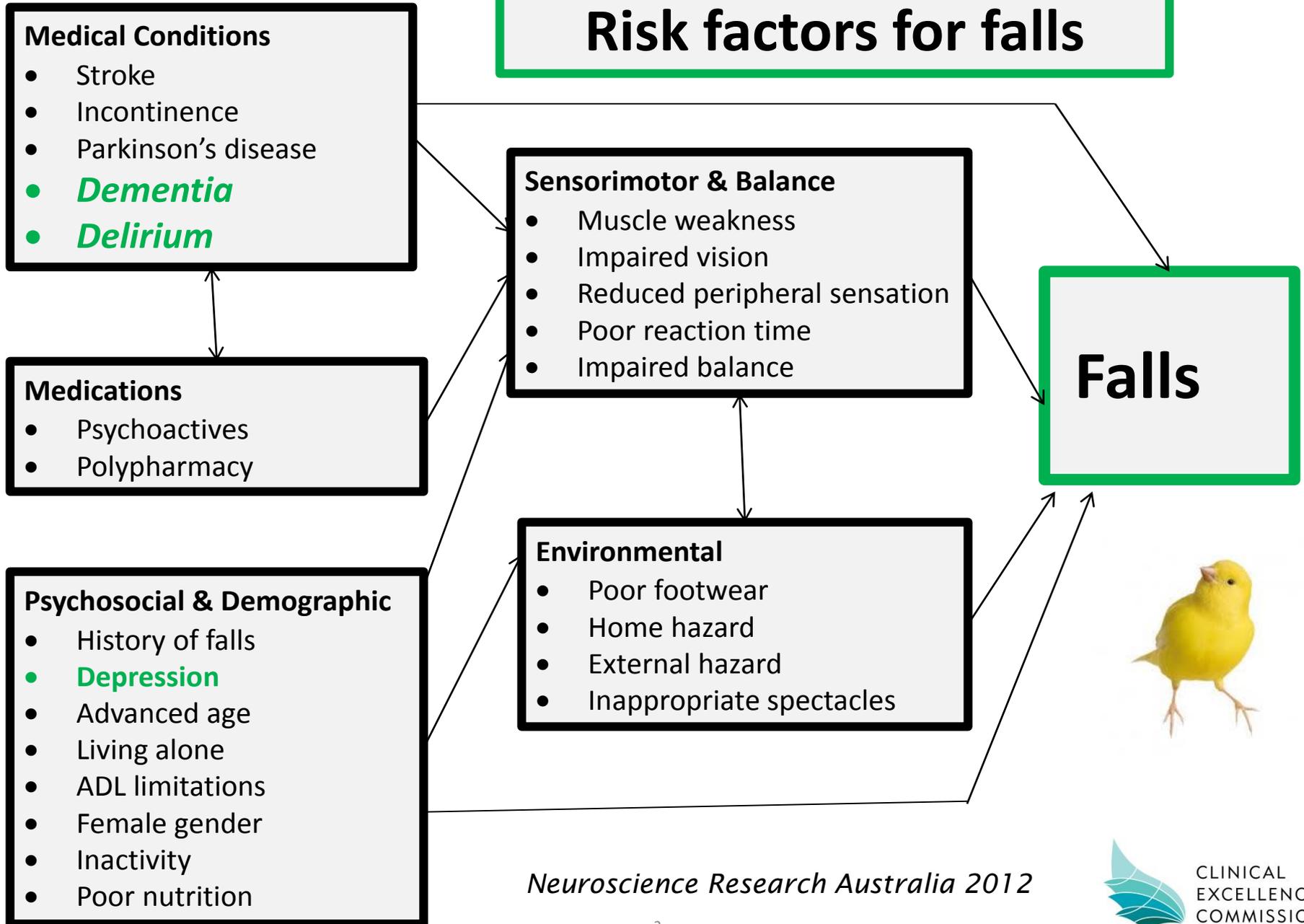




Falls Prevention is *everyone's business*®

**Lorraine Lovitt
Leader, NSW Falls Prevention Program
Clinical Excellence Commission
August 2017**

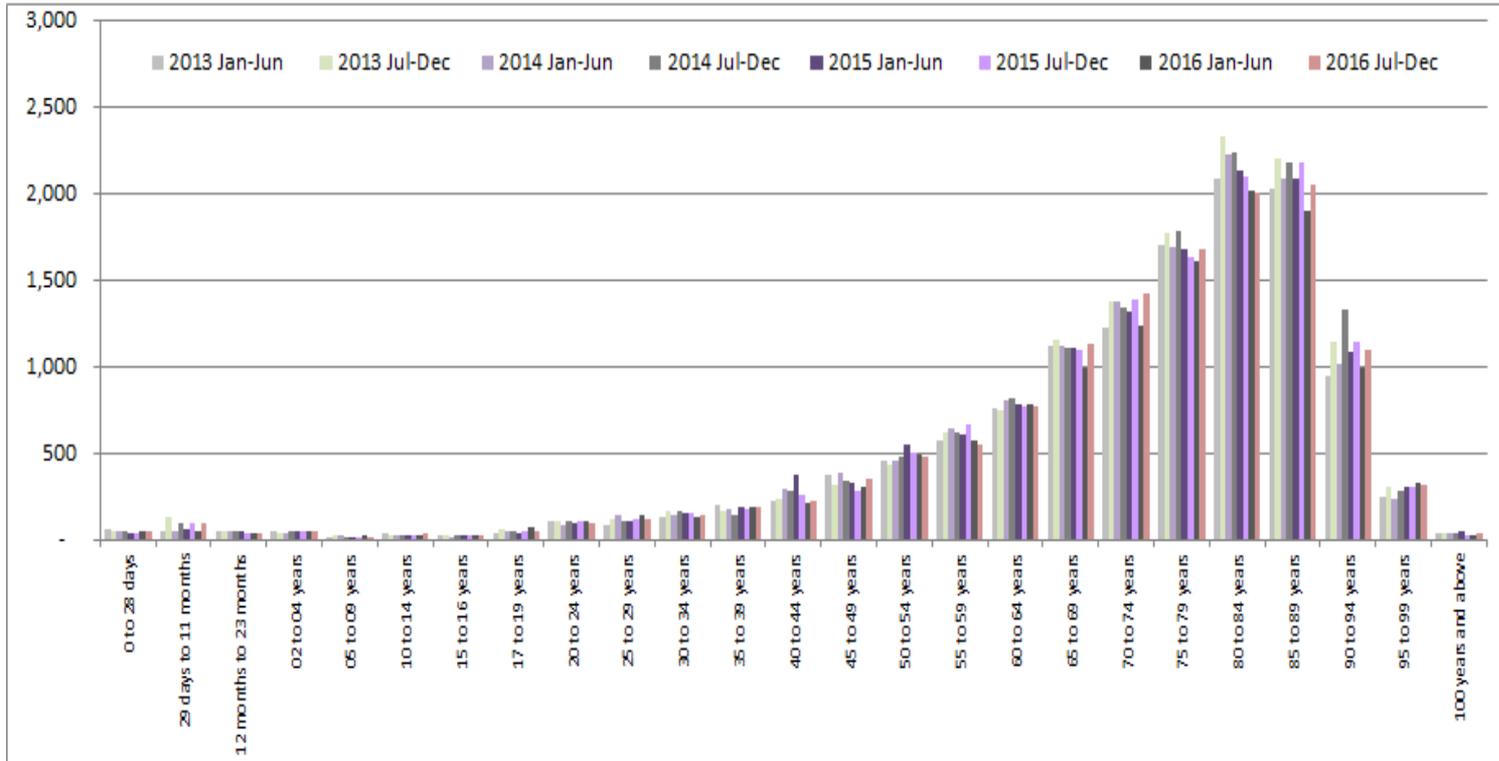
Risk factors for falls



I would like to acknowledge the traditional owners of the land on which we are meeting today and acknowledge that we are on Aboriginal land and I pay respect to the elders past and present and extend that respect to other Aboriginal people present.

As we share our own knowledge, teaching, learning and research practices may we also pay respect to the knowledge embedded forever within the Aboriginal Custodianship of Country

IMS Falls by age, January 2013 - December 2016



<http://www.cec.health.nsw.gov.au/clinical-incident-management>



Leadership and co-ordination, Integrating with key partners



**Local Health Districts/Networks
&
LHD Falls Co-ordinators**

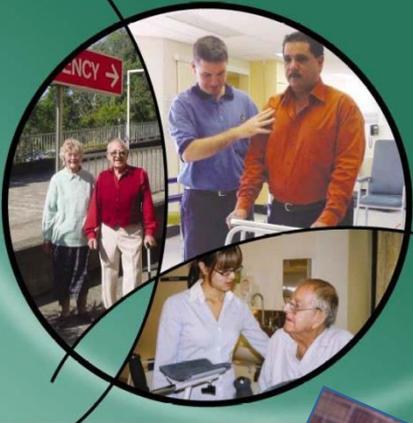
**External
Agencies**

*Residential
Aged Care*



Preventing falls and harm from falls in older people.

Best practice guidelines for Australian hospitals and residential aged care facilities 2005



Preventing Falls and Harm from Falls

National Safety and Quality Health Service Standards

June 2011



CLINICAL EXCELLENCE COMMISSION

Ten years of quality and safety

Post Fall



CEC POST FALL GUIDE

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Emergency Response Systems and if at any time a staff member is concerned about a patient they can call for a Clinical Review.



