Contents

1. Summary 3
2. Introduction 5
   2.1 Background of falls in healthcare settings 5
   2.2 Objectives 6
   2.3 Definition of fall 7
   2.4 Scope 7
   2.5 Guiding policy 7
3. Methodology 8
   3.1 Limitations 9
4. Considerations 9
   4.1 Special considerations 9
   4.2 Communication considerations 9
5. Guidelines on post-fall management 10
6. Acknowledgements 15
7. Appendices 16
   Appendix A: Explanatory notes - Guidelines on Post-Fall Management 16
   Appendix B: Links to relevant diagnostic tests 20
   Appendix C: Medical Record Post-Fall Management Guidelines Checklist 21
   Appendix D: Post-Fall Management Checklist Audit Tool 23
   Appendix E: Acronyms and abbreviations 25
   Appendix F: Feedback Form – Post-Fall Management Guidelines in WA Healthcare Settings 26
8. References 30
1. Summary

Guidelines on Post-Fall Management

A printable version of this two page summary is available at http://www.healthnetworks.health.wa.gov.au/network/fallsprevention.cfm

Stop and Consider

- Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy are at an increased risk of intracranial, intrathoracic, intraabdominal haemorrhage.\(^1\)\(^,\)\(^2\)
  - Anticoagulants include, but are not limited to, warfarin, heparin, enoxaparin (Clexane), dalteparin (Fragmin), rivaroxaban, dabigatran, apixaban.
  - Antiplatelet drugs include, but are not limited to, aspirin, clopidogrel, aspirin plus dipyridamole (Asasantin).
- Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.
- The risk versus harm of continuing anticoagulant therapy post-fall should be considered by the treating team.
- There may be late manifestations of head injury up to 72 hours.
- Fall incidents resulting in surgical intervention or those assigned Severity Assessment Code (SAC) 1-3 are to be reviewed within 24 hours.
- Special consideration for older patients should also be given because of atypical or subtle presentations of fractures and closed head injury.

Immediate post-fall procedures

- Do not move patient initially, reassure patient.
- Call for assistance.
- Immobilise cervical spine if head and neck pain is reported or suspected.
- Check for other potential injuries.
- Vital signs observations (blood pressure, pulse, respiration rates, oxygen saturation, blood sugar, temperature, pain).
- Neurological observations and assessments, including Glasgow Coma Scale\(^7\), speech, eye movements and pupil abnormalities.
- Activate Medical Emergency Team (MET) or Medical Emergency Response (MER) if patient meets criteria for prompt care.
- Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in the level of consciousness.
- Clean and dress wounds – consider immunisation status for tetanus.
- Patient movement should be guided by local policy guidelines.
- Notify Medical Officer (MO)/Nurse Practitioner (NP) and request a review or refer to local clinical escalation procedure. Also notify Clinical Nurse Specialist/ Senior Nurse.
- Consider need for pain relief and offer analgesia as indicated.
- Order relevant investigations – consider ECG, x-rays, CT scan and blood tests (full blood count, coagulation profiles, septic screening).
- If any doubts about appropriate investigations and management, contact the appropriate senior medical person.
Within 6 hours post-fall

- Record vital signs and neurological observations every 30-60 minutes for 4 hours then review.
- Promptly action any observations outside of acceptable parameters.
- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Continue investigation and treatment of injuries sustained.
- Notify Next of Kin and provide patient, family and carer falls risk management education.

Post-fall review

- Document fall in medical record. Include mechanisms of fall, location, time, injury and actions taken.

Reassess falls risk status

- Complete FRAMP.
- Refer to relevant staff.
- Develop or update care plan.

Communication

- Communicate incident, outcomes and care plan to all relevant staff.

6 to 12 hours post-fall

Unwitnessed fall and/or hits head OR is on anticoagulants/ antiplatelet medication

- Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by parameters on the observational chart; 4 hourly if stable.

Witnessed fall and did not hit head

- Continue vital signs observations 4-6 hourly for 72 hours then review.

For all patients

- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Ensure care plan and FRAMP are in place, effective and updated as required.
- Review investigation results.
- Modify environment to reduce falls.
- Refer to relevant staff.
- Continue patient, family and carer education on falls risk management.

12 to 48 hours post-fall

Unwitnessed fall and/or hits head OR is on anticoagulants/ antiplatelet medication

- Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by parameters on the observational chart; 4 hourly if stable.

Witnessed fall and did not hit head

- Continue vital signs observations 4-6 hourly for 72 hours then review.

For all patients

- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Ensure all tests results have been reviewed by MO/ NP and actioned.
- Continue investigation and treatment of injuries sustained.
- Ensure FRAMP and care plan are in place, effective and updated as required.
- Review by other relevant staff is recommended. This includes physiotherapist, occupational therapist and pharmacist review within 48 hours post fall; Consider dietician (if patient is malnourished), podiatry and specialist nurse review.
- Continue patient, family and carer education on falls risk care.

