Falls Management

POLICY AND PROCEDURE

1. Scope

This Falls Management in the Community policy applies to all employees of Subee Newlake supporting clients in the community. This policy is intended to provide a frame work of best practice and minimize risk

2. Purpose

This guideline is to assist:
- ensure each Client has a mobility plan which is developed with input from the client, the client's representative and health professional;
- ensure all clients are assessed for Falls risk; and
- provide a framework for ensuring appropriate measures are implemented and regularly reviewed to reduce the risk of client Falls and subsequent harm.

3. Desired Outcome

- To maintain a quality and safe standard of service delivery support
- To reduce a negative or adverse outcome to a fall.
- Implement support strategies to assess falls risk in a timely manner and facilitate strategies as aligned to client's goal and needs.
-To ensure the appropriate level of assistance and/or supervision

4. Background

Falls are not something that should just be expected nor are they a reason for restraint to be implemented. Each client should be individually considered in relation to their risk factors, the timing and type of fall and a range of approaches considered. Whilst many assessments of the client are undertaken by the Subee Newlake RN and occupational therapist/physiotherapist, carers are well placed to "know the client" and these insights are valuable tools in preventing a fall.

For clients on anticoagulant medication:
All unwitnessed and witnessed falls (where a client has hit their head) will require medical review in hospital.

5. Definitions

Fall has the meaning given by the World Health Organization, being an event which results in a client coming to rest inadvertently on the ground or floor or other lower level or a sudden, unintentional change in position, causing a client to land at a lower level on an object, the floor, the ground or other surface, and includes:
- slips and trips;
- falling into other people;
- being lowered;
- loss of balance;
- Found on the floor;
- legs giving way.

All instances where a client is found on the floor should be treated as a Fall.

FRAT means the Falls Risk Assessment Tool developed by the Peninsular Health Falls Prevention Service, as updated from time to time.

Full Physical Assistance means one on one physical effort from another person or persons is required throughout the walking or transfer or bed movement task.

Standby Assistance means standby in case physical effort or verbal cues from one person is required during the specified activity of walking or transfers or bed movement. This involves a commitment of support workers on a one to one basis and setting-up activities for a client is required to enable a task of walking or transfer or bed movement in a safe manner. These activities may involve but are not limited to locking wheels on a wheelchair or adjusting foot plates or side arm plates, handing the client a mobility aid, setting up/checking the bed pole or monkey bars, guiding with bed mechanism, fitting of callipers, leg braces or lower limb prostheses.

Supervision means setting-up activities for a client is required to enable a task of walking or transfer or bed movement in a safe manner. These activities may involve but are not limited to locking wheels on a wheelchair or adjusting foot plates or side arm plates, handing the client a mobility aid, setting up/checking the bed pole or monkey bars, guiding with bed mechanism, fitting of callipers, leg

braces or lower limb prostheses. Supervision also comprises of verbal prompts needed to enable safe walking or transfers or bed movement.

6. Risk factors for falls

Potential risk factors for falls includes but is not limited to:

Intrinsic - Personal factors
- History of falling
- Deterioration in health, mobility and strength associated with ageing
- Impaired gait and balance
- Certain medical conditions such as: Parkinson, Dementia, Depression, Osteoporosis, Cataract, Glaucoma, Low BP, Incontinence
- Lack of exercise linked with poor muscle tone and low bone density
- Alcohol use
- Polypharmacy, diuretics and / or medications that affect balance, vision, alertness e.g. sedatives, antipsychotics, anti-Parkinson's, antihypertensive medications
- General fatigue or associated with wandering / pacing behaviour
- Inadequate nutrition and diet
- Impaired cognition / confusion
- Diabetes mellitus
- Anticoagulants

Extrinsic - Environmental factors
- Uneven or loose surfaces such as: cracked footpath, loose pebbles.
- Inadequate lighting
- Slippery floors
- Activities of daily living
- Time of day
- Hospitalisation
- People traffic, crowds
- Poor steps / stairways design or repair
- Height of chairs
- Unfamiliar surroundings
- Unsecured covers such as carpets, rugs Inadequate footwear

The greater the number of risk factors, the greater their chance of falling. By reducing the number of risk factors we can also reduce the falling or the number of falls.