IMMEDIATE RESPONSE	<p>Basic life support Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABCD)</p> <p>Rapid assessment Pain, bleeding, injury, fracture Do not move until assessed: examine cervical spine and immobilise if there is an indication of injury</p> <p>Observations BP, P, R, T, SpO₂, Blood Glucose and Pain Score, Neuro Observations</p>	CLINICAL REVIEW	RAPID RESPONSE
ONGOING OBSERVATIONS and MONITORING	<p>BP, P, R, T, SpO₂, Pain Score, Neuro Observations, BGL (if indicated)</p> <ul style="list-style-type: none"> At least hourly for a minimum of 4 hours 4 hourly for the next 24 hours or as clinically indicated, then REVIEW - ongoing observations as required <p>CHECK FOR SEPSIS Does this patient have sepsis risk factors or signs & symptoms of infection? and Does this patient have observations in the yellow zone?</p> <p>CHECK FOR DELIRIUM Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion?</p> <p>CHECK FOR HEAD INJURY Does this patient have a head injury? <small>Refer to PD2012_013: Initial Management of Closed Head Injury in Adults. Algorithm: Initial Management of Adult Mild Closed Head Injury</small></p> <p>Strong indicators for a CT Scan include (see algorithm for full list of risk factors):</p> <ul style="list-style-type: none"> The patient is on anticoagulants, antiplatelets, or with a known coagulopathy, (check INR/APPT). Has an abnormal GCS or fluctuating changes in cognition, changes in behaviour, or increasing confusion. Has large facial or scalp bruising, nausea, vomiting or persistent severe headache. Age ≥ 65 years (clinical judgement required). <p>Are you concerned about this patient and or family, carer has reported concerns?</p> <p style="text-align: center;">THERE MAY BE MANIFESTATIONS OF HEAD INJURY AFTER 24 HOURS - CONTINUE TO MONITOR -</p>	CLINICAL REVIEW	RAPID RESPONSE
COMMUNICATE	<ul style="list-style-type: none"> Reassure the patient and explain all treatment and investigations. All patient falls are to be reported to medical officer for review. Notify the person responsible (family/carer/friend) with permission and inform them about the fall. If the person is not able to communicate effectively engage with the substitute decision maker. Discuss appropriate treatment options and clarify if there is an Advance Care Directive in place - symptom management is important. Implement plan of care and inform staff of care plan. Communicate at clinical handover - observations, falls risk and interventions in place. 	CLINICAL REVIEW	RAPID RESPONSE
DOCUMENT	<ul style="list-style-type: none"> Treatment, palliation/escalation process and outcome documented in the clinical record. Change falls status to: HIGH RISK and record in clinical record and complete revised care plan. Complete IIMS report and note incident and IIMS number in the clinical record. Complete a review of fall event with ward clinical leadership team. Complete CEC Incident Review for any serious injury/outcome from fall. 	CLINICAL REVIEW	RAPID RESPONSE

Immediate response
(Assessment & observations)

Ongoing observations & monitoring

Communicate

Document

Key conditions to be on alert for:

- Delirium
- Head injury – monitor patients on anticoagulants
- Sepsis

Post Fall Huddles

Community

FROP-Com

NSW Health
FROP-COM COMMUNITY FALL RISK SCREEN

Screen all people 65 years and older (45 years and older Aboriginal & Torres Strait Islander peoples)

FALLS HISTORY

1. Number of falls in the past 12 months?

- None (0)
- 1 fall (1)
- 2 falls (2)
- 3 or more (3)

FUNCTION: ADL status

2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?

- None (completely independent) (0)
- Supervision (1)
- Some assistance required (2)
- Completely dependent (3)

BALANCE

3. When walking and turning, does the person appear unsteady or at risk of losing their balance?

- No unsteadiness observed (0)
- Yes, minimally unsteady (1)
- Yes, moderately unsteady (needs supervision) (2)
- Yes, consistently and severely unsteady (needs constant hands on assistance) (3)

Total Risk Score

Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25	0.7	1.4	4.0	7.7					
Grading of falls risk	0 - 3 Low risk			4 - 9 High risk						

MEDICATIONS

If one or more medications below are taken refer to General Practitioner/Medical Officer for review

These can increase fall risk:

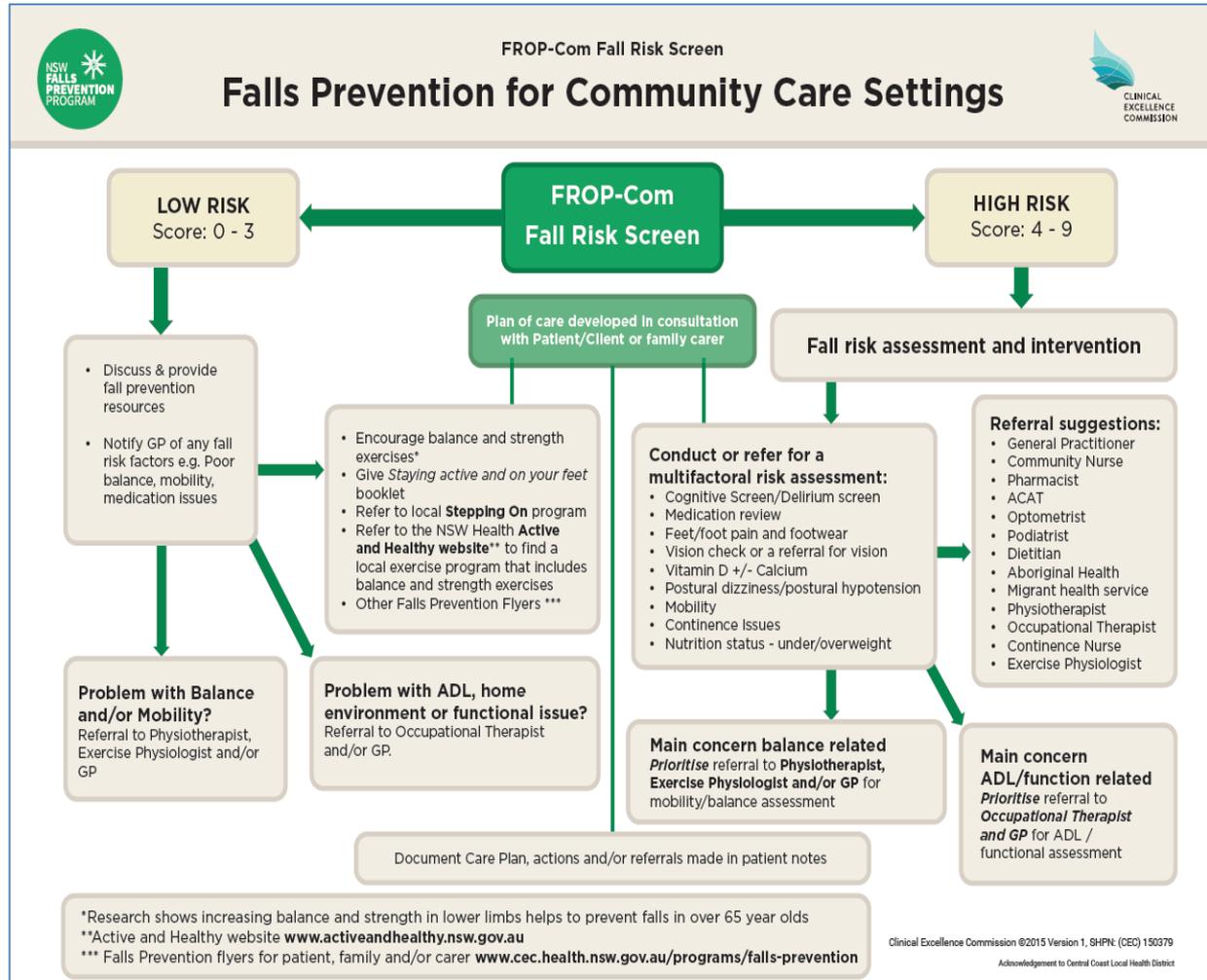
Antipsychotics Antidepressants Sedatives/hypnotics Opioids

Print Name _____ Designation _____

Signature _____ Date ____/____/____

ACKNOWLEDGEMENT: National Ageing Research Institute

NO WRITING



Procedure Following a Fall



NOTE: Any fall may lead to serious consequences in the older population

CLINICAL REVIEW - GP

Timely review of person by the General Practitioner

CALL AMBULANCE

Rapid Response: Dial Triple 0 (000)

If person requires basic life support

- Remain calm and reassure person and family members
- Immediate Response: Apply DRABCD (Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defibrillator if available)

Check for signs of Injury

Observe for unusual body posture, active bleeding, bruising, new pain, neurological signs

- Leg shortened, rolled outwards could indicate a broken hip
- Deformed wrist/arm could indicate a fracture
- Bruising/bleeding around the head could indicate concussion/head injury
- Confusion: disorientation, agitation, restlessness and changes in usual behaviour - could indicate head injury
- Is the person on anti-coagulants? If yes - be alert for head injury, there is an increased risk of intra-cranial injury/internal bleeding
- If you have concerns based on your clinical judgement, call for a clinical review/rapid response

Person has had a fall and is UNABLE to get to their feet/has an Injury/acute confusion and is unable to be treated and stabilised

- CALL an AMBULANCE Triple 0 (000)
- Take observations (BP, Pulse, Respirations, Neuro obs) - if trained
- Contact a support person and GP
- Make person comfortable and monitor for signs of shock or other change in condition
- DO NOT leave client unattended

Person is found on the floor - has no obvious Injury and is able to get to their feet OR person reports that they have had a fall

- Where required assist person into a chair - as per procedure page 15 *Staying Active and on your feet* booklet or CEC Flyer *How to get up from a fall*
- Discuss the incident with the person and assess for any change in function (ADL/mobility)
- Contact person responsible or significant support person/carer - and if not available facilitate follow-up call/s to check on condition
- Contact their GP to inform them of the fall and relay any relevant information
- Warn the person/family/carer of delayed signs: dizziness, blurred vision, headaches, confusion (disorientation, agitation, restlessness and changes in behaviour - be alert for head injury), sudden onset of pain or new pain, inability to weight bear
- Advise them to contact their GP and/or ambulance if any of these signs develop
- Gain consent from the person to make referrals to appropriate services for falls risk assessment and management if required
- Do not leave the person until stabilised, or, if possible, when a support person is with them