48 to 72 hours post-fall

- if patient is considered stable at 72 hours, return to pre-fall level of observations.
- All specialist and allied health review must be completed and plan of care/ treatment documented in the patient’s notes for falls risk management.

Considerations within 72 hours post-fall

Optimise secondary prevention of further falls by:

- Consider Vitamin D testing.
- Consider bone mineral density scan if patient is at risk of osteoporosis.
- Consider use of hip protectors.
- Continued patient, family and carer education on falls risk management.
- Consider Fear of Falling and refer to Social Worker or Clinical Psychologist.

Note: Clinical protocol does not replace clinical judgement. Care outlined in this clinical protocol must be altered if it is not clinically appropriate for the patient.
2. Introduction

2.1 Background of falls in healthcare settings

Falls and falls-related injuries cause substantial morbidity and mortality among older Australians.\(^9\) The hospital setting is associated with an increased risk of falling among older people due to additional falls risk factors from being in a new environment with poorly recognised physical and environmental hazards. Accordingly, falls were the second most frequently reported clinical incident in Western Australia (WA) hospitals in 2010-11 with a total of 4,911 incidents, averaging 3 falls incidents per 1,000 bed days.\(^10\) Two percent (or 120) of all fall incidents in 2010-11 were associated with significant (Level 7 outcome) or severe harm (Level 8 outcome) based on the Clinical Incident Management System (CIMS) outcome levels (Refer to Appendix A of the Learning from Clinical Incidents: A Snapshot of Patient Safety in WA 2008-2010 report for a description of the outcome levels).\(^10\) These types of incidents include those that result in a fractured or dislocated neck of femur, transfer to the intensive care unit, increased length of stay in hospital, permanent disability or, even death. Additionally, between 1 July 2006 and 30 June 2011, a total of 30 sentinel events\(^1\) due to complications of an inpatient fall were reported in WA hospitals, out of which there were 21 patient deaths. The most common contributing factors to complications of an inpatient fall were policy/procedures/guidelines, communication and patient factors.\(^11\)

In 2010-11, the majority of falls in WA hospitals were sustained by patients aged 65 years or more (74% or 3,613) while those aged 85 years or more had the highest rate of falls (7.6 falls per 1,000 bed days). Around 24% of falls were associated with a fall on the same level, for example while walking or standing. The most frequently reported contributing factors associated with falls were patient contributing factors (93%) followed by staff contributing factors (5%) and system contributing factors, mainly environmental hazards (2%). Among patient contributing factors, the most common reasons were ‘pathophysiological factors’, ‘physical impairments’, ‘failure to follow instructions’, and ‘confusion or disorientation’. Among staff contributing factors, the most common reasons were ‘poor teamwork or supervision’, ‘communication problem’, ‘distraction or inattention’ and ‘inadequate staff’.\(^10\)

\(^1\) Sentinel events are notified rare events that lead to catastrophic patient outcomes. 10. Department of Health Western Australia. Learning from Clinical Incidents: A Snapshot of Patient Safety in Western Australia 2010-2011. Perth: Department of Health WA; 2012.
Case study

An elderly person from a culturally and linguistically diverse (CALD) background who spoke no English was admitted for investigation into right sided chest pain and shortness of breath. The patient was prescribed enoxaparin at therapeutic dose following assessment and clinically elevated D Dimers. The patient was noted to be independent with all activities of daily living with family assisting in interpreting. The patient had a witnessed fall and hit their head sustaining a bruise on the L temple area. Neurological observations commenced and continued for 24 hours. Enoxaparin was not reviewed so the patient continued to receive the therapeutic dose. The patient did not have a CT scan. 58 hours post fall, the patient became unconscious requiring intubation and transfer to the intensive care unit. A CT scan showed a large subdural haematoma which due to the size and anticoagulant status ensured that any surgery would have an adverse outcome. Family decided on palliative care and the patient passed peacefully the next day. Subsequent investigation indicated that the patient had had some headaches but was reluctant to tell family members. No official interpreter was brought in to assist during the patient’s stay in hospital.

Strategies that have been implemented in WA to decrease the number of patient falls include active participation of health services in the Safety and Quality Investment for Reform (SQuIRe) Falls Clinical Practice Improvement initiative and the Falls Prevention Health Network, implementation of a state-wide Stay On Your Feet WA® Falls Risk Assessment and Management Plan Operational Directive (SOYFWA® FRAMP OD), development of individual care plans for patients as well as dissemination of the Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals by the Australian Commission on Safety and Quality in Healthcare (ACQSHC).

Falls may be the first and main indication of another underlying condition in a patient and those who fall once are two to three times more likely to fall again.

There is still considerable scope for improving patient safety in WA healthcare settings and it is important for all hospital staff to take all falls seriously and to know what to do in the event of a patient fall. Post-fall management guidelines will be useful in the assessment, management and follow-up of patients after a fall. The likelihood of further harm after a fall can be reduced if there is prompt and systematic assessment and management, with early recognition of deterioration in the patient’s condition. In addition, the ACQSHC recommends that all hospitals should have their own clinical practice guidelines for preventing and responding to falls. The WA Sentinel Event Report 2010/2011 also recommends the development of a multidisciplinary falls protocol as well as increased staff education on falls prevention and management.

