Government of **Western Australia**
Department of **Health**

# Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018

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# Contents

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# Overview

## Introduction

Falls and falls-related injuries cause substantial morbidity and mortality among older Australians. The hospital setting is associated with an increased risk of falling among older people due to additional risk factors from both illness and being in an unfamiliar environment.

Falls were the second most frequently reported clinical incident in Western Australia (WA) hospitals in 2016–17, with 5510 incidents. Severity Assessment Code (SAC) 1 falls incident notifications increased from 54 in the previous year to 79 in 2016–17. 60% per cent were unwitnessed falls, with walking being the activity most frequently undertaken at the time of the fall. Of the 79 SAC 1 clinical incidents related to falls, 14 had an outcome of death.[1]

A review of the *Post Fall Management Guidelines in Western Australian Healthcare Settings 2015*[2] was undertaken by a large working party of health professionals from across public, rural, and private inpatient facilities in WA. Rigorous examination of patient safety, current evidence on all aspects of post fall care, and the roles of health professionals took place. The objective was to update the existing guidelines with current evidence and expert opinions, to continue optimising patient safety and care post fall. These revised guidelines also meet the *National Safety and Quality Health Service Standards for Hospitals*,[3] the *Cognitive Impairment Australian Commission on Safety and Quality in Health Care Clinical Standards*,[4] *Preventing Falls and Harm from Falls in Older People and Best Practice Guidelines for Australian Hospital and Residential Aged Care Facilities.*[5]

Extensive consultation of multidisciplinary health professionals, unregulated health care workers, and consumers from across WA was undertaken. This yielded rich feedback, which has been incorporated in the document where considered appropriate.

## Purpose of the guidelines

The purpose of the *Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings* (the Guidelines) is to ensure the continued delivery of optimal patient care and patient safety following a fall. They aim to reduce the risk of further falls and harm from falls along with the early detection of physical and cognitive deterioration. Guidelines for nursing, medical, occupational therapy, physiotherapy, and pharmacy are included to assist with directing multidisciplinary care for the patient post fall.

The intent of the Guidelines is that they:

- Replace the current *Post Fall Management Guidelines in Western Australian Healthcare Settings 2015.*[2]
- Inform and complement falls management care, identifying and managing clinical and cognitive deterioration, utilisation of clinical escalation policies, and the procedures of all WA hospitals and health services.
- Apply to all inpatients/residents who sustain a fall in WA hospitals, health services, and multi-purpose sites. The term ‘patient’ when used in these guidelines refers to this group of individuals.
- Target an audience that includes medical staff, nursing staff, occupational therapists, physiotherapists, pharmacists, and other relevant clinical staff. They may also be useful for unregulated health workers including aboriginal health care workers, patient care assistants, assistants in nursing, and allied health assistants in WA hospitals, health services and multi-purpose sites.

- Assist the health professional's decision-making about appropriate treatment and care for specific clinical circumstances. They do not replace clinical judgment. It is acknowledged that there will be case-by-case circumstances where exceptions to these guidelines will be necessary for best patient care. Clinicians are encouraged to justify and document these exceptions within the patient's health care record.
- May need modifying to ensure their suitability for falls in children.

These evidence-based guidelines provide the recommended care of the patient following a fall. It is acknowledged that facilities/areas may be unable to meet aspects of the guidelines, due, in part, to location and resources. There are opportunities for adaptation at a local level. This has been outlined within the text where it has been considered appropriate.

The appendices provide additional information to guide assessment and intervention for nursing staff, medical staff, occupational therapy, physiotherapy, and pharmacy. Included is material and advice about post fall huddles, clinical investigation, and several tools that may be beneficial for staff.

A catalogue of the literature reviewed during the process can be obtained by utilising the contact details at the beginning of the document.

## Applicability

These guidelines are intended for use by all health professionals employed in inpatient facilities and multi-purpose sites in WA. They are also available for use by private health care facilities.

A community guideline for post-fall care is available on request (see contact e-mail).

## Guidelines' requirements and use

- Approval to implement these guidelines should be sought from the relevant level prior to implementation in health care facilities.
- Communication with the patient's family/carer must be undertaken with the full consent of the patient unless clinical assessment indicates otherwise.
- It is expected that health professionals (and unregulated care workers) will have at least minimum knowledge of the post-fall process and responsibilities.
- Implementation among and education of relevant staff is the responsibility of individual facilities.
- These guidelines can be divided into the general process and individual disciplines for easy accessibility by the multidisciplinary health professionals.
- When a patient falls the immediate post-fall process should be followed.
- The nursing guideline is ideally kept with the patient's bedside health care record, with the date and time of the fall documented.
- Pathways are presented to cover various situations for example witnessed/unwitnessed falls. The accompanying observations should be completed as advised.
- The guidelines recommend actions at 4, 6, 24, and 48 hours. These actions are undertaken for all falls regardless of whether the fall was witnessed or unwitnessed.
- Communication is a vital component and should be considered at each step.
- Medical and allied health professionals are advised to conduct their reviews and care as per their discipline-specific guidelines.