When you return to the office

- Complete an IMS report as appropriate
- Document actions - communicate fall information at Clinical Handover
- Make referrals to appropriate disciplines to conduct falls risk assessment and management



Information following a fall at home

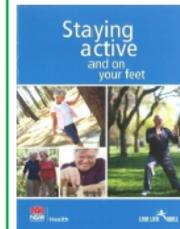
One in three people over 65 living in the community will have at least one fall during the next 12 months. Many fall more than once. This can lead to a loss of confidence and independence.

Seek medical attention after a fall if you:

- take anticoagulant medicines (blood thinners) as you may be at increased risk of injury and bleeding
- have a headache that gets worse, or will not go away
- feel dizzy or faint
- are nauseated or are vomiting
- have blurred vision or slurred speech or saying things that don't make sense
- feel increasingly sleepy, restless, confused, agitated, a change in behaviour
- have increased pain
- cannot move part of your body, or have increased clumsiness or balance problems.

After a fall, visit your GP to discuss:

- exercise that is best for you to reduce falls
- how to improve your mobility
- how to manage chronic health conditions
- your medications (that might lead to a fall)
- bone health
- if you need vitamin D
- any vision problems
- any foot pain or problems



Staying Active and on Your Feet booklet

- Health and lifestyle checklist
- How to get up from a fall
- Exercises to do at home
- Home safety checklist

For a copy of the booklet and to find an exercise program close to you

Visit: www.activeandhealthy.nsw.gov.au

Acknowledgement to:
Staying Active and on Your Feet booklet
2010 www.activeandhealthy.nsw.gov.au

For further information scan this with your smart phone

Email: falls@cec.health.nsw.gov.au
Web: www.cec.health.nsw.gov.au

Clinical Excellence Commission© 2012 Version 1, SHPN: (CEC) 120315



CEC Resources




Falls Prevention – Postural Hypotension

Postural hypotension (or orthostatic hypotension) is when your blood pressure drops when you go from lying down to sitting up, or from sitting to standing. When your blood pressure drops, less blood goes to your organs and muscles. This can make you dizzy and more likely to fall.

Are you feeling any of these symptoms: dizziness, light-headedness, blurred vision, or feeling about to faint?

When do symptoms tend to happen?

- When sitting up or standing up too quickly
- When getting out of bed too quickly
- After a large meal or excessive alcohol drinking
- During exercise
- When you are ill or frail



What are some of the causes?

- Taking certain medications for blood pressure, heart, mood and Parkinson's disease.
- Dehydration due to not drinking enough fluids, vomiting or diarrhoea.
- Prolonged bed rest.
- Certain conditions e.g. diabetes, heart problems, Parkinson's disease and anaemia.
- Excessive amounts of alcohol.

What you can do

- Tell your doctor about your symptoms.
- Get out of bed slowly. First sit up, then sit on the side of the bed, then stand up.
- Take your time when changing position, such as when getting up from a chair.
- Have something steady to hold onto when you stand up.
- Take it steady when walking or get support if you feel dizzy.
- Exercise gently before getting up (move your feet up and down and clench and unclench your hands) or after standing (march in place).
- Drink 6-8 glasses of water daily, unless you have been told to limit your fluid intake.
- Avoid standing still over a long time.
- Avoid taking very hot baths or showers.
- Try sleeping with extra pillows to raise your head.

Acknowledgement to:
 80/100 fall prevention partnership project
 (The University of Sydney, Northern Sydney Medical Centre,
 Clinical Excellence Commission)

©2010 Funded by Health Services for Disease Control and Prevention,
 United States.

For further information scan this with your smart phone

Email: info@newfalls.com.au
 Web: www.newfalls.com.au






Falls Prevention – Urge Incontinence

You may find that you have less warning about going to the toilet and your bladder may need to be emptied more often. You may also be woken up a few times at night to go to the toilet. It may also cause you to be incontinent.

If you have urge incontinence, seek help from a qualified health professional



Urge incontinence can cause falls in these ways

- Rushing to the toilet, may cause you to pay less attention to your surrounds causing you to slip or trip over things.
- Getting out of bed quickly and hurrying to get to the toilet in the dark or when feeling sleepy.
- Not using a walking aid for support (if required) when you are in a hurry to reach the toilet.
- Having a disturbed sleep can cause you to be at a higher risk of falling during the day if you are tired and drowsy.

What you can do

- Seek help from your doctor.
- Check with your doctor if your medications are causing the problem.
- Your doctor may refer you to a continence specialist: physiotherapist, nurse or doctor.
- Avoid drinking too much or too little fluid. Your doctor can help you work out your appropriate fluid intake.
- Cut back on caffeine and alcohol, especially before going to bed at night.
- Ensure the path to the toilet is free from clutter, obstacles and slipping hazards.
- Ensure that there is good lighting to the toilet. Use night lights for route to the toilet at nights.
- If the toilet is not nearby, place and use urinals or commode chairs close to the bed.

