinical and personal care that is best practice, tailored and effective in managing associated risks.**<br>**The governing body, will ensure safe systems and processes exist to monitor, review, and continuously improve compliance with this policy.**<br>• **Falls risk is screened and documented •**<br>• **Falls risk is assessed, if required, and documented •**<br>• **Appropriate multifactorial strategies are available and used •**<br>• **Falls are reported and investigated to ensure that falls, and the harm endured from them, is minimised** |
| **Screening and assessing risks of falls and harm from falling** | **All residents are screened for falls risks on admission and when clinically indicated.**<br>**Individualised strategies are implemented to remediate the potential risk of harm from falls.** |
| **Preventing falls and harm from falling** | **All identified risk factors are addressed, and remediation strategies are developed together with the resident and/or their representatives, and Whiddon team members.**<br>**All parties actively participate in actioning these prevention strategies.** |
| **Communicating with residents and team members** | **Consumers, their representatives and Whiddon team members foster timely intervention and prevention.**<br>**Falls are everyone's business.** |

[6] Australian Commission on Safety and Quality in Health Care Standard 10 Preventing Falls and Harm from Falls

## Terms and Definitions

### Governance

The set of relationships and responsibilities established by Whiddon between its executive, workforce, and stakeholders (including residents). Governance incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way an organisation is directed, administered, or controlled. Governance arrangements provide the structure through which the objectives (clinical, social, fiscal, legal, and human resources) of the organisation are set, and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance.

Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests, and actions of different participants in the organisation in order to achieve the organisation's objectives.

### Fall

The World Health Organisation defines a fall as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

At Whiddon, when a person rolls from a low line bed to crash mat, if the mat is at a lower level than the bed, the incident is considered a fall. If a resident rolls from a crash mat to the floor, this also fits the definition of a fall.

Where a resident has slid from a chair or bed and has come to rest at a lower height, this is also an incident and considered to be a fall.

### Falls Risk Factor Checklist

A detailed list of falls risk factors. This checklist is individualised and can be completed by AIN's, Registered nurses or allied health professionals. The resident and their representative, and other non-clinical Whiddon team members are also encouraged to contribute by reporting any risks they identify to the clinical teams.

### Falls Risk Reduction Action List

A detailed list of evidence-based falls risk management strategies. Used in conjunction with the Falls Risk Factor Checklist, this tool will develop a targeted action plan, individualised to the resident's risk factors. This plan should be developed and updated by the registered nurse, or Allied Health, in consultation with the resident and/or their representative.

### Mobility Assessment Tool

Mobility assessment is a detailed review of a person's capacity to mobilise, equipment required to support mobility/transfers, and physical assistance required. This assessment assists in implementing individualised strategies to reduce the risk of a resident falling, while supporting him/her to mobilise.

### Falls with Injury

Falls with injury are defined as a fall that results in the resident sustaining (but not limited to) a wound, bruise, laceration, sprain, strain, fracture, concussion, increase in pain.

## Falls without Injury

Falls without injury are defined as a fall where the resident does not sustain any of the injuries listed above.

## Head Injury

Any trauma to the head.

## Anticoagulant/ Anti-platelet Therapy

Anticoagulants/ anti-platelets are drugs that reduce the body's ability to form clots in the blood. These drugs may make increase the risk of bleeding that may be difficult to control.

## Glasgow Coma Scale (GCS)

The GCS is a neurological assessment tool that is a validated instrument to assess and record a person's

neurological function. (Neurological observations)

## Roles and Responsibilities

Falls are everyone's business. Residents, their representatives, visiting health professionals, volunteers and Whiddon teams all share some responsibility for falls prevention.

Whiddon team members, including executives, service managers, clinicians, care staff, wellbeing and lifestyle, educators, hospitality team members, property team and quality team all have a role to play. Registered Nurses are responsible and accountable to ensure residents are assessed for falls and preventative strategies are implemented, documented, and communicated. They are responsible for the assessment and management of residents who have sustained a fall.

## Falls Assessment

- All residents should be individually assessed to identify all known fall risk factors:
    - on admission
    - after every fall incident or other change in health status
    - at scheduled intervals (e.g., 3 monthly)
- All risk factors are to be addressed, even if the falls risk appears low.

## Falls Prevention

Preventing falls is paramount. Having one fall dramatically increases the risk of further falls. Standardised, evidence-based falls prevention interventions should be in place for all residents. Both residents and their representatives, should be provided with the opportunity to work with the Whiddon team to develop strategies to maintain safety while supporting independence.