## 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.<br>• Documentation of rationale required.<br><br>Continue with instructions below. | Neurological observations:<br>• Half-hourly for a minimum of 2 hours until GCS of 15 or patient considered back to their normal level of cognition achieved.<br>• Continue if GCS remains < 15 or patient not considered at normal level of cognition. Report to MO and continue as per instructions.<br>If patient has GCS of 15 or patient considered back to their normal level of cognition then continue:<br>• Hourly for 4 hours.<br>• Two-hourly 4 hours.<br>• Four-hourly for 40 hours (to make total of 48 hours from time of fall).<br>• 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

## 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.

# 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.

- 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.**

# Occupational therapy guidelines

## Introduction

Post inpatient fall the Occupational Therapist's (OT) role is to complete an analysis of the inpatient fall, identify the patient's falls risk factors and contributing factors to falls. Assessment, intervention, and recommendations are to relate to the core Occupational Therapy areas of practice.

The OT, when completing an inpatient post fall assessment, focuses on:

- Patient's Activities of Daily Living (PADLs), including the effects of vision.
- Patient's Cognition.
- Environment (Hospital).

Additional supporting information can be found in Appendix 2. They do not provide an exhaustive list of interventions. They are a guide to what could be considered in the post fall analysis. Not all interventions are suited to all patients. OT-specific interventions should be patient-centred and match individual needs.

## Standard

The OT should assess all patients who have a fall whilst an inpatient within **two working days** where possible.

## Referral process post inpatient fall to occupational therapy

Nursing/medical or allied health can refer to the OT for an inpatient post falls assessment. The OT can also obtain referrals via journey board meetings, screening processes or by asking nursing or medical staff.

## Post fall occupational therapy assessment and interventions

The OT inpatient falls assessment needs to consider the following:

1. Falls Analysis:
    - Background information surrounding the fall, the mechanism of injury, where did the fall occur, when did the fall occur and what activity was being undertaken at the time of the fall. To avoid patients being asked the same questions, the OT should access maximum information from the referrer, medical notes, Multidisciplinary Team (MDT) meeting and other sources.
2. Falls Risk Factor Identification and Occupational Therapy Interventions:
    - The risk factors and interventions focus on the core OT areas (see above) and how they relate to the inpatient's day-to-day function on the ward. Please refer to Appendix 2.

## Documentation

- Complete the falls analysis and identify the falls risk factors/interventions in the areas of Activities of Daily Living (ADL) including the effect of vision, cognition, and the environment. Document your findings clearly and concisely in the integrated inpatient notes or as per local documentation requirements. The Occupational Therapy sticker for patient's health record (Appendix 2.2) provides an example of documentation that could be utilised.
- If any further intervention is required from an OT, ensure this is documented in the integrated notes as required.

# Physiotherapy post fall guidelines

## Introduction

The role of Physiotherapy is integral to the multidisciplinary management and care of patients who are at risk of falling or have fallen.

## Referral process post inpatient fall to physiotherapy

Nursing/medical or allied health can refer to Physiotherapy for a patient falls assessment following an inpatient fall. The Physiotherapist can also obtain other referrals via journey board meetings, screening processes or by asking nursing or medical staff.

Following the notification of an inpatient fall, a Physiotherapist should review the patient within two working days, or as per local policy.

The following guidelines are recommended:

## Assessment

- Liaise with relevant nursing staff and refer to the patient health care records to investigate details, nature of, and events preceding the fall.
- If not known from a prior allied health assessment, investigate the patient's preadmission level of mobility and function (for example level of assistance required, use of walking aid, etc.); identify any preadmission and/or current falls risk factors.
- Involve carers (with patient consent where possible) in assessments, especially for patients with cognitive impairment.
- Determine if the patient has had a review by a Medical Officer (MO), Senior Nurse, or Nurse Practitioner (NP). Review the results of any medical investigations performed (for example X-ray and CT scans).
- Confirm if the patient has medical clearance to mobilise or is restricted to 'Rest in Bed'. Ideally, the MO has documented this prior to assessing and mobilising the patient. However, to prevent delays, a verbal approval may be sought. Document the name and designation of the MO providing the orders in the patient health care record.
- When medically stable, the patient should receive a comprehensive assessment. This may include a mobility, strength and balance assessment and any other assessment determined appropriate at that point in care.
- If the patient is unable to participate in the assessment due to pain, difficulty in weight-bearing, acute confusion, or another reason, the Physiotherapist should refer to the MO for further review/investigations.

## Intervention

- According to assessment findings, and in collaboration with the multidisciplinary team, eliminate/control risk factors to reduce the risk of falls and harm from falls.
- Supply equipment if required (for example walking aids).
- Continue/commence patient rehabilitation (if indicated) incorporating specific balance and muscle strengthening components.
- Monitor for any behavioural or thinking changes during subsequent interactions with the patient that could indicate a delirium. Escalate any concerns to the MO.
- In partnership with the patient and their carer/family, provide information about falls risk factors, risk reduction strategies, physiotherapy treatment, and the ongoing management plan. (Ensure patient consent to family/care involvement if possible).
- Where indicated, support staff with the new mobility/manual handling recommendations.

## Documentation

- Clearly and concisely, document clinical assessment findings, recommendations, and strategies to reduce risk and harm from further falls, to ensure safety when mobilising, for both patients and staff.
- Update the Falls Risk Assessment and Management Plan (FRAMP).
- Where applicable, update patient's mobility chart and any other site-specific communication tools, as per local policy.
- Communicate recommendations to nursing staff to enable the updating of nursing care plans and highlighting the patient as a Falls Risk.
- Communicate recommendations.

## Discharge planning

Identify post-discharge rehabilitation and falls-prevention needs, completing timely referrals and handovers to appropriate local community services (including Physiotherapy, Occupational Therapy, Nursing, and Falls Clinics or as outlined as per local service discharge).

Further information is available at Appendix 3.