Acknowledgement to:
 80/100 fall prevention partnership project
 (The University of Sydney, Northern Sydney Medical Centre,
 Clinical Excellence Commission)

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 United States.

For further information scan this with your smart phone

Email: info@newfalls.com.au
 Web: www.newfalls.com.au






How to get up if you have a fall

Know what to do - it is important to have an emergency plan:

- Call for help - keep a list of family and friends' phone numbers near the phone, or program them into the phone for one-touch dialling
- Keep a phone within reach, in case it is hard to get up
- Consider a device that raises an alarm in case of an emergency
- Let family and friends know how to get into your house if you can't let them in.

1. Roll onto your side



2. Crawl or drag yourself to a chair



3. Face the chair and get up on your knee



4. Bring one knee forward and put that foot on the floor, then use the chair to push up with your arms, until you are upright enough to pivot your bottom around to sit



5. Rest for a while before standing up



If you can't bend your knees very well, slide along on your bottom, then lift your hips onto something higher, such as stairs. Then you can pull yourself upright again.

You might like to practice these techniques, so if you ever need to get up from the floor, you will feel more confident.

You should see your doctor after a fall if:

- You are taking anticoagulant medicines
- You are worried about your balance
- You bump your head, feel drowsy or unwell
- You have a pain that concerns you.

Acknowledgement to:
 Staying Active and on Your Feet project
 2010 www.ahmhs.org.au/activeandontake

For further information scan this with your smart phone

Email: info@newfalls.com.au
 Web: www.newfalls.com.au



Share the care: Falls Prevention is everyone's business

April Falls 2016

Falls are preventable.
We all have a role to play.

NSW FALLS PREVENTION PROGRAM

1st April 2016
APRIL FALLS DAY
Share the Care: Falls Prevention is everyone's business®

CLINICAL EXCELLENCE COMMISSION

This poster was developed and is used with the kind permission of SA Health, Government of South Australia.

CARERS: YOUR ROLE IS KEY

TALK TO STAFF
if you notice any changes
in the patient's condition

NSW FALLS PREVENTION PROGRAM

1st April 2016
APRIL FALLS DAY
Share the Care: Falls Prevention is everyone's business®

CLINICAL EXCELLENCE COMMISSION

Acknowledgment to GGLHD & HGLHD. Reproduced with their permission.



Engage with Carers





Is my patient more confused?

YES



NO



A patient with confusion is a **high fall risk**



Be alert to **DELIRIUM**



Recognise and respond to patients with dementia / delirium

What is the clinical cause of confusion?

? UTI / infection

? Dehydration

? Constipation / urinary retention

? Post anaesthetic

? Acute illness



APRIL FALLS DAY
1st April 2015



Temperature, pulse, BP are Vital Signs



Level of cognition is a Vital Sign



People with Dementia and / or Delirium are at risk of harm



Be alert to **DELIRIUM**



Recognise and respond to patients with dementia / delirium



APRIL FALLS DAY
1st April 2015





COGNITIVE
DECLINE
PARTNERSHIP
CENTRE



CHOPs
CARE OF CONFUSED
HOSPITALISED OLDER PERSONS

Care of Confused Hospitalised Older Persons (CHOPs) Program

Anthea Temple Project Officer ACI

Cath Bateman Project Officer ACI

Results shown in this presentation are **preliminary**



CLINICAL
EXCELLENCE
COMMISSION



Created by nurses at Guy's and St Thomas' Barbara's Story is a series of 6 films which has changed attitudes to dementia in hospitals across the world – see complete video at: <http://www.guysandstthomas.nhs.uk/news-and-events/2014-news/20140331-barbaras-story-youtube.aspx>



State-wide investment to build capacity



**Stepping On
with confidence**

Stepping On is an exciting and friendly community group program for seniors. It is designed to build knowledge, strength and confidence to remain independent at home.

