Monash Health

Preventing Falls and Harm from Falls

Clinical Guideline

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AUTHOR/S

This Clinical Guideline has been developed by the Preventing Falls and Harm from Falls Sub-Committee.

TARGET AUDIENCE and SETTING

All Monash Health employees in all clinical areas of Monash Health.

DEFINITIONS

Fall: A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (World Health Organisation, 2018).

BACKGROUND

- Falls are a frequently occurring health issue, and significant risk for all patients at Monash Health. Falls may have significant physical, psychosocial and financial burdens to individuals, families and healthcare organisations.
- Falls prevention is complex and inter-professional in nature.
- It is essential that an ongoing process of individualised risk assessment, clinical decision making, intervention and documentation occurs to **prevent falls** and **reduce harm from falls** for all patients.
- The Australian Commission on Safety and Quality in Health Care (ACSQHC) advocates for adoption of their Preventing Falls and Harm from Falls in Older People Best Practice Guidelines for Australian Hospitals (2009). This guideline underpins and informs Monash Health's care directives and organisational strategies associated with the prevention of falls

- A link to the Best Practice Guidelines for Australian Hospitals can be found here

PRECAUTIONS and CONTRAINDICATIONS

- Staff are encouraged to use clinical judgement in conjunction with targeted risk assessment findings to determine the patient/client/care recipient's level of risk for falls.
- All patients/clients/care recipients with a history of falls or who have sustained a fall during admission must be considered a High Risk for falls.
- Documentation in the health record is required if a patient/client/care recipient declines screening, assessment or implementation of suggested prevention and management strategies, together with reasons given for their refusal.

CLINICAL GUIDELINE

Maintaining a safe environment for all patients/clients/care recipients

Patient safety is an important part of the culture at Monash Health. All patients/clients/care recipients are considered at risk of falling. Simple prevention strategies must be put in place to ensure the risk of injury is minimised. A safe environment must be maintained for all patients within Monash Health. Standard safety measures must be put in place for all patients regardless of identified risk. Refer to: Falls standard care Implementation Tool

Consumer, family and/or carer education and engagement

- Many patients/clients/care recipients, families and/or carers are unaware of the environmental risks when in hospital due to being in an unfamiliar environment accompanied with increased levels of anxiety related to hospital admission. It is important that staff understand the level of knowledge and perceptions of falls risk that the consumer, family and/or carer may have.
- It is important that consumers, families and/or carers are engaged in the development of the falls prevention plan including goals of care.
- Opportunities to reduce deconditioning, maintain or improve levels of mobility through safe mobilisation must be implemented.
- Strategies to reduce falls risk must be discussed with the patient/client/care recipient, families and/or carers to promote shared responsibility.
- Patients/clients/care recipients, families and/or carers must be provided with information regarding falls prevention upon admission and upon request.

Risk assessment

Falls risk assessment is a detailed and systematic process using a validated risk assessment tool in conjunction with a comprehensive clinical assessment and clinical judgement. The falls risk assessment is used to identify a person's risk factor for falling. This facilitates development of a care plan to address the identified risk factors.
As part of admission, all **adult** patients must have a medical falls risk assessment completed. Refer to: Medical Falls Risk Assessment (Adult)

The validated risk assessment tools used at Monash Health are:

Risk assessment tool	Clinical area used
• Falls Risk Assessment Tool ○ **Paper based clinical areas-** Falls Prevention MRI33 ○ **EMR based clinical areas-** EMR iView and Falls Prevention Care Plan	• Adult inpatient • Haemodialysis • Hospital in the Home (HITH)
• Little Schmidy Falls Risk Assessment	• Paediatric inpatient • Monash Children's Hospital at Home • Mental Health Child and Adolescent inpatient
• Maternal Observation and Response Chart MRF13	• Maternity inpatients
• Falls Risk Assessment Tool (FRAT) MAR17	• Residential Services
• Falls Risk for Older People in the Community (FROP-Com) Screen MRI84 **and** Falls Risk For Older People- Community Setting (FROP-Com) MRI84 (I)	• Monash Health Community (Adult) • Mental Health Aged Persons Mental Health Community

Conducting the falls risk assessment

Acute & Subacute clinical areas:
The falls risk assessment must be completed within **8 hours of presentation** to Monash Health.