2.2 Objectives

Responding to a patient fall incident requires the provision of immediate first aid, medium and longer term care, and documentation. The Post-Fall Management Guidelines in WA Healthcare Settings outlines the responsibilities of hospital and health service staff after a patient has fallen and aims to:

- highlight the importance of post-fall management
- enable a consistent and best-practice approach to post-fall assessment, management and follow-up in WA hospitals, health services and multi-purpose sites (MPS)
- minimise harm from falls and falls-related injuries among patients in WA hospitals and health services.
2.3 Definition of fall
The World Health Organization defines a fall as ‘an event which results in a person coming to rest inadvertently on the ground or floor or other lower level’. This means that as long as a person falls unintentionally onto a lower level, whether or not it is on the ground, it is considered a fall.

2.4 Scope
These guidelines are intended:

- to inform and complement the falls and clinical deterioration and escalation policies and procedures of all WA hospitals and health services and should be adapted to local settings, circumstances and available resources.
- to be easily accessible.
- to apply to all inpatients/residents who sustain a fall in WA hospitals, health services and multi-purpose sites (MPS). The term ‘patient’ when used in these guidelines refers to this group of individuals.
- for a target audience including medical, nursing and other clinical staff and unregulated health workers and carers in WA hospitals, health services and MPS. Unregulated health workers include patient care assistants, assistants in nursing, Home and Community Care (HACC) support workers and aboriginal health care workers.
- to assist the health professional’s decision-making about appropriate treatment and care for specific clinical circumstances but not to replace clinical judgment. It is also acknowledged that there will be case-by-case circumstances where exceptions to this policy will be necessary for best patient care. Clinicians must justify and document these exceptions within the medical record.

These guidelines may need to be tailored to ensure their suitability for falls in children.

A Supplementary Guideline document containing discipline specific guidelines for post-fall management in healthcare settings is also available.

2.5 Guiding policy
These guidelines have been developed in alignment with the following policies:

Australian Commission on Safety and Quality in Healthcare. Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals; 2009.

Department of Health, WA. Falls Prevention Model of Care for the Older Person in Western Australia. Perth: Health Networks Branch, DOH WA; 2008.


Department of Health, WA. Model of Care for the Older Person in Western Australia. Perth: Aged Care Network, DOH WA; 2008.

Department of Health, WA. Consent to Treatment Policy for the Western Australian Health System 2011 (3rd edition). Perth: DOH WA.

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2 The Carers Recognition Act 2004 defines a carer as a person providing unpaid ongoing care and support to a family member or friend with care needs due to chronic physical or mental ill health, intellectual or physical disability or age related disability. (Accessed at http://www.austlii.edu.au/au/legis/wa/consol_act/cra2004197/.)
3. Methodology

These guidelines are based on post-fall management guidelines developed by Sir Charles Gairdner Hospital and the ACQSHC ‘Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009’. Additionally, the guidelines development team (see 6. Acknowledgements for list of members) undertook a literature review to identify best practice on post-fall management in Australia and internationally. Existing guidelines that were reviewed included:


In areas where there is no recognised evidence, these guidelines have been developed based on expert opinion and consensus. These guidelines have been reviewed by the Falls Prevention Health Network Executive Advisory Group and the Falls Prevention Community of Practice which comprises experts in falls management and policy development, including falls specialists, geriatricians, physiotherapists, occupational therapists, aged care clinical nurse consultants and clinical nurse specialists.

The guidelines have also undergone a public consultation using an online feedback form which was disseminated broadly to allow for further comments and feedback. Those targeted during the consultation include members of the Falls Prevention Health Network and WA Department of Health staff. Approximately 50 feedback responses were received and the feedback was considered and incorporated into the guidelines. The final draft of the guidelines was endorsed by the Falls Prevention Executive Advisory Group and the Falls Prevention Community of Practice prior to submission to and approval by the A/Director General, WA Department of Health.

A small working group with representation from relevant clinicians will be convened by the Falls Prevention Health Network every 5 years to review the guidelines and ensure the recommendations reflect current evidence-based practice. The next review is due in 2018.
3.1 Limitations
A limitation of a guideline is that it simplifies clinical decision-making. Decisions to adopt any particular recommendations must be made by the health professionals in consideration of:

- available resources
- local services, policies and protocols
- the patient’s circumstances and wishes
- age-appropriateness and patient co morbidities
- available personnel and devices
- clinical experience of the practitioner
- knowledge of more recent research findings.

There were limitations in the development process of these guidelines. Non-systematic review methods were used as a systematic review was beyond the capacity of the guidelines development team and it was not possible to follow the National Health and Medical Research Council’s requirements for developing and grading clinical practice guidelines. Furthermore, work is currently underway to gather local data on the incidence and outcomes of falls in WA hospital settings and was not available for consideration and inclusion during this guideline development process but will be used to inform future versions.