# Pharmacy post fall guidelines

## Introduction

Medications are recognised as a major contributor to falls, and pharmacists can play an active role in reviewing medication regimens to optimise therapy and minimise the likelihood of further falls.[7] This includes taking a comprehensive approach to reviewing the patient's clinical condition, screening for medications most likely to be implicated, and collaborating with Medical Officers (MO) and patients themselves (or carers) to implement interventions to reduce the risk of falls and harm from falls.[7, 8]

Pharmacists should review patients within two working days of a fall, which may occur in person or via remote review or telehealth. Pharmacists should also, if possible, attend the post-fall huddles (if facilities undertake these), or otherwise at the next available opportunity for review.

## Initial assessment and review

The initial assessment will consist of a clinical review covering at a minimum:[7-9]

- Review of patient's current clinical condition and medication plan.
- Review of documentation related to the patient's clinical condition and medication plan at the time of the fall.
- Review of potential issues regarding falls-related medication management.
- Assessment of potential medication-related contributors to the fall, including:
    - Medications directly contributing to falls such as side effects of a medication, for example hypotension secondary to levodopa administration.
    - Medications indirectly contributing to falls such as symptoms of under- or un-treated conditions, for example tremor secondary to sub-optimal medication regimen in Parkinson's disease.
- Assessment of appropriateness of medication management for complications associated with the fall:
    - Bone integrity, including fracture and bone density.
    - Pain management.
    - Bleeding risk and anticoagulation management.
    - Fear of falling associated with medications.

The Initial assessment and clinical review should include screening to determine the appropriateness and clinical need for a comprehensive falls medication review.[8]

## Comprehensive medication review

If a comprehensive medication review is needed, pharmacists may do this at the time of initial review or within two working days of the fall. Referral may alternatively be made for a timely medication review in the community, dependent on appropriateness and availability of services. The comprehensive medication review should include:

- Consideration of the patient's clinical condition, medication plan, and potential falls-related medication issues.[7-9] The approach outlined for 'the initial assessment and review' may guide this.
- Meaningful engagement with the patient or carers to guide recommendations if possible.[10, 11]
- Development of appropriate evidence-based recommendations to the patient's medication plan.
- Communication of relevant changes to the medication plan to the MO, General Practitioner, patient, or carer, etc. and educating of the patient or carer on medication self-management strategies.[8-11]

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| Support for the development of the Guidelines was provided from Health Networks<br>Abbreviation Key to Health Services, Hospitals, and Districts are available on page 20 | | | | |

| Abbreviation Key to Health Services, Hospitals, and Districts | | | |
|---|---|---|---|
| **AKG** | Armadale Kalamunda Group | **NMHS** | North Metropolitan health Service |
| **AHC** | Albany Health Campus | **OPH** | Osborne Park Hospital |
| **BRH** | Bunbury Regional Hospital | **RGH** | Rockingham General Hospital |
| **DOH** | Department of Health WA | **RPH** | Royal Perth Hospital |
| **EMHS** | East Metropolitan Health Service | **SJOG** | Saint John of God Health Care |
| **FHHS** | Fremantle Hospital and Health Service | **SMHS** | South Metropolitan Health Service |
| **FSH** | Fiona Stanley Hospital | **SW** | South West |
| **GS** | Great Southern | **WACHS** | Western Australian Country Health Service |
| **K** | Kimberley | **WB** | Wheatbelt |
| **MW** | Mid-West | | |

# Appendices

## Appendix 1: WA Post Fall Guidelines: Definitions and explanatory notes

| Procedure | Rationale |
|---|---|
| **DRSABCDE** | Complete initial assessment of patient (refer to local clinical deterioration policy).<br>**D** = Danger<br>**R** = Response<br>**S** = Send for help<br>**A** = Airway<br>**B** = Breathing<br>**C** = Circulation<br>**D** = Disability<br>**E** = Exposure |
| Bedside investigations.<br>Vital signs observations (blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level, temperature, pain, and ECG).<br>Neurological observations and assessments, including Glasgow Coma Scale.<br>Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in the level of consciousness. | A fall is a critical event and there is a need for close observation of the patient's condition.<br>Recording of vital signs and level of consciousness provide information on the patient's condition. Recording assists in identifying further deterioration.<br>All assessment findings must be documented.<br>• Low blood sugar levels may have precipitated the fall and treated immediately.<br>• Fallers can lose consciousness in syncope falls but be unaware that this has happened, so head injury cannot be excluded except in witnessed falls.<br>• ECG will identify any arrhythmias, cardiac changes that may have contributed to the fall.<br>• 4AT/CAM (as per local policy) will assist in identifying delirium and further investigation maybe required. |
| **Notify Next of Kin (NOK).**<br>**Refer to local 'Open Disclosure' policy.** | Notification of the patient's NOK of any unplanned event that results in or has the potential to result in injury is to occur as soon as possible following the event or within 4 hours of occurrence. |