Hospital in the Home:
The falls risk assessment must be completed within **24 hours of admission** to Hospital in the Home.

Maternity:
The falls risk assessment must be completed within **8 hours of admission** to Monash Health.

Monash Children's Hospital at Home:
The falls Risk Assessment is completed on the initial visit to the child in their home.

Monash Health Community:
Patients **65 years of age and** older (50 years and older for Aboriginal & Torres Strait Islander peoples):

- Complete FROP-Com Screen on initial face to face assessment.

Patients **under 65 years of age** (under 50 years of age for Aboriginal & Torres Strait Islander peoples):

- Clinicians to use their clinical judgement as to whether a FROP-Com Screen is appropriate. The following factors are to be considered in decision making :
    - reported or observed mobility issues
    - previous history of falls or near misses
    - reported fear of falling
- Complete the FROP-Com Screen as clinically indicated

As part of the overall risk assessment, particular consideration is required for possible **intrinsic** and **extrinsic** risk factors that may increase the likelihood of falls, including medications (refer to: Falls Risks and Medications- Implementation Tool).

Intrinsic Risk Factors	Extrinsic Risk Factors
• Cognitive impairment – delirium, dementia • Medical conditions – cardiovascular (bradycardia, hypotension); neurological (Parkinson's disease, stroke, seizures); musculoskeletal; rheumatologic • Visual/hearing deficits • Incontinence, urgency (urinary and faecal), urinary frequency, nocturia • Medications – antihypertensive, psychotropics, benzodiazapines, diuretics, opioid • Language barriers • Mobility / balance limitations • Feet and poor footwear • Syncope / postural Hypotension • Dizziness / vertigo • Age • history of falls • Poor nutrition / hydration	• Poor observation • Environmental – slippery or wet flooring, poor lighting, no access to call bell • Equipment – position of gait aid, bed type, chair type, position of personal property, no or inappropriate footwear • Work practices/ward culture

The falls risk assessment tool does not replace clinical judgment, if a patient/client/care recipient does not present with a high risk score but is thought to be high risk by medical or nursing staff, allied health, family or carers, extra precautions to protect such patients/clients/care recipient must be documented and actioned.

A clinician can increase the patient/client/care recipient's risk score e.g. if a patient scores as a low risk but the clinician feels this does not accurately reflect the patient's true risk then the clinician can score the patient as a medium or high risk. **Clinicians are not authorised to reduce the patient/client/care recipient's falls risk score.**

For **inpatients**, the bedside mobility chart must be updated to reflect the current risk. Refer to: [Falls prevention mobility chart Implementation Tool]

Frequency for ongoing falls risk assessment:
The minimum expected frequency for ONGOING falls risk assessment is outlined below:

All patients/clients/care recipients	Prior to transfer or discharge from Monash Health

Acute	• Daily
	• Following:
	  ○ A fall
	  ○ A deterioration in clinical condition
	  ○ A change in treatment (E.g. post operatively, medication change)

Sub-acute areas/Rehab	• Weekly
	• Following:
	  ○ A fall
	  ○ A deterioration in clinical condition
	• A change in treatment (E.g. post operatively, medication change)

Dialysis	• Monthly
	• Following:
	  ○ A fall
	  ○ A deterioration in clinical condition

Hospital In The Home	• Every visit **or** once daily for multiple visits per day
	• Following:
	  ○ A fall
	  ○ A deterioration in clinical condition
	  ○ A change in treatment (E.g. post operatively, medication change)

Mental Health	Refer to as relevant: • Acute • Subacute areas (TSU, SECU, PARCS, CCU) • Monash Health Community

Maternity	• Prior to initial ambulation (including post epidural, antepartum or postpartum haemorrhage, caesarean section or other surgery)
	• Following:
	  ○ A fall
	  ○ A deterioration in clinical condition

Monash Health Community	• On initial assessment

	• As required
Neonatal & Paediatric	• Daily • Following: ○ A fall ○ A deterioration in clinical condition
Residential	• Following: ○ A fall ○ A deterioration in clinical condition ○ A change in treatment e.g. medication change ○ On care recipient of the day

Specialist areas:

Neonatal & Paediatrics

As babies and children start moving around more, they're more likely to have falls as they grow and develop their motor skills.