4. Considerations

4.1 Special considerations
Patients who are prescribed antiplatelets or anticoagulants have an increased risk of sustaining an intracranial, intrathoracic or intraabdominal haemorrhage after a fall.\textsuperscript{1, 2} The intra-cranial haemorrhage may occur even if they did not hit their head. A suitably qualified clinician should be consulted prior to continuing anticoagulant use post-fall. Special consideration for older patients should also be given because of atypical or subtle presentations of fractures and closed head injury.

4.2 Communication considerations
For guidance when communicating with patients with decision making ability, refer to the Consent to Treatment Policy for the Western Australia Health System 2011.\textsuperscript{19}

Language and cultural differences should not be barriers to accessing healthcare. The Department of Health Legislative Branch advises all services should provide appropriate interpreting services and warns about the seriousness of legal liability. The WA Health Language Services Policy\textsuperscript{30} requires the need for an interpreter to be determined; provision of an interpreter in cases where such a need is determined; and establishing that the interpreter utilised is appropriately qualified.

Consideration should also be given to overcoming communication barriers for patients with dementia or other neurological conditions which may impact on their ability to communicate. Furthermore, consider assessment of the family/carer’s ability to understand and/or carry out post-fall instructions once the patient has returned home.
5. Guidelines on post-fall management

Stop and Consider

- Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy are at an increased risk of intracranial, intrathoracic, intraabdominal haemorrhage.\textsuperscript{1,2}
  - Anticoagulants include, but are not limited to, warfarin, heparin, enoxaparin (Clexane), dalteparin (Fragmin), rivaroxaban, dabigatran, apixaban.
  - Antiplatelet drugs include, but are not limited to, aspirin, clopidogrel, aspirin plus dipyridamole (Asasantin).
  - Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.
- The risk versus harm of continuing anticoagulant therapy post-fall should be considered by the treating team.
- There may be late manifestations of head injury up to 72 hours.
- Fall incidents resulting in surgical intervention or assigned Severity Assessment Code (SAC) 16 are to be reviewed within 24 hours.
- Special consideration for older patients should also be given because of atypical or subtle presentations of fractures and closed head injury.

Immediate post-fall procedures

(Potential injuries: fracture, soft tissue injury or no observable injury)

- Do not move patient initially, reassure the patient.
- Call for assistance.
- Immobilise cervical spine if head and neck pain is reported or suspected.
- Check for other potential injuries:
  - When examining a patient, be aware that they may not draw attention to all of their injuries (some patients may not want to be a bother or may be cognitively impaired).
  - The head, neck, clavicles, shoulders, wrists, hips and ankles should be examined.
  - Identify sites of tenderness/swelling/deformity and range of movement (e.g. a shortened, externally rotated leg may indicate a hip fracture).
- Vital signs observations (blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level, temperature, pain).
- Neurological observations and assessments, including Glasgow Coma Scale, speech, eye movements and pupil abnormalities, facial asymmetry, power, reflexes and plantar responses.
- Activate Medical Emergency Team (MET) or Medical Emergency Response (MER) if patient meets criteria for prompt care. Emergency Telehealth Services can be activated where available. Refer to WA Health Operational Directive - Medical Emergency Response OD0040/07.
- Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in the level of consciousness.
- Clean and dress wounds – consider immunisation status for tetanus.
- Patient movement should be guided by local policy guidelines.
- Notify Medical Officer (MO)/ Nurse Practitioner (NP) and request a review or refer to local clinical escalation procedure.

\textsuperscript{No Longer Applicable
Rescinded 17 Oct 2018}
• Notify Clinical Nurse Specialist/ Senior Nurse.
• Consider need for pain relief and offer analgesia as indicated.
• Conduct relevant investigation as appropriate – consider blood tests (full blood count, coagulation profile, septic screening), electrocardiogram (ECG), x-rays, computed tomography (CT) head scan.
• If any doubts about appropriate investigations and management, contact the appropriate senior medical person e.g. after hours registrar.

Additional considerations regarding CT head scans:
• A CT head scan should be arranged urgently if:
  o There is suspicion of a head injury (altered level of consciousness, headache, amnesia, vomiting, increased confusion)
  o If the patient hit their head AND is coagulopathic
  o See Canadian CT Head Rule 4 for more information on diagnostic pathways
• Consider an urgent CT if the patient is difficult to assess because of dementia, sedation, intoxication.
• Where CT is not immediately available, continue observations and take appropriate action if any observations fall outside acceptable parameters or if there are any visual changes, speech disturbance and focal motor/ sensory changes.
• Consideration as to whether the patient management will be altered by CT should be made, such as patient / carer preferences and whether the patient would be considered appropriate for neurosurgical intervention. This dialogue should be clearly documented and discussed with treating specialist.