| Procedure | Rationale |
|---|---|
| **Reassess falls risk status**<br>Complete Falls Risk Assessment and Management Plan (FRAMP) and refer to relevant staff, for example Physiotherapist, Occupational Therapist, and Pharmacist, to review.<br>Develop an individualised care plan for the patient and implement age-appropriate falls prevention strategies. | Falls risk is not a static process and requires ongoing assessment.<br>Exposure to acute care treatment and procedures can increase risk of falling and delirium by reducing coping mechanisms and/or increasing problems with perception and mobility. |
| **Communication**<br>All staff involved in the care of the patient to be informed of incident outcome and revise care plan.<br>As per local guidelines, notify MO and Senior Nurse when a patient falls.<br>Interpreter to be utilised where appropriate.<br>Communication with the patient/carer/family is to be adapted to meet individual health literacy needs. Cultural needs and preferences must also be considered. | To continue post-fall management of the patient, all staff need to be aware of the fall and the new interventions put in place.<br>Interpreter use will assist in increased communication with the patient re: the fall and ongoing risks/treatment and reassurance.<br>Where possible, prior to involving family/carers, obtain patient consent that they agree to this intervention.<br>Information and discussion with patient/carer/family must be delivered in a manner that meets their health literacy, any learning disabilities, and/or cultural needs.<br>Partnership with the patient is required to develop plan of care. |
| **Reviews by other relevant staff are recommended. This includes:**<br>• Physiotherapist within 2 working days post fall.<br>• Occupational Therapist within 2 working days post fall.<br>• Pharmacist review within 2 working days post fall. | This will assist in identifying further risk factors and interventions required to reduce the risk of falls, harm from falls and changes in cognition.<br>Reviews are undertaken according to local policy. |

## Appendix 2.1: Occupational therapy supporting information

These guidelines direct your intervention following an inpatient fall. The role of the Occupational Therapist is to undertake an analysis of the fall and identify targeted interventions to address risks relevant to the three key Occupational Therapy areas of ADL (including the effects of vision), cognition, and environment. These risk factors and interventions are evidence-based and aim to reduce the risk of falls and harm from falls.

### 2.1.1. Occupational therapy activities of daily living (ADL)

| Risk factors for falls | Recommendations |
|---|---|
| • Decreased independence with Personal ADLS (PADL):<br>  o Showering.<br>  o Dressing.<br>  o Toileting.<br>  o Grooming.<br>  o Eating.<br>  o Transfers in ADL context.<br>• Incontinence/urgency/ nocturia.<br>• Decreased standing balance in functional activity Pain/ fatigue/ breathlessness when participating in PADL. | <u>OT-Specific Interventions:</u><br>• Work with the patient to locate and keep frequently used items within reach to prevent awkward postures and reduce number of times needed to sit/stand.<br>• Advise patient to sit whilst dressing/showering.<br>• Encourage use of grab rails in the bathroom and educate regarding the benefits and purpose of the rails.<br>• Educate patient, staff, and family/carer about the need for urinal bottle or commode chair to be within reach at bedside.<br>• Educate and support patient to negotiate regular toileting plan with nursing staff.<br>• Determine required assistance and/or supervision with PADL (identify which PADL tasks need to be addressed).<br>• Grade and adapt functional activity that the patient is completing as appropriate.<br>• Educate about and facilitate non-pharmacological symptom management, for example fatigue management, energy conservation, stress management.<br>• Encourage patient to dress in own clothing. Ensure clothing and footwear are well-fitting and appropriate for the ward setting. Educate in dressing strategies that are safe and promote independence.<br>• Review the Falls Risk Assessment and Management Plan (FRAMP) minimal interventions regarding ADL. |

### 2.1.2. Occupational therapy effects of vision on ADL

| Risk factors for falls | Recommendations |
|---|---|
| • Visual Impairment (for example visual field loss, macular degeneration cataracts, diabetic retinopathy, glaucoma).<br>• Visual-perceptual issues/changes.<br>• Wearing glasses (bifocal/multifocal). | • Minimise bed moves to retain familiar environment.<br>• Position frequently-used objects close by patient's visual field. Work with patient to determine optimal position.<br>• Educate patient to request frequently-used objects be repositioned in the same place.<br>• Ensure patient's own glasses are available in hospital for use.<br>• Allow patient adequate time to adjust to lighting changes before engaging in ADL.<br>• Educate patients of risk when using bifocal and multifocal glasses, i.e. increased time taken with visual adjustment and impacting vision with steps, etc.<br>• Ensure visual impairment sign above bed.<br>• Facilitate orientation of patient to time and place daily through environmental prompts and/or prompts from staff and family.<br>• Review the FRAMP minimal interventions regarding visual impairment. |

### 2.1.3. Occupational therapy cognition

Patients with cognitive impairment are at risk of falls. If cognitive impairment is suspected, a cognitive assessment is essential to determine the impact of impairment on the patient's daily activities. Please follow the local area guidelines/policy regarding cognitive review/assessment. Consider an assessment if delirium is present and escalate as appropriate to medical team for review.

| Risk factors for falls | Recommendations |
|---|---|
| **Acute/short-term diagnosis** (contributing to admission and causing cognitive impairment):<br>• Delirium, encephalopathy, post-ictal, acute vascular event or stroke, concussion.<br><br>**Chronic/long-term diagnosis** (may not be reason for admission, but cognitive impairment may be pre-existing):<br>• Past stroke, Acute Brain Injury/Traumatic Brain Injury, dementia diagnosis (Lewy body, Alzheimer's disease, Vascular dementia, Fronto-temporal dementia), past neoplasm, intellectual impairment, neurodegenerative disease, for example Multiple Sclerosis, Parkinson's disease.<br><br>**Mood:**<br>• Depression, anxiety, bipolar, schizophrenia, mental health issues affecting cognition.<br><br>**Behaviour:**<br>• Wandering, restlessness, agitation, aggressive.<br>• Fear of falling/loss of confidence. | • Assessment of call bell use and provision of alternative call bell as required.<br>• Reorientation: calendar, environmental prompts, clocks, day clothes.<br>• Investigate and prompt usual ADL routines: when/how do they shower/dress, usual toileting/nocturia practices, usual meal routines.<br>• Communicate patient routine to all staff with timetable at bedside.<br>• Educate and work in partnership with patient and family about cognitive issues being falls risks and about strategies to minimise the impact of the risks.<br>• Advise Multidisciplinary Team as appropriate on individualised falls risk factors, for example need for environmental signs, regular checks on patient, and call bell use.<br>• Determine if assistance and/or supervision with PADL (specify which tasks require assistance).<br>• Minimise bed moves to ensure consistent environment.<br>• Ask family to bring in familiar items for the patient, for example pillow, blanket, and clothes.<br>• Set up inpatient environmental signage to label commonly used areas, such as the toilet, shower, or things in the patient's space.<br>• Review the FRAMP minimal interventions regarding cognitive changes. |