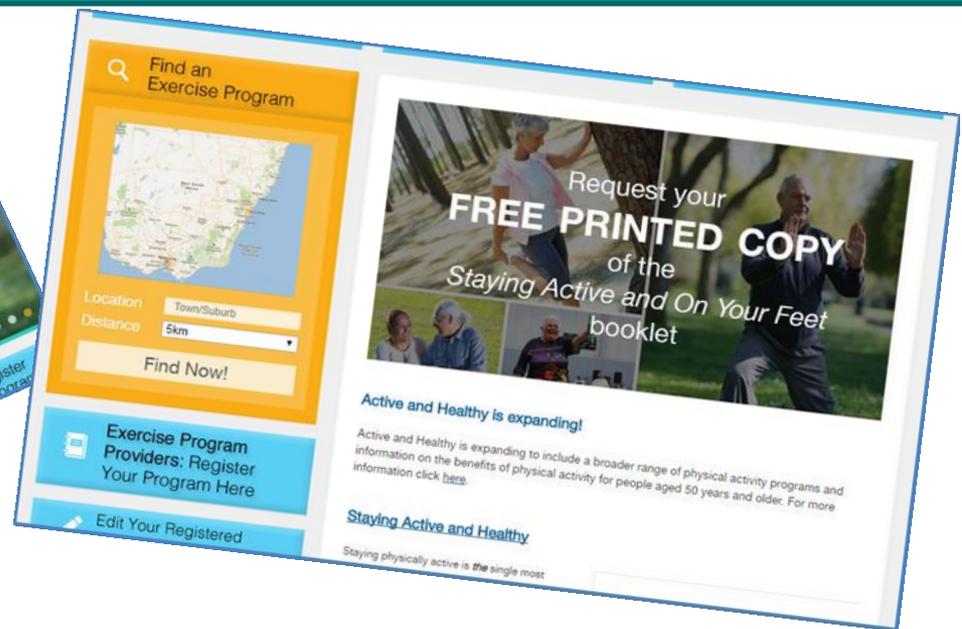
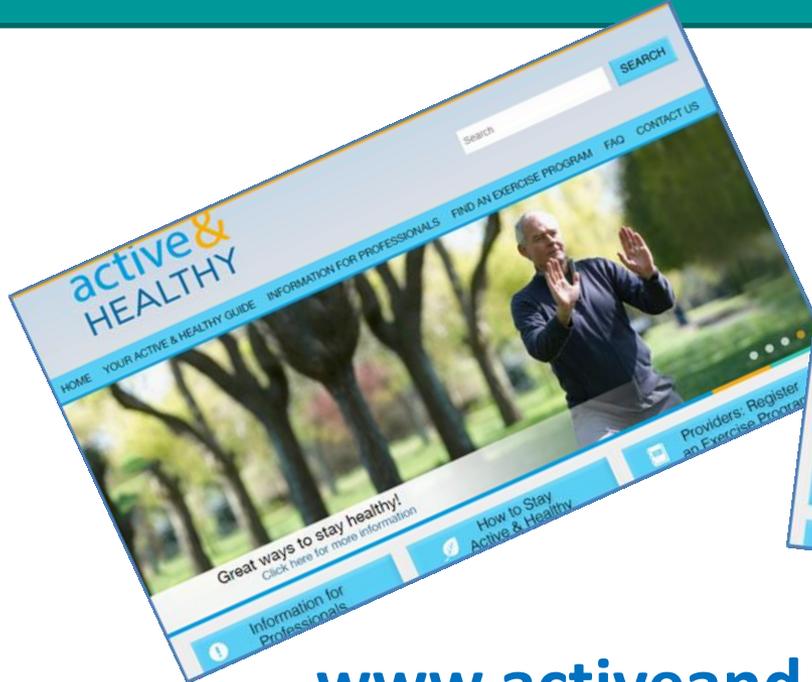


For further information on a Mosman group please contact:
Claire Vandenburg on 02 9462 9333. Starts March 30th



- **2038** Stepping On programs have been delivered throughout the state in more than **12 languages**
- **21,954** participants have completed the program.
- as at (June 2017)

(Stepping On © Clemson & Swann)

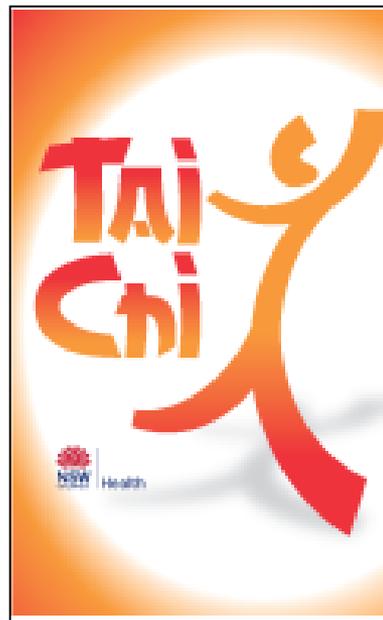
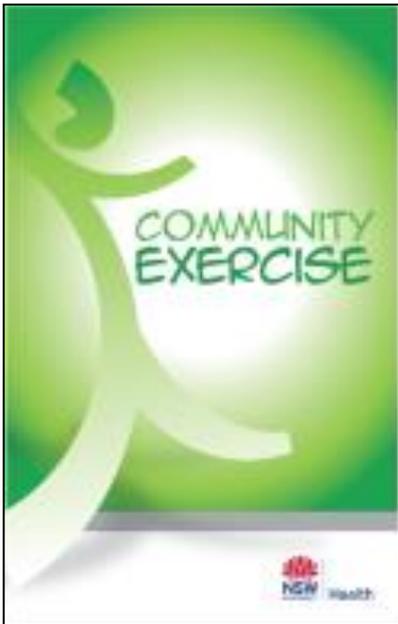