Recommended actions within 6 hours post-fall and ongoing care
• Initially record vital signs and neurological observations every 30-60 minutes for 4 hours then review.
• Any observations that fall outside acceptable parameters on the observation chart should prompt an appropriate response according to the review criteria on the observation chart and following local clinical escalation procedures.
• Notify MO/ NP of any change in observations including visual changes, speech disturbance and focal motor/ sensory changes.
• Continue investigation and treatment of any injuries sustained.
• Notify Next of Kin (NoK) and carer (if applicable) subject to patient’s consent, or condition such that person is unable to give consent themselves. Consider psycho-social needs of significant others. Document all attempts to contact NoK. Refer to local ‘Open Disclosure’ policy.
• If not already identified as high risk of falls injury, flag as per local policy.
• Ensure all minimum standards as per Stay On Your Feet WA® Falls Risk Assessment and Management Plan (SOYFWA® FRAMP), are in place.
• Provide preliminary patient, family and carer education on falls risk management.
• Complete Clinical Incident Form (CIF). Refer to the statewide Clinical Incident Management Policy6 or local policies.
• Consider need for transfer to tertiary health service if at secondary health service.
Post-fall review

- Talk to relevant staff about the nature of the fall. Talk to the patient about the fall and symptoms arising from the fall.
- Document fall in medical record. Details should include the mechanisms of fall (e.g. slip, trip, overbalance, dizziness), location, time and circumstances of fall, evidence of injury, any loss of consciousness, relevant environmental information, what falls risk strategies were in place at the time of fall and actions taken.
- Reassess falls risk status
- Complete SOYFWA® FRAMP and refer to relevant staff for review e.g. physiotherapist (PT), occupational therapist (OT), pharmacist and dietician to review.
- Develop an individualised care plan for patient and implement age-appropriate falls prevention strategies. Ensure that patient carers are identified and involved in care planning. This may include assessing the carer’s ability to provide post discharge care and offering information and support to enable them to do so.

Communication

- All staff involved in care of the patient to be informed of incident outcome and revise care plan and handover notes accordingly. Refer to WA Health Clinical Handover Policy.20
- As per local policy, notify Senior Nurse/NP when patient falls.

Recommended actions 6 to 12 hours post-fall

<table>
<thead>
<tr>
<th>If fall was not witnessed and/or patient hits head OR is on anticoagulants/antiplatelet medication</th>
<th>If fall was witnessed and patient did not hit head AND is not on anticoagulants/antiplatelet medication</th>
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</thead>
<tbody>
<tr>
<td>Then complete the following observations:</td>
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</tr>
<tr>
<td>Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable. Refer variances to MO for indications of further review.</td>
<td>Continue vital signs observations at least 4-6 hourly for 72 hours then review.</td>
</tr>
</tbody>
</table>

- Notify MO/ NP of any change in observations including visual changes, speech disturbance and focal motor/ sensory changes.
- Ensure strategies have been put in place to prevent further falls. This includes ensuring the SOYFWA® FRAMP and care plan are in place, effective and are updated as required.
- Review results of bloods, x-rays and urinalysis with MO/ NP for treatment options; ensure MO/ NP aware of any abnormality in results.
- Modify environment to reduce falls and ensure continued safety of the patient including safe and easy access to personal belongings and equipment.
- Ensure referrals to relevant staff have been made.
- Continue patient, family and carer education on falls risk management.
Recommended actions 12 to 48 hours post-fall

**If fall was not witnessed and/or patient hits head OR is on anticoagulants/antiplatelet medication**

Then complete following observations:

Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable. Refer variances to MO for indications of further review.

- Notify MO/ NP if any change in observations including visual changes, speech disturbance and focal motor/ sensory changes.
- Ensure all tests results have been reviewed by a MO/ NP and actioned as required.
- Continue investigation and treatment of any injuries sustained.
- Ensure falls prevention strategies are appropriate for the patient’s particular risk factors and documented in the care plan – if any concerns, reassess and implement strategies.
- Review by other relevant staff is recommended within the following timeframes.

Alternative methods of obtaining advice may need to be used at sites where allied health and other specialist staff are not available on site in these timeframes (e.g. Telephone advice, Telehealth, remote review of medication chart by Pharmacist). This includes:
  - Physiotherapist within 48 hours post-fall
  - Occupational therapist within 48 hours post-fall
  - Pharmacist review within 48 hours post-fall
  - Dietician review if patient is malnourished
  - Podiatry if indicated
  - Specialist nurse (e.g. continence, wound care, aged care) if indicated.
  - Continue patient, family and carer education on falls risk management.

**If fall was witnessed and patient did not hit head AND is not on anticoagulants/antiplatelet medication**

Then complete following observations:

Continue vital signs observations at least 4-6 hourly for 72 hours then review.

- Notify MO/ NP if any change in observations including visual changes, speech disturbance and focal motor/ sensory changes.
- Ensure all tests results have been reviewed by a MO/ NP and actioned as required.
- Continue investigation and treatment of any injuries sustained.
- Ensure falls prevention strategies are appropriate for the patient’s particular risk factors and documented in the care plan – if any concerns, reassess and implement strategies.
- Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable. Refer variances to MO for indications of further review.