### 2.1.4. Occupational therapy environment

| Risk factors for falls | Recommendations |
|---|---|
| • Patient out of immediate sight of nursing staff (single room or away from nursing station).<br>• Distracted or coerced by others within shared room.<br>• Difficulty managing distance from bed to bathroom.<br>• Inability to re-locate own bed within shared room.<br>• Difficulty locating commonly used areas, for example toilet, sink, shower.<br>• Clutter around bed space or within corridors.<br>• Inappropriate bed or chair height.<br>• Over bed/bedside table too high or low for use by patient.<br>• Inappropriate lighting/lack of control over lighting.<br>• Poor floor surface integrity.<br>• Floor surface hazards, for example spills, water, food.<br>• Pressure reduction (for example alternating air), mattress impacting on ability to transfer.<br>• Commonly used items not within reach.<br>• Foot stool in environment. | • Negotiate moving patient to visible area or shared room if considered needed.<br>• Negotiate moving patient to bed space near bathroom to assist with access and orientation.<br>• Provision of clock and/or calendar to assist with orientation to date and time.<br>• Clearly label bed space with patient's name and use belongings to make it a familiar space.<br>• Set up appropriate inpatient environment signage labelling commonly used areas (patient bed space, and bathroom/shower/toilet).<br>• Adjust or replace over bed/bedside table to ensure appropriate height.<br>• Review appropriateness of bed rail (for example half or full side) and consider need to change type.<br>• Ensure patient can reach and use available lighting switches.<br>• Inform shift coordinator/nursing manager if repair of the floor surface is required.<br>• Ensure floor surface clean and dry.<br>• Ensure static setting used for transfer on/off alternating air mattresses.<br>• Keep frequently used items within reach.<br>• Educate the need to position frequently used objects within patient's visual field or positioned in the same place.<br>• Review FRAMP minimal interventions regarding environment. |

## Appendix 2.2: Occupational therapy sticker for patient's health care record

**Actual size 13cm x 10cm.**

### Occupational Therapy Inpatient Falls

### Assessment and Intervention Summary

**3-point patient ID confirmed by: □ patient □ other**

**Time of inpatient fall**……

**Activity being completed when fall occurred**…….....

**Risk factors identified following inpatient fall:**

□ADL……

……

□Cognition……

……

□Environment……

……

**OT Specific Intervention / Recommendations:**

……

……

……

……

……

**□ FRAMP Reviewed + documentation completed**

**□ OT Intervention for discharge planning required**

OT: …… Ext/Page…….…… Date……

Acknowledgment: Sir Charles Gairdner Hospital

Further details and template can be obtained via
Falls.ManagementWA@health.wa.gov.au

## Appendix 3.1: Physiotherapy post fall guidelines cue card

**These are pocket size and can be put with your ID badge for handy reference**

**POST FALL PHYSIOTHERAPY GUIDELINES**

ENSURE PHYSIO GUIDELINES HAVE BEEN REVIEWED

1. Review within one working day.
2. Medical clearance to mobilise.
3. Objective assessment.
4. Eliminate/control fall risk factors.
5. Prescribe w/aid if needed.
6. Monitor and report any changes in cognition or pain.
7. Educate patient and carer.
8. Handover to nursing staff.
9. Update FRAMP and care plans.

**POST FALL PHYSIOTHERAPY DOCUMENTATION**

ENSURE PHYSIO GUIDELINES HAVE BEEN REVIEWED AND DOCUMENT

- Fall details.
- Cleared to mobilise.
- Previous level of mobility.
- Objective assessment findings.
- Mobility Status.
- Patient/carer education.
- Handover to N/S.
- Updates on FRAMP.
- Local care plans/charts updated.
- Concise Physiotherapy plan.
- Falls risk on handovers and referrals.

Further details and template can be obtained via
Falls.ManagementWA@health.wa.gov.au

Acknowledgement: Fremantle Hospital Health Service, WA, Royal Perth Hospital, Sir Charles Gairdner Hospital

## Appendix 3.2. Physiotherapy post fall documentation proforma

Appendix A – An example of documenting PHYSIOTHERAPY, POST-FALL REVIEW.
This form is usually printed onto health care documentation, completed and filed into the patient's health care record at the corresponding date / time.

