Share the care: Falls Prevention is everyones’ business

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Lead, NSW Falls Prevention Program
Clinical Excellence Commission
2016
I would like to acknowledge the traditional owners of the land on which we are meeting today and to pay respect to the elders past and present and extend that respect to other Aboriginal people present.
Clinical Excellence Commission

The Clinical Excellence Commission is responsible for leading safety and quality improvement in the NSW public health system.
Share the care: Falls Prevention is everyone’s business
April Falls 2016

Engage with Carers
Win!

1st April 2016

APRIL FALLS DAY

Show us how you have prevented falls or raised awareness of falls in your ward or work area in the last 12 months (April 2015 - April 2016) ... Easy!

To Enter

Using the entry form, list the top 3 strategies you have used to:
- prevent falls or falls injury
- reduce or maintain an already low falls rate, or
- raise awareness of falls prevention to staff and patients/carers.

Strategies must be:
- cost effective, sustainable, and engage patients and/or carers.

Entries close on Monday 2nd May 2016

Return the completed entry to: Tugrid Hutchinson, Project Officer, NSW Falls Prevention Program tugrid.hutchinson@health.nsw.gov.au

eMR – Hospital and CHOC
OMS Falls Risk Screen Form

Ontario Modified STRATIFY (Sydney Scoring) Falls Risk Screen

Leopard: Spotted
MRN: 831
DOB: 17/07/1975
AGE: 36 Years
MC: 99999999999

Completed On
- Admission
- Post Fall
- Change of Condition
- When Appropriate

History of Falls
Did the patient present to hospital with a fall or have they fallen since admission?
Yes: Yes or No
No: Yes or No

Mental Status
Is the patient confused (i.e. unable to make purposeful decisions, disorganized thinking and memory impairment)?
Yes: Yes or No
No: Yes or No

Is the patient disoriented (i.e. lacking awareness, being mistaken about time, place or person)?
Yes: Yes or No
No: Yes or No

Is the patient agitated (i.e. fearful affect, frequent movement and anxious)?
Yes: Yes or No
No: Yes or No

Vision
Does the patient require eyeglasses continually?
Yes: Yes or No
No: Yes or No

Does the patient report blurred vision?
Yes: Yes or No
No: Yes or No

Toileting
Does the patient have glaucoma, cataracts or macular degeneration?
Yes: Yes or No
No: Yes or No

Are there any alterations in sensation (i.e. frequency urgency, incontinence, nocturia)?
Yes: Yes or No
No: Yes or No

Transfer Score (TS)
- Independent - use of aids to be independent is allowed.
- Minor help - one person exist to needed supervision for safety.
- Much help - one strong assist help or two normal people - physical assist.
- Unable - no sitting balance, mechanical lift.

Mobility Score (MS)
- Independent - no aids are used including crutches.
- Independent - with aids including crutches.
- Needs extra help of one person (physical or verbal) assistance.
- With another independent including cane etc.
- Immobile.

Total TS + MS Score

TOTAL OMS Score

Score > 9 = HIGH FALL RISK

ALERTS

Mental Status
Yes: Task in care compass to complete:
- AMTS
- CAM
- communication plan with family & carer
- behavioural chart with family and carer
No: DRAT

Toileting – toileting plan
Mobility /transfer – P/T Consult
Both consider mobilising equipment of assistance by 2

A task will drop on the doctor’s list for a medication consult

Prompts for supervision

CLINICAL EXCELLENCE

Ten years of quality and safety
NSW Falls – IMS Data current
New IMS system with revised falls data set
Falls by age, January 2013 – June 2015

Target Group?
Medical Conditions
- Stroke
- Incontinence
- Parkinson’s disease
- **Dementia**
- **Delirium**
- **Malnutrition**

Medications
- **Psychoactives**
- Four or more medications

Psychosocial & Demographic
- History of falls
- Depression
- Advanced age
- Living alone
- ADL limitations
- Female gender
- Inactivity
- Poor nutrition

**Risk factors for falls**

Sensorimotor & Balance
- Muscle weakness
- Impaired vision
- Reduced peripheral sensation
- Poor reaction time
- Impaired balance

Environmental
- Poor footwear
- **Hospital ward clutter/bathrooms**
- Home hazard
- External hazard
- Inappropriate spectacles

Falls

Neuroscience Research Australia 2012
Complexity of Care – co-morbidities

a fall is an indicator that something is not right

Revised ACSQHC National Standard - Comprehensive Care

Confusion: Cognition/Dementia/Delirium
Nutritional status – malnutrition
Mobility – frailty (poor balance and strength)
Vision
Medications
Pressure Injury
End of life care
Post fall safety huddle

- engage with patient/family carer
- led by NUM – or nominated lead: multidisciplinary if possible
- apologise for this event – want to work out what happened to prevent it happening again
- document agreed actions

Bathroom floor – patient thought that there was water on the floor – moved to avoid and fell!