Recommended actions 48 to 72 hours post-fall

- If patient is considered stable at 72 hours, return to pre-fall level of observations.
- All specialist and allied health review must be completed and plan of care/ treatment documented in the patient’s notes for falls risk management.

Explanatory notes on the post-fall management guidelines are provided in Appendix A. Additionally, a Medical Record which can be used as a checklist for these post-fall management guidelines is provided in Appendix C and an audit tool to monitor use of the checklist in Appendix D. Refer to the Post-Fall Management Guidelines: Supplementary Discipline Specific Guidelines for further information.
Further considerations within 72 hours post-fall
Optimise secondary prevention of further falls using the following strategies where applicable and age-appropriate:

- Consider Vitamin D testing. (see Australian and New Zealand Bone Mineral Society (ANZBMS) position statement)\(^5\)
- Consider bone mineral density scan if patient is at risk of osteoporosis and is deemed appropriate by the MO/NP.
- Consider use of hip protectors\(^8\). Ensure staff are aware of correct application techniques and indications for use.
- Continued patient, family and carer education on falls risk management.
- Consider Fear of Falling and refer to Social Worker or Clinical Psychologist.
6. Acknowledgements

The following individuals are acknowledged for their contribution as a member of the guidelines development team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
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</table>

We would like to acknowledge the following organisations for their contribution to these guidelines:

- Falls Advisory Committee, Sir Charles Gairdner Hospital
- Occupational Therapy Department, Sir Charles Gairdner Hospital
- Physiotherapy Department, Sir Charles Gairdner Hospital
- Royal Perth Hospital
- New South Wales Falls Prevention Network
- Sydney South West Area Health Service
- WA Country Health Service
- WA Falls Prevention Community of Practice.

No Longer Applicable
Rescinded 17 Oct 2018
### 7. Appendices

**Appendix A: Explanatory notes - Guidelines on Post-Fall Management**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
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| Potential injuries: fracture, soft tissue injury or no observable injury | • Many injuries can be sustained during a fall.  
• Assess the patient for immediate life threatening danger and administer first aid.  
• Ensure the patient’s airway is clear, monitor breathing and apply firm pressure to any sites of obvious bleeding.  
• Neck pain/ injury indicate the neck should be immobilised according to local policy.  
• Head injury, hip or other fracture and/ or soft tissue injury following a fall dictate specific action according to local policy. |
| • Do not move patient initially  
• Call for assistance  
• Immobilise cervical spine if head and neck pain is reported or suspected  
• Check for other potential injuries. | |
| Vital signs observations (blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level, temperature, pain).  
• Neurological observations and assessments, including Glasgow Coma Scale.  
• 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 the patient’s condition needs to be observed closely.  
• Recording of vital signs and level of consciousness provide information on the patient condition and any further deterioration against these can be more readily assessed.  
• All assessment findings must be documented.  
• Low blood sugar levels may have precipitated the fall and need to be treated immediately.  
• Fallers can lose consciousness in syncope falls but be unaware that this has happened so head injury cannot be excluded except in witnessed falls. |
<p>| Patient movement should be guided by local policy guidelines. | • Safe manual handling techniques should be used to prevent further injury. The patient movement should be guided by local policy. |</p>
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Notify MO / NP and request a review.</td>
<td>• A medical review should be undertaken as soon as possible for assessment and investigations to be initiated.</td>
</tr>
<tr>
<td></td>
<td>• In some areas such as some mental health facilities and rural hospitals there will not always be a doctor in residence; however some patients will require urgent medical examination with a reasonable timescale.</td>
</tr>
<tr>
<td></td>
<td>• Falls are often a precursor warning to changes in the patient’s underlying condition.</td>
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<tr>
<td></td>
<td>• If the patient has been immobilised as a precautionary measure, access to investigation and treatment must be speedy to avoid prolonged immobilisation and associated risks.</td>
</tr>
<tr>
<td>• Consider need for pain relief and offer analgesia if indicated.</td>
<td>• Analgesia needs to be considered carefully and only given if prescribed by a MO. Some analgesia can mask deterioration in a patient or create other complications.</td>
</tr>
<tr>
<td>• Conduct relevant investigation as appropriate – consider blood tests (full blood count, coagulation profile, septic screening), electrocardiogram (ECG), x-rays, computed tomography (CT) head scan.</td>
<td>• Intrathoracic, intraabdominal and in particular intracranial bleeding as a result of a fall can occur at any age however in older adults this may occur even with a minor head injury due to the cerebral changes associated with aging.</td>
</tr>
<tr>
<td></td>
<td>• Older patients are more like to develop chronic subdural haematomas than younger patients.31</td>
</tr>
<tr>
<td></td>
<td>• Full blood picture and septic screening will identify if an infection is present; ECG will show any new changes; x-ray and CT will diagnose injuries and care required.</td>
</tr>
<tr>
<td><strong>Arrange urgent CT Head Scan if:</strong></td>
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<tr>
<td>- There is suspicion of a head injury (altered level of consciousness, headache, amnesia, vomiting, increased confusion).</td>
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</tr>
<tr>
<td>- If the patient hit their head AND is coagulopathic.</td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td>• Acute neurological deterioration has been reported as occurring anywhere from immediately post fall to 72 hours.</td>
</tr>
<tr>
<td>- Initially record vital signs and neurological observations 30-60 minutely for 4 hours then review.</td>
<td>• For the first 6 hours the risk of intra-cranial haemorrhage is highest. This is why observations continue for this length of time.31</td>
</tr>
<tr>
<td>- Continue neurological observations 4 hourly for 72 hours.</td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>Rationale</td>
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<tr>
<td>- If patient on anticoagulants/ antiplatelets do not give until consulting a suitably qualified clinician.</td>
<td>- Patients on anticoagulants/ antiplatelets are at a higher risk of developing a Traumatic Brain Injury.(^1,2)</td>
</tr>
</tbody>
</table>
| - Notify Next of Kin (NoK)  
- Refer to local ‘Open Disclosure’ policy. | - The patient’s NoK must be notified of any unplanned event resulting in or with the potential to result in injury as soon as possible following the event or within 12 hours of occurrence. |
| - Complete Clinical Incident Form (CIF)  
- Refer to local ‘Incident Management’ policy. | - All staff are responsible for the mandatory reporting of all incidents they identify using the Clinical Incident Management System (CIMS).  
- This provides facilities and WA Health with a means to monitor incidents so that systems improvement opportunities are readily identified and acted on. |