It is important to prevent harm from falls by adjusting the environment to suit by:

- reducing the height of falls
- providing softer surfaces to fall on if falls are anticipated
- keep the environment free from sharp edged furniture

Refer to the Falls Prevention Standard Care Implementation Tool for further information with regard to paediatric falls prevention.

Developing a falls prevention and intervention plan:

- Update the falls risk assessment then review and implement the prevention and management care plan
- The falls prevention plan must be developed as a collaboration between the patient/client/care recipient, family and/or carers and the interdisciplinary team to address relevant risk factors, physical condition and clinical setting
- Regardless of the identified risk rating, all patients/clients/care recipients require the consideration and consistent delivery of fundamental care practices to prevent falls
- Refer to the Falls prevention standard care Implementation Tool to identify and implement interventions for falls prevention
- Include education strategies for patients/clients/care recipients in the individualised falls prevention plan
- Discuss the falls risk with the interdisciplinary team and complete referrals as necessary including: Occupational Therapy, Physiotherapy, Podiatry, Dietetics, Continence Nurse, Pharmacy, Ophthalmology etc.
    - Referrals to relevant multidisciplinary team must be made when the patients has any of the following:
        - Medium to High Falls Risk
        - patient/client/care recipient has sustained a fall
        - limited functional participation & mobility
        - requires specialised equipment (including 4WF and crutches)

- Requirements for documenting the prevention and intervention plan in the different clinical settings are set out in Documentation

Discharge planning:
Prior to discharge, ongoing falls risk factors are to be identified in long-term prevention strategies incorporated into the discharge or transfer plan of care.
It is the responsibility of clinical staff to ensure that patients/clients/care recipients 'at risk' of falls who may be amenable to further assessment or management are referred for follow up post discharge to the relevant service e.g. General Practitioner, Occupational therapy, Physiotherapy, Community Rehabilitation or Community Health Programs

All patients/clients/care recipients require an individualised, coordinated and interdisciplinary approach to discharge that is consistent with best practice. Refer to: Patient discharge (Operational Policy)

Documentation:
Effective **communication** and **documentation** of the falls risk, prevention strategies and patient/client/care recipient, family and/or carer education is required.

The principles and processes for falls risk assessment and prevention remain consistent throughout all areas of Monash Health. However, methods of documenting associated findings and implementation plans will vary between settings, units and departments.

For paper based clinical areas
Complete as relevant:

- Falls Prevention MRI33
- Little Schmidy Falls Risk Assessment
- Falls Risk Assessment Tool (FRAT) MAR17
- Falls Risk for Older People in the Community (FROP-Com) Screen MRI84 **and/or** Falls Risk For Older People- Community Setting (FROP-Com) MRI84 (I)
- Maternal Observation and Response Chart MRF13

For EMR based clinical areas
Refer to:

- Adult Risk Assessment Documentation in iView and CareCompass QRG
- Little Schmidy Falls Risk Assessment QRG

ADDITIONAL RESOURCES

- Assessment, Care Planning and Discharge
- Bed Rails- Implementation Tool
- Discharge planning
- Falls Prevention Standard Care- Implementation Tool
- Falls Risk and Medications- Implementation Tool
- Post Falls- Procedure
- Preventing falls in pregnancy (patient information)

KEY LEGISLATION AND STANDARDS

National Safety and Quality in Health Service Standards. Standard 5: Comprehensive Care Standard

REFERENCES

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KEYWORDS

Trip, slip, turn

Document Governance	
Supporting Policy	Falls Prevention Operational Policy
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