7. Procedure

Assessing the risk - Optimal fall prevention will involve a care team approach from the client, GP, OT/PT, RN, service coordinator and support worker. Risk assessment completed prior to starting services. RN completes FRAT and clinical review on clients at risk of falls or as part of review post fall or near miss.

Identification of falls risk factors - Provision of suitable furniture, lighting and environment for the client's safe negotiation and access. Education of support workers to ensure comprehensive knowledge of clients' requirements. Support workers must follow care plan directions and report any changes to service coordinator/RN about clients mobility or environment they may impact falls risk. Service coordinator to update care plan and risk assessment accordingly.

Medical & Medication review - Client's at risk of falls are to be referred to the GP for a comprehensive medical / medication review. This review may include review of medications by the Pharmacist. Long acting sedative-hypnotic medication should be avoided. Regular review of medication modifications may be needed at the time of intercurrent illness because of altered pharmacokinetics.
Sensory Evaluation (vision)- Referral to the optometrist to determine if a change in vision has occurred increasing the risk to fall.
Appropriate footwear - Initial assessment includes assessment of client footwear to ensure appropriateness.
Hip protectors – May be assessed as clinically required to reduce the risk of adverse outcomes following a fall.
Assistive devices - The plan should assess the client for any assistive devices necessary. Subee Newlake RNs or service coordintors will make appropriate referrals in consultation with client/ representative for allied health professional assessments.
Comprehensive continence management - Bladder control is a complex integration of psychological, social, environmental, physical and anatomical factors. Urgency

needs to be addressed as it significantly increases the risk of falling.

Comprehensive behaviour assessment / strategies - Investigation and alleviation of causes of restlessness, agitation in high-risk individuals such as pain, discomfort, loneliness, hunger, thirst or environmental irritations (e.g. noise).

Exercises - Support worker can provide hands on exercises as per the allied health professional care plan. Documentation that the program as assessed is followed. Changes to a client's ability to participate must be reported to the Manager.

Restraint – Can often cause more severe injuries so should be minimised, and ideally eliminated. Consider all other alternatives sensor mats, non slip mats, High/Low beds, fall out mat, increased observation, activity. Subee follows restrictive practice reporting procedures within the guidelines of the various regulatory bodies if a client has a restraint in process.

Observations post fall

Complete first aid or call 000.
Contact the office to inform a client has had a fall.
Team leader or RN will give further instructions if needed.

It is important post incident that a thorough assessment of the client is undertaken to ensure that no physical injury has occurred. The risk of head injury is a real consideration and can be harder to identify in a client that may have cognitive changes already and poor pupil or limb movement before the fall.

What are you looking for?

Identify the changes that signify something is different.
- Changes in the basic observations themselves (BP, Pulse, pupil size, etc.)
- Changes in the client's conscious state
- Changes in the client's ability to move/use their limbs to the extent they were before
- Unusual changes to their speech / thought patterns
- The client complaining of just not feeling right.

Any change at all should be immediately to the office who will contact Subee Newlake RNs or ask you to ring 000.

Remember these changes may occur in the day or so after the fall so support worker should be continuing to observe and report any changes in the few days following the fall.

The mobility assessment and mobility and/or allied health plan should be included in a client's care plan and communicated to all support workers providing hands on mobility assistance to the Client.

Even minor changes in the mobility status of a client can lead to fall. Early interventions in these cases are important for the maintenance of the client safety and wellbeing.

8. Risk Management

A risk assessment in completed on all clients prior to commencing services. This includes review of intrinsic and extrinsic factors

Subee clients identified as high falls risk will meet the high needs criteria and marked so on TRACK.

Alerts will be placed on support workers roster that client is high falls risk.

Emergency Preparedness Plan section of TRACK will identify falls risk and any mobility ais required in case of an emergency.

All witnesses or report falls to be reported and documented as an incident.

Incident register is reviewed at monthly and discussed at management and clinical meetings

Clinical review and FRAT will be organised for clients that have had more than 1 fall on the incident register.

Clinical review for aged care clients and NDIS/iCare complex clients includes medication review and will include a FRAT if appropriate.

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Allied health professionals and GPs involved in clients will be informed and review may be requested.

Any new recommendations will be relayed to support staff and care plan updated.

Client manual handling equipment is on an equipment maintenance program and documented on TRACK under equipment and clinical review forms.

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