**Post-fall review**

- Document fall in medical record. Details should include the mechanisms of fall; location; time; circumstances; evidence of injury, any loss of consciousness; relevant environmental information, what falls risk strategies were in place at the time of fall and actions taken.

- The patient’s medical record needs to contain a full account of the incident, actions taken and results. The entry allows clear communication of the incident to all members of the multidisciplinary team who take part in the patient’s care.  
- It also provides a legal record of the incident in the patient’s episode of care.

**Reassess falls risk status**

- Complete SOYFWA® FRAMP and refer to relevant staff e.g. physiotherapist, occupational therapist, pharmacist and dietician to review.  
- 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.  
- Exposure to acute care treatment and procedures can increase risk of falling by reducing coping mechanisms and/ or increasing problems with perception and mobility.

**Communication**

- All staff involved in the care of the patient to be informed of incident outcome and revise care plan.  
- As per local guidelines notify Senior Nurse/ NP when a patient falls.  

- To continue post-fall management of the patient all staff need to be made aware of the fall and the new interventions put in place.  

- Modify environment to reduce falls and ensure continued safety of the patient.

- Environmental assessment will identify any hazards that may have contributed to the fall. These hazards need to be corrected and environmental interventions put into place.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Review by other relevant staff is recommended. This includes:  
  - Physiotherapist within 48 hours post-fall  
  - Occupational therapist within 48 hours post-fall  
  - Pharmacist review within 48 hours post-fall  
  - Dietician review if patient is malnourished  
  - Podiatry if indicated. | Physiotherapist, occupational therapist and pharmacist must follow post-fall management guidelines for allied health.  
Social worker review will assess patient’s risk of developing post-fall syndrome and action a plan to prevent/ reduce this risk.  
Malnutrition is associated with increased risk of falls among older people so review by a dietician in malnourished patients is recommended.  
Podiatry has been shown to reduce falls by up to 36% and has a high Quality Adjusted Life Years per dollar ratio. |
| Continued patient, family and carer education. | Education can increase patient awareness of why they fell.  
Education can enable the patient, family and carer to understand how to minimise the risk of falling again. |
| Consider Vitamin D testing. | Vitamin D deficiency is common. Vitamin D supports key mineral absorption and metabolism (especially calcium in the bones). Vitamin D deficiency contributes to falls risk factors. |
Appendix B: Links to relevant diagnostic tests

- Australian Commission on Safety and Quality in Healthcare. Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals; 2009.
- Department of Health Western Australia. Canadian Computed Tomography (CT) Head Rule; 2012.
### Appendix C: Medical Record Post-Fall Management Guidelines Checklist

**Guidelines on Post-Fall Management - Checklist**

(Affix patient identification label here)

<table>
<thead>
<tr>
<th>Facility:</th>
<th>URN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name:</td>
<td>Given names:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Sex: [ ] M [ ] F</td>
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</tbody>
</table>

**Stop and Consider:** Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy are at an increased risk of intracranial, intra-thoracic, intra-abdominal haemorrhage. The risk versus harm of continuing anticoagulant therapy post-fall should be considered by the treating team.