Glare – not water
Safe Use of Mobility Aids

- Walking Stick
- Wheeled Walker
- Pick Up Frame
- Forearm Support Frame

- Introduction
- Fitting of Mobility Aid
- Correct Walking Pattern
- Common Mistakes
- Safety Checklist
Safe use of Mobility Aids

SAFETY CHECKLIST

- Always check for signs of bending, deformity, breakage or corrosion
- Protruding or Missing Screws
- Split or loose hand grips
- Worn rubber tips
- The safe user weight limit sticker

Wheeled Walker 0602

Walking Stick 0502
Opportunistic case finding in primary and secondary care settings

- Older people in contact with health professionals are to be asked routinely whether they have had a fall in the past year and observed for balance and gait deficits – regardless of the health care setting in which they present.

- And are to be offered interventions to manage fall risk and in particular where they will benefit from balance and strength training as appropriate.

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance are to be offered multifactorial fall risk assessment & individualised interventions.
FROP – Com Fall Risk Screen

Procedures Following a Fall

1. **Clinical Review - GP**
   - Review of person by the General Practitioner.
   - Initial assessment of physical and functional ability.
   - Review of medications and possible side effects.
   - Referral to Occupational Therapist, Exercise Physiologist, and/or GP.

2. **Call Ambulance**
   - If person requires basic life support.
   - If person has a fall and is unable to get to their feet or has an injury/acute confusion and unable to be treated and stabilised.
   - If person is found on the floor with no obvious injury and unable to get to their feet or reports that they have had a fall.

3. **Check for signs or injury:**
   - Check for a fall.
   - Check for any open wounds.
   - Check for any broken bones.
   - Check for any injuries.

4. **Referral Suggestion:**
   - General Practitioner.
   - Community Nurse.
   - Physiotherapist.
   - Occupational Therapist.
   - Exercise Physiologist.

5. **ADL/Function related referral to Occupational Therapist and GP for ADL/functional assessment:**
   - Referral to Occupational Therapist and GP for ADL/functional assessment.
   - Referral to Physiotherapist, Exercise Physiologist, and/or GP for mobility/balance assessment.

6. **Document Care Plan, actions and referrals made in patient notes:**
   - Document care plan, actions, and referrals made in patient notes.

**Note:** Any fall may lead to serious consequences in the older population.

**LOW RISK**
- Score: 0 - 3
  - Plan of care developed in consultation with patient/family or carer.
  - Conduct or refer to a multifaceted risk assessment:
    - Cognitive Screen/Collaborative Screen
    - Medication review
    - Vision check or referral for vision
    - Labelling and falls signs
    - Postural stability/proprioception
    - Mobility
    - Confidence in self

**HIGH RISK**
- Score: 4 - 9
  - Review of patient’s and family’s needs.
  - Conduct or refer to a multifaceted risk assessment:
    - Cognitive Screen/Collaborative Screen
    - Medication review
    - Vision check or referral for vision
    - Labelling and falls signs
    - Postural stability/proprioception
    - Mobility
    - Confidence in self

**FALL RISK ASSESSMENT AND INTERVENTION**
- Review of patient's and family's needs.
- Conduct or refer to a multifaceted risk assessment:
  - Cognitive Screen/Collaborative Screen
  - Medication review
  - Vision check or referral for vision
  - Labelling and falls signs
  - Postural stability/proprioception
  - Mobility
  - Confidence in self

**PROBLEM WITH BALANCE AND/OR MOBILITY?**
- Related to Physiotherapy, Exercise Physiologist and/or GP.

**PROBLEM WITH ADL, HOME ENVIRONMENT OR FUNCTIONAL ISSUE?**
- Related to Occupational Therapist and/or GP.
### Tests for Balance and Strength

- **guide and DVD**

<table>
<thead>
<tr>
<th>Client reports</th>
<th>Client risk factor for falls</th>
<th>Balance and/or Strength test</th>
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| • Feeling wobbly or unsteady while standing still  
  • Falls while standing still e.g. waiting in a queue or washing up  
  • Generally feels unsteady while doing any ADL’s | Reduced or loss of Balance | Near Tandem Stance |
| • Client reports a fall or unsteadiness while reaching for items | Reduced Leaning balance | Functional Reach Test |
| • Client reports a fall when moving around or over objects, such as loose mats, or a grandchild’s small toy | Reduced Stepping Balance | Four Square Step Test |
| • Client reports a fall while walking or unsteadiness while walking  
  • Unable to ‘keep up’ with a friend or partner | Reduced Gait speed | 10 m walk test (Can be 4m, 6m or 8m) |
| • Client reports their leg gave way due to weakness  
  • Difficulty getting in or out of a chair or car seat | Reduced lower leg strength | Five times sit to stand |
Care of the older person in residential aged care

Vitamin D supplementation

Medication review

Multidisciplinary intervention
Barbara's Story is a series of 6 films which has changed attitudes to dementia in hospitals across the world – see complete video at:
NSW Snapshot

NSW Falls Indicators

Research Partnerships and Collaboration

• Neuroscience Research Australia
• The George Institute for Global Health
• Sydney University
• Monash University

NSW Falls Prevention Network
ACI Aged Health Network
Musculoskeletal Network
Nutrition Network
10 years in quality and safety in health care

The **real value** of our work is seen in wards and hospitals, in community and residential aged care through the engagement and adoption of CEC programs and best-practice initiatives by clinicians and health executives.
Falls Prevention is everyone’s business®

Join the NSW Falls Prevention Network:
http://fallsnetwork.neura.edu.au

View active and healthy website:
www.activeandhealthy.nsw.gov.au