Falls are multifactorial and complex in nature so prevention strategies should be implemented in combination rather than in isolation. Using any one intervention on its own is unlikely to reduce falls. Whiddon has developed an evidence-based Fall Risk Checklist (here) and Falls Risk Reduction Action List (Here) that should each be individualised and

actioned for residents. All new residents and those undergoing their regular, scheduled review require the Fall Risk Checklist to be completed, and a list of priority Falls Risk Reduction Actions to be developed, and implemented, to minimise the risk of falls.

Falls should be reported each month via a Clinical Indicator report and quarterly for the National Quality Indicators.

## Involving residents and their representatives in falls prevention.

### Clinicians (e.g. registered nurses, allied health professionals) should consider the following actions to encourage residents to participate in preventing fall:

- Ensure the falls prevention message is presented within the context of people staying independent for longer, Whiddon has named our falls prevention approach "Live it UP" – a positive message regarding maintaining mobility, staying on their feet, and enjoying life.
- Educate and discuss falls risks and falls preventions strategies with residents, and their representatives.
- Conduct and record falls prevention education.
- Find out what preventative strategies the resident is willing to adopt to prevent falls.
- Offer information in languages other than English.
- Develop falls prevention programs that are flexible enough to accommodate the residents' needs, circumstances, and interests.
- Place falls prevention information, resources in suitable common areas used by residents and family members. Managing falls in Care Homes

## First response:

The circumstances surrounding a fall (witnessed or unwitnessed) are of critical importance. However, this information is often difficult to obtain and may need to be sourced from other people e.g., other Whiddon team members, visitors, or others.

All falls (unwitnessed and witnessed) require the following steps to be undertaken by the registered nurse and/or AIN:

- Before moving resident, check for danger and signs of life: response, airway, breathing.
- If not responding, immediately alert RN and contact emergency services
- Reassure resident, if responsive
- Head to toe assessment for injury, pain (using Pain Chek), or deformity – call ambulance if significant injury/pain is observed.
- Immobilise neck if head/neck pain reported.
- Identify if the person is on anticoagulant/ anti-platelet therapy. If YES continue with all observations and call an ambulance for a medical assessment to determine if the resident is to be transferred to hospital.

- Perform observations and measure : Blood pressure, Temperature, Pulse, Respirations, and BGL (where indicated).
- If the resident is known to have sustained a head strike or the fall was unwitnessed (so a head strike cannot be ruled out) conduct Neurological observations (including the Glasgow Coma Scale - GCS).
- Apply First aid.
- Determine the most appropriate manual handling technique for relocating the resident to bed/chair.
- Inform the General Practitioner as soon as possible.
- Inform the person's representative.
- Document all observations and actions taken in the hospital transfer form (where relevant), progress notes and incident form.

## Post fall monitoring and management:

- If the resident is known to have sustained a head strike or the fall was unwitnessed (so a head strike cannot be ruled out), Neurological signs should be monitored every 30 minutes for one hour, then hourly for 4-hours, then 4-hourly until 24 hours of observation have been reached.
- If the person is on anticoagulant/ anti-platelet therapy and the ambulance team do not transfer the resident to hospital, continue to take neurological and vital sign observations 4-hourly for 72 hours.
- Increase frequency of observations (neurological and vital signs) and seek medical attention if any deterioration in GCS score or mental status (alertness, cognition, or behaviour) is noted.
- The healthcare team can consider further investigation or transfer to hospital in accordance with the clinical evidence, the resident's wishes, the resident's advance care plan or the wishes of the resident's authorised representative.
- Perform a comprehensive post-fall assessment within 24 hours of a resident's fall, using the multi- factorial Live it UP Fall Risk Checklist (Here) and Falls Risk Reduction Action List (Here) to develop an individualised falls prevention plan.
- Discuss recommendations with the resident and handover all actions to the team so that strategies to address all risk factors are implemented.