**PHYSIOTHERAPY**
**POST FALL REVIEW**

| | |
|---|---|
| **Identify** | 3 points identification (ID): Name □, date of birth □, address □. Unable to state, information and identification obtained from family/carer □ No ID band refer to local policy |
| **Situation**<br>Details of fall, time, location, mechanism | Date of fall: Informed by:<br><br>Medical Review post fall **Y** ☐ **N** ☐ |
| **Observations**<br>vital signs, imaging | <br><br>Reviewed imaging post fall ☐ **N/A** ☐<br>Delirium present? Y ☐ N ☐<br>Details if applicable: |
| **Background**<br>Pre-admission mobility, Pre fall mobility, including aid used | Pre-admission mobility documented in notes: **Y** ☐ Date: **N** ☐<br>Details:<br><br>Pre-fall mobility documented in notes: **Y** ☐ Date: **N** ☐<br>Details: |
| **Assessment**<br>Current mobility if appropriate, balance and strength assessment if appropriate | **Falls Risk Factors identified**:<br>□ Age > 65<br>□ Acute medical condition<br>□ Recent surgical intervention/post op<br>□ Previous fall<br>□ Past medical history<br>□ Polypharmacy >5 meds<br>□ Psychoactive medications<br>□ Incontinence<br>□ Reduced mobility/balance<br>□ Impaired vision<br>□ Wandering behaviour<br>□ Environment/lighting<br>□ Footwear<br>□ Malnutrition<br>□ Impaired cognition<br>□ Dementia<br>□ Delirium<br>□ Reduced insight<br>Details: |

| | |
|---|---|
| **Assessment Continued...**<br>(Current mobility if appropriate, balance and strength assessment if appropriate) | **Cleared to mobilise by medical team** Y ☐ N ☐<br>Documented Y ☐ N ☐<br>Verbal approval gained Y ☐ N ☐<br>Name and Contact details of medical team approver:<br><br>Bed Mobility:<br><br>Sit To Stand:<br><br>Ambulation:<br><br>Any limitations to ongoing participation? (e.g. pain, acute confusion) Y ☐ N ☐<br><br>Further Physiotherapy Intervention: |
| **Recommendation**<br>Mobility/falls management recommendations (e.g. sensor mat, visual bed, PCA, Susan table) | Mobility Recommendations:<br><br>Falls Risk Management Recommendations:<br><br>Falls Education provided to patient and carer:<br><br>Follow up PT required Y ☐ N ☐ If yes, details and referrals made: |

**Name:** **Signature:** **Date:**
**Designation:** **Page:**

Acknowledgments: Physiotherapy Department Sir Charles Gardiner Hospital, Perth, Western Australia. Contact: Ian Cooper, Head of Department, Ian.Cooper@health.wa.gov.au

## Appendix 4: Post fall multidisciplinary huddle / safety huddles

The following information is a guide only, identified from literature and experiences of inpatient facilities across Western Australia (WA) that have implemented this practice. It includes a brief background, example of the process, team members, and a checklist that can aid the discussion and tools that may assist with documentation.

WA facilities who have already implemented Post Fall Multidisciplinary Huddles (PFMH) are happy to share their experiences and lessons learned. Details can be obtained from Falls.ManagementWA@health.wa.gov.au

### Background

PFMH provides a structured format where staff gather to discuss a patient fall. 'It is a professional dialogue after an event that focuses on performance standards and enables team members to identify what happened, why it happened, and how to prevent future incidents.'[12] Patients and families are also involved where possible. This continues to demonstrate the partnership between health professionals and patients/families/carers.

The multidisciplinary (MD) team receive immediate communication and feedback regarding the incident, identify interventions to reduce the risks and ensure implementation of these. While comparable to MD meetings, the distinction is that only **one** patient is the focus and it is brief.[12]

Staff can perceive increasing awareness, team collaboration, and encourage a culture of increased efficiency and planning.[13, 14] Team effectiveness can also expand by >20% by utilising this process.[12]

Complex health care facility systems can impede the ability to deliver reliability in the PFMH.[15] Challenges include added pressure on staff time but following the embedding of the practice, the challenges reduce.[13, 14] Senior leadership is key to success.[12]

### Purpose of PFMH: [12]

- Improve patient outcomes (reducing falls risk, risk of injuries, falls and injuries), and promote improved quality of optimal care provision.
- Increase/enhance MD communication/collaboration post fall.
- Clarify safety concerns.
- Identify interventions required.
- Identify referrals required.
- Develop an individualised plan of care for the patient.
- Identify barriers to progress, and create strategies to address these barriers.

### Process

Ideally, the PFMH should take place as soon after the fall as possible; however, this is often impractical. It is suggested that the PFMH needs to take place within 24 hours (depending on area/facility and local policy) for the fall at a time that is considered appropriate for each area.

It is not considered appropriate to be part of the patient journey meetings but as a separate focus and kept as brief and succinct as possible. Length of time will vary due to the complexity of the patient health situation and the fall but the recommendation is to keep the PFMH to less than ten minutes.

- PFMH members include as a minimum (where possible):
    - Clinical Nurse Specialist/Clinical Nurse Manager/Shift Coordinator.
    - Physiotherapist.
    - Occupational Therapist.

    - Pharmacist.
    - Medical Officer from treating team.
    - Primary nurse during that shift.
    - Other (consider patient).
- The PFMH team choose the lead.
- Gather in an identified area, preferably the patient bedside if deemed appropriate.
- Discuss the fall, with the team and patient, identifying the contributing factors and interventions to be implemented by the MD team.
- Essential to ensure full support for the patient/family/carer during the discussion.
- The huddle leader has the responsibility to keep the huddle short and focused, ensuring each necessary topic is discussed.[12]
- The Lead of the huddle documents the results in the patient's health care record along with allocated interventions.
- All handovers are to include interventions employed.
- Patient and family apprised of the outcome, if possible by a previously identified IP team member present at the huddle.
- Interventions are allocated to appropriate team members.
- The Lead will need to follow up to ensure implementation of interventions has occurred.