www.activeand healthy.nsw.gov.au

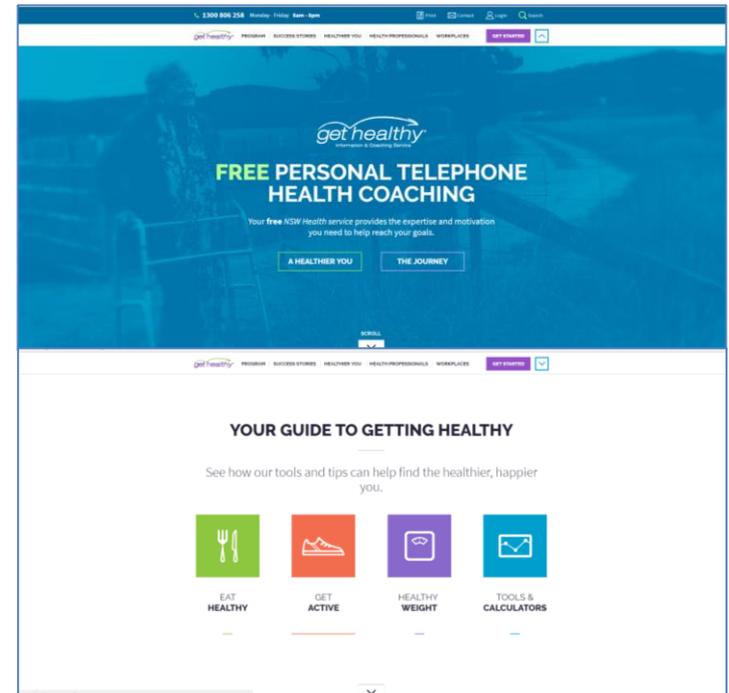
- As of 30 June, there were 825 program providers & 850 exercise program s
- 785 of these are registered as fall prevention programs and
- 65 are registered as general physical activity programs.

Google Analytics	31 March 2016 - 31 March 2017
Number of page views	215,535
Number of sessions	48,467
Number of users	35,644
Average number of pages viewed per session	4.41
Percentage of sessions accessed in NSW	89.8%

Support to Rural Volunteers to deliver Tai Chi and Physical Activity Programs



NSW Health - get healthy



LIFE

NSW Falls Prevention Network

- Network list serve
- Newsletters & updates
- Annual Network forum held 19 May 2017

Home About Us Events News Resources Contact Us

Upcoming Events

NSW Falls Prevention Network Forum
Friday 22nd May 2015
The Wesley Conference Centre, 220 Pitt St Sydney
[Forum Flyer](#)
[Register Now](#)

Hunter New England LHD- NSW Falls Prevention Network Rural Forum
Thursday 26th March 2015
The Sebel Kirton Park, Pokolbin
[Forum Flyer](#)
[Final Program](#)
Map -[Directions from Newcastle](#), [Directions from Upper Hunter](#)

Australian and New Zealand Falls Prevention Society
6th Biennial Australasian Falls Prevention Conference, Sydney
[View Plenary Presentations](#)

From the Blog

[NSW Health Falls Snapshot](#)
The NSW Ministry of Health has produced a Snapshot on Preventing Falls and Harm from Falls that provides a summary of the current...

[Cochrane review on exercise for reducing the fear of falling](#)
This Cochrane review looked at 30 studies and concluded that exercise interventions in community-dwelling older people probably re...

[April Falls Day®/Month 2015](#)
April Falls Day®/Month 2015 - Theme: Confusion and Falls Don't let Confusion Cloud the risk of falls A suite of resources h...
[Read more on the blog](#)

Helpful Resources

National Safety and Quality Health Service Standards (NSQHSS)
Standard 10: Preventing falls and harm from falls Hospital Strategies.
Watch videos on the following:
[Case Studies on how to complete a falls risk screening and management plan](#)

FALLS LINKS

Volume 9 April Falls Issue Newsletter of the NSW Falls Prevention Network

Welcome April Falls Day®/Month

Special Edition Falls Links Newsletter
This newsletter highlights some of the activities that occurred in NSW Local Health Districts throughout April 2014 as part of April Falls Day®/Month 2014.
We thank all staff and organisations who actively participated in April Falls Day®/Month activities in hospital, community and residential care services in their local health districts.
We also acknowledge the assistance of Ms Natasha Clancy, a Health Promotion Course student intern from the University of Wollongong who compiled this newsletter.

Medicate right to stay upright.

"Falls Prevention is Everyone's business®"

Inside this Issue	
CEC April Falls Day® 2014	2
April Falls Day®/Month Reports from LHDs	3
Falls Network Information How to join and communicate through the network.	23

fallsnetwork.neura.edu.au

NSW FALLS PREVENTION NETWORK

<http://fallsnetwork.neura.edu.au>



Thank you

Questions

For further information:
CEC-FALLS@health.nsw.gov.au

www.cec.health.nsw.gov.au