## Post fall management strategies

| | Fall Descriptor | | | |
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| Observation and Action | **Unwitnessed fall or Witnessed fall with head strike** | **Witnessed fall with NO head strike or Fall with significant injury** | **Witnessed fall with NO significant injury.** | **Roll from low line bed to crash mat with no injury. NB: Falls from a normal bed height cannot be included in this category. There must not be any hard surface e.g., bedside table in range** |
| | **Neurological observations, BP, Pulse, Temp and Resps (BGL if clinically indicated)** | **Neurological observations, BP, Pulse, Temp and Resps (BGL if clinically indicated )** | **Neurological observations, BP, Pulse, Temp and Resps (BGL if clinically indicated)** | **Neurological observations, BP, Pulse, Temp and Resps (BGL if clinically indicated)** |
| | **Head to toe assessment Assessment at time of fall:** | **Head to toe assessment Assess injured area manage accordingly** | **Head to toe assessment** | **Head to toe assessment** |
| | **Observation frequency:**<br>• **½ hourly for 1 hour post fall**<br>• **Hourly for 4 hours**<br>• **Every 4 hours until 24 hours post initial fall.**<br>• **each shift for a further 24 hours.**<br>• **If on anticoag/antiplatelet – continue for 72 hours** | **Observation frequency**<br>• **Every 4 hours until 24 hours post initial fall.**<br>• **each shift for a further 24 hours.** | **Observation frequency**<br>• **x 1 per shift for a further 24 hours.** | **Observation frequency**<br>• **x 1 set of Observations** |
| | **Pain must be assessed at the time of fall. *(If no* initial pain, re- assess each shift for 48 hours)** | **Pain must be assessed at the time of fall. (If no initial pain, re- assess each shift for 48 hours)** | **Pain must be assessed at the time of fall. *(If no* initial pain, re- assess each shift for 24 hours)** | **Pain must be assessed at the time of fall. *(If no* initial pain, re- assess each shift for 24 hours)** |

**NB: Clinical Judgement should be used when assessing residents post fall.**
**Staff may increase the frequency of observations based on Clinical Findings, however decisions to decrease the frequency of observations post fall, can only be made by the treating doctor.**

**Registered nurses are expected to use clinical judgement if the resident is not recovering as expected in the initial hours/days following the fall. The presence of the following symptoms may require escalation by calling 000 for emergency service assessment/ hospital transfer:[7][8]**

- Headache/ nausea/ vomiting
- Confusion/Light-headedness/Dizziness/Trouble with memory, concentration, attention/ mood changes
- Blurred Vision/ Tired eyes/Ringing in the ears/Altered taste in the mouth.
- Increased fatigue/lethargy/altered sleep.
- Increased pain

Please note also that if the GP has stipulated a different regime the RN must also continue to monitor and document as per the above protocol.

**Reference:** National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on the Review of the Department of Veterans Affairs Examinations for Traumatic Brain Injury. Evaluation of the Disability Determination Process for Traumatic Brain Injury in Veterans. Washington (DC): National Academies Press (US); 2019 Apr 10. B, Definitions of Traumatic Brain Injury. Available from: https://www.ncbi.nlm.nih.gov/books/NBK542588/

## Comprehensive assessment following a fall.

For all falls, a comprehensive assessment should be conducted, within 24 hours. The Fall Risk Checklist (Here) is used to identify all relevant risk factors present for the individual care recipient. The clinical team map the risk factors identified to the Falls Risk Reduction Action List (Here) to generate practical and individualised strategies to be actioned to prevent future falls. A full list of preventative actions is generated for all new residents. For scheduled reviews, or post fall assessments, the clinical teams use these tools to generate a short list of priority actions (e.g., 1-5 actions) that are best suited to the resident's individual risk factors – these actions are recorded in the resident's notes, on handover, and the Care Plan.

## Analysing falls – looking for patterns

For high-quality care and risk management, information about falls must be collected and collated to monitor falls incidence, identify falls patterns, identify ways of preventing future falls and provide feedback on the effectiveness of falls prevention programs. When preparing the Clinical Indicator Report each month, the clinical leads should also use eQstats to generate reports on times of day, area of falls, type of fall and residents who have fallen ≥twice. This can assist in determining patterns. Patterns may raise questions for

[7] Recognition and management of patients who are deteriorating NSW Health PD2020-018

[8] Australian Commission on Safety and Quality in Health Essential Element 2 escalation of care

example: are there sufficient staff rostered at particular times of day in this part of our Home? is there an area that needs to be reviewed for lighting/access/floor surface/ hazards etc.

A more in-depth analysis of some falls may be required, particularly where there has been a serious injury or adverse outcome for the resident. A review of a serious fall can address both individual and broader system issues to provide greater understanding of causation and future prevention. This is sometimes known as a root cause analysis. A root-cause analysis is always required if a fall results in serious injury or death. In some jurisdictions, a fall in residential care that results in death will be reported to the state coroner if the treating doctor does not issue a medical certificate.

Falls data is reported to the NQI each quarter. This Policy and Guideline and associated resources will allow Whiddon to stand at the forefront of falls prevention and management.