Consider the following questions:

1. Risk Factors:
    - Did we know the patient was at risk?
    - Has the patient had a previous fall while in hospital?
    - Were minimum interventions in place?
    - If interventions were selected on the Falls Risk Assessment and Management Plan (FRAMP) were they in place?
2. Establish what patient and staff were doing and why:
    - What was the patient doing at the time they fell?
        - Be specific, for example transferring, going to the bathroom.
        - Ask why multiple times.
    - What were the staff caring for the patient doing when the patient fell?
        - Ask why multiple times.
3. Determine underlying root causes of fall:
    - What was different this time compared to other times when patient was engaged in the same activity?
        - Ask why multiple times.
4. Interventions for implementation:
    - How could we have prevented this fall?
    - What changes made in the patient's plan of care will decrease the risk of future falls?
    - What patient or system problems require communication to other departments or disciplines?

## Outcomes

- Decrease in falls rates (this may not occur immediately but as the practice is embedded).
- Decrease in injuries from falls.
- Increased patient satisfaction.
- Increased staff satisfaction.
- Increased skills in the analysis of falls and identification of further interventions.

## Examples of post fall management huddle (PFMH) documentation tools for the patient's health care record

| **Interprofessional Post Fall Huddle Plan** | |
|---|---|
| **Staff/patient present:** | |
| **Patient/family present:** | |
| **Fall Date and Time:** | **Location:** |
| Two main contributing factors to the fall: | |
| **Recommendations and Interventions with name of professional to complete this:** | |
| | |
| **Referral and Assessments required:** | |
| Medical ☐SRN ☐Physio ☐OT ☐Pharmacy ☐Falls CNC ☐Other☐<br><br>FRAMP updated correctly ☐ | |
| **Signature:**<br><br>**Name and Designation: Date:** | |

**Acknowledgements:** Sir Charles Gairdner Hospital, Osborne Park Hospital, Western Australia Country Health Services

**MDT Falls Prevention Plan**

People present:

Fall Date and Time:

Location:

Recommendations/Interventions

Updated: FRAMP ☐ Nursing Care Plan ☐ Mobility Chart ☐ Individualised Care Plan ☐ Education to patient/family/carer ☐

Date: Name/Signature:

**Acknowledgements:** Osborne Park Hospital

Further details and templates can be obtained from
Falls.ManagementWA@health.wa.gov.au

## Appendix 5: Clinical incident investigation templates

Clinical incident reporting is an integral part of the organisation's commitment to improving patient outcomes and provision of a high-quality service. The principle objective is to limit potential or actual incident/event consequences and reoccurrence and manage risk to the organisation. To be effective, clinical incident management requires a "whole of organisation" approach that fosters a "no blame" reporting culture. Staff are to follow the West Australian Clinical Incident Management Policy[16] and local area policy.

Facilities and areas will often have their own template to utilise for clinical investigation of falls. The following is an example that guides staff through the investigation of a fall incident, to identify contributory factors and make recommendations that address any system issues identified to prevent recurrence. It is available for use and is suitable for adaption to suit all areas/facilities.

## Event Description – Clinical incident

| Date of fall | | Time | |
|---|---|---|---|

Keep the description concise and factual.
What was the patient's activity at the time of the fall?
Recent relevant results, i.e. bloods, urine, vital signs, etc.
Any factors that may have increased risk of fall, i.e. recent bed move, low Hb, change of condition, etc.
Describe the fall.
Describe the location and any features of the location that may have contributed to the fall.
Was the fall witnessed by (designation)?
Observations immediately post fall including outcome if known.
Describe the outcome for the patient and any intervention required because of the fall including increased length of stay.

## Patient information

| | | |
|---|---|---|
| Admission date and diagnosis | Age | |
| Co-morbidities | | |
| Acute admission | Yes | No |
| Residential care | Yes | No |
| Community care | Yes | No |

## Risk Assessment

| | | | |
|---|---|---|---|
| FRAMP (local tool) complete | Yes | | No |
| FRAMP (local tool) is up to date (updated as per screening criteria) | Yes | | No |
| Identified as high falls risk | Yes | | No |
| Falls risk documented in Nursing Care Plan | Yes | | No |
| Shift handover identified high falls risk | Yes | No | N/A |
| All appropriate strategies to reduce falls risk implemented and documented in care plan | Yes | | No |
| If no explain | | | |
| All minimum standards in place – refer to FRAMP (local tool) | Yes | | No |
| If "No", explain: | | | |

## Risk factors

| | | | |
|---|---|---|---|
| Medications known to increase falls risk | Yes | | No |
| Recent changes to medications | Yes | | No |
| Recent change in condition | Yes | | No |
| Evidence of infection | Yes | | No |
| Recent change to cognitive state | Yes | | No |
| Recent delirium screen | Yes | | No |
| Recent change of location | Yes | | No |
| If "Yes", was patient oriented to new location? | Yes | No | N/A |
| Restraint in use | Yes | | No |
| If "Yes", explain: | | | |
| Mobility issues | Yes | | No |
| Mobility aids used appropriately | Yes | | No |
| Suitable level of supervision in place | Yes | | No |
| If "No", explain: | | | |
| Continence issues | Yes | | No |
| Recent changes to vision | Yes | | No |
| Visual aids used appropriately | Yes | | No |
| Footwear was appropriate | Yes | | No |
| If "No", explain: | | | |

## Post fall intervention

| | | |
|---|---|---|
| Initial and focused assessment documented | Yes | No |
| Medical Officer notified | Yes | No |
| Medical Officer review in timely manner (as per local policy) | Yes | No |
| Post fall observations attended as per procedure | Yes | No |
| Appropriate investigations undertaken in timely manner | Yes | No |
| Appropriate treatment/transfer in timely manner | Yes | No |
| FRAMP (local tool) and care plan updated | Yes | No |
| Adequate handover to clinician/service accepting care | Yes | No |
| | | |

## Consumer/patient consent

| | | |
|---|---|---|
| Family/carer notified | Yes | No |
| Open disclosure commenced with patient/family/carer | Yes | No |
| Consumer advised and informed of treatment, medication | Yes | No |
| Risks and benefits discussed including risk of receiving no care or treatment | Yes | No |
| Alternatives to treatment discussed | Yes | No |
| This discussion regarding treatment is documented | Yes | No |

## Identified issues/contributing factors

## Causal Statement

Start with the root cause, add the immediate contributing factor/s and then state the result.

## Recommendations – Specific, Measurable, Accountable, Realistic, Timely

Write specific, clear recommendations, and assign them to an accountable person.

## Outcome Measures

How will you know that there has been an improvement? Outcome measures must have a reporting structure to monitor the progress of implementation.

| **Check for strength of recommendations** | |
|---|---|
| **Stronger Actions Eliminate (Highest Effect)** | **Intermediate actions – Control (Intermediate Effect)** |
| Architectural/physical plant changes | Increase in staffing/decrease in workload |
| New device with usability testing | Software enhancement/modifications |
| Engineering control (forcing functions) | Enhanced documentation/communication |
| Simplify a process and remove unnecessary steps | Checklist/cognitive aid/clinical pathway |
| Standardise equipment and processes | Eliminate look and sound likes |
| Tangible involvement and action by leadership in support of patient safety | Eliminate/reduce distractions (sterile medical environment) |
| **Weaker actions – Accept (Lower Effect)** | Read back all actions |
| Double checks | |
| Warnings and labels | |
| New procedure/memorandum/policy | |
| Training and/or additional study/analysis. | |
| **Acknowledgements:** West Australian Country Health Service, Safety and Quality. | |

## Appendix 6: Auditing questions

Each health service/facility may have adapted the Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings and thus the auditing will vary. Below are suggestions of auditing questions for each discipline.

### Nursing

1. Date and Time of fall recorded in patient health care record? YES / NO / NA
2. Minimum interventions completed as applicable? YES / NO / NA
   i.e. baseline observations, neurological observations, blood glucose level, ECG, cognitive impairment screening using the: AMT4 / 4AT / CAM
3. Patient moved correctly depending on injury and manual handling policy? YES / NO / NA
4. Next of Kin notified within four hours of the fall? YES / NO / NA
5. FRAMP rescreened within four hours of the fall? YES / NO / NA
6. Post Fall Huddle took place within one working day of the fall? YES / NO / NA

### Physiotherapy

1. Was the patient reviewed by a physiotherapist within two working days following their fall? YES / NO / NA
2. Was the patient cleared to mobilise by the medical team prior to the physiotherapist review? YES / NO / NA
3. Was education provided to the patient and/or carer regarding their falls risk and falls prevention strategies and documented on page 4 of the FRAMP in addition to the patient's medical record? YES / NO / NA
4. Was there a referral for follow up completed upon discharge? YES / NO / NA

### Occupational therapy

1. Was the patient referred to Occupational Therapy post inpatient fall? YES / NO / NA
2. Was the patient seen within two working days of the inpatient fall by an Occupational Therapist? YES / NO / NA
3. Has at least one risk factor and one intervention been identified and documented by an Occupational Therapist in the post fall assessment? YES / NO / NA

### Pharmacy

1. Was a pharmacist involved in reviewing the patient's medication regimen within two working days of a fall occurring? YES / NO / NA
2. Was there any documented evidence of pharmacist review and communication of suggested interventions to other healthcare professionals and patients/carers? YES / NO / NA

### Medical

1. Is there documentation of hip examination? (for example comment on position of leg (not shortened, externally rotated), hip movement, hip tenderness, or bruising): YES / NO / NA
2. Is there documentation of assessment for head injury? (for example did they hit their head, evidence of head bruising or

laceration, assessment of mental state, assessment for focal neurological signs): YES / NO / NA

3. Was the patient assessed within 4 hours of falling? (aim for 90% compliance with this): YES / NO / NA

## General – all disciplines

1. Was the patient reviewed as per local policy by:
    a. Occupational Therapist? YES / NO / NA
    b. Physiotherapist? YES / NO / NA
    c. Pharmacist? YES / NO / NA
2. Is it documented that the patient/family/carer received information (customise to local practice for example received a certain booklet) about the fall:
    a. Nursing? YES / NO / NA
    b. Occupational Therapists? YES / NO / NA
    c. Physiotherapist? YES / NO / NA
    d. Medical? YES / NO / NA

## Reviews

These guidelines will be reviewed and evaluated as required to ensure relevance and currency. This policy will be reviewed within the maximum time frame of three years.

| Version | Effective from | Effective to | Amendments |
|---|---|---|---|
| **1.0** | 2015 | 2018 | Original version |
| **1.01** | 2018 | 2021 | Updated guidelines |

The review table indicates previous versions of the policy and any significant changes.

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