**Date of fall:**

**Time of fall:**

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Actions</th>
<th>Initial</th>
<th>Date</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td><strong>Immediate procedures</strong></td>
<td>o Do not move patient initially, reassure the patient.</td>
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<td></td>
<td>o Call for assistance.</td>
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<td></td>
<td>o Immobilise cervical spine if head and neck pain is reported or suspected.</td>
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<td></td>
<td>o Check for other potential injuries.</td>
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<tr>
<td></td>
<td>o Vital signs observations (blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level, temperature, pain).</td>
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<tr>
<td></td>
<td>o Neurological observations and assessments, including Glasgow Coma Scale, speech, eye movements and pupil abnormalities, facial asymmetry, power, reflexes and plantar responses.</td>
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<td></td>
<td>o Activate MET / or MER if patient meets criteria for prompt care.</td>
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<td></td>
<td>o Observe for delirium and new or worsening confusion, headache, amnesia, vomiting or change in level of consciousness.</td>
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<tr>
<td></td>
<td>o Clean and dress wounds – consider immunisation status for tetanus.</td>
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<tr>
<td></td>
<td>o Patient movement should be guided by local policy guidelines.</td>
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<tr>
<td></td>
<td>o Notify Medical Officer (MO)/ Nurse Practitioner (NP) and request a review.</td>
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<tr>
<td></td>
<td>o Notify Clinical Nurse Specialist/ Senior Nurse.</td>
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<tr>
<td></td>
<td>o Consider need for pain relief and offer analgesia as indicated.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Conduct relevant investigation as appropriate – consider blood tests (Full Blood Count, Coagulation profile, septic screening), Electrocardiogram (ECG), x-rays, CT head scan.</td>
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</tbody>
</table>

**Within 6 Hours Post-Fall**

| o Record vital signs and neurological observations every 30-60 minutes for 4 hours then review. | |
| Any observations that fall outside acceptable parameters on the observation chart should prompt an appropriate response according to the review criteria on the observation chart and following local clinical escalation procedures. | |
| Notify MO/NP of any visual changes, speech disturbance and focal motor/ sensory changes. | |
| Continue investigation and treatment of injuries sustained. | |
| Notify Next of Kin and carer (where applicable). | |
| If not already identified as high risk of fall injury, flag as per local policy. | Page 1 of 2 |
| Ensure minimum standards as per Stay On Your Feet WA® Falls Risk Management Tool are in place. | Please turn over |
### Post-Fall Management

**Post-Fall (continued)**

- Provide preliminary patient, family and carer education on falls risk management.
- Complete Clinical Incident Form.
- Document fall in medical record.
- Complete Stay On Your Feet® [Fall Risk Assessment and Management Plan](#) (FRAMP) and refer to relevant staff.
- Develop individualised care plan, with post-fall management strategies.
- Communicate incident, outcomes and care plan to all relevant staff.

### 6-12 Hours Post-Fall

**Unwitnessed fall and/or hits head OR is on anticoagulants/antiplatelet medication**

- Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable. Refer variances to MO for indications of review.

**Witnessed fall and did not hit head AND is not on anticoagulants/antiplatelet medication**

- Continue vital signs observations at least 4-6 hourly for 72 hours then review.
- Notify MO/NP of any visual changes, speech disturbance and focal motor/sensory changes.
- Ensure the FRAMP and care plan are in place, effective and are updated as required.
- Review results of investigations with MO/NP for treatment options and flag abnormalities in results.
- Modify environment to reduce falls.
- Ensure referrals to relevant staff have been made.
- Continue patient, family and carer education on falls risk management.

### 12-48 Hours Post-Fall

**Unwitnessed fall and/or hits head OR is on anticoagulants/antiplatelet medication**

- Continue neurological observations based on patient’s condition; 30-60 minutely as indicated by the parameters on the Observation Chart; 4 hourly if stable. Refer variances to MO for indications of review.

**Witnessed fall and did not hit head AND is not on anticoagulants/antiplatelet medication**

- Continue vital signs observations at least 4-6 hourly for 72 hours then review.
- Notify MO/NP of any visual changes, speech disturbance and focal motor/sensory changes.
- Ensure all test results have been reviewed by MO/NP and actioned.
- Ensure care plan is in place and effective.
- Ensure referrals to relevant staff have been made.
- Continue patient, family and carer education on falls risk management.

### 48-72 Hours Post-Fall

**Note:** There may be late manifestations of head injury up to 72 hours

- If patient is considered stable at 72 hours, return to pre-fall level of observations.
- All specialist and allied health review must be completed and plan of care / treatment documented in the patient’s notes for falls risk management.
# Appendix D: Post-Fall Management Checklist Audit Tool

<table>
<thead>
<tr>
<th>Auditor:</th>
<th>Ward:</th>
<th>Date:</th>
<th>Yes = ☑</th>
<th>No = ☐</th>
<th>Not applicable = N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Number</td>
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<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td><strong>Immediate procedures</strong></td>
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<tr>
<td>o Called for assistance.</td>
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<tr>
<td>o Patient not move until assessed for injuries and safety.</td>
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<tr>
<td>o Cervical spine immobilised if head and neck pain was reported or suspected.</td>
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<tr>
<td>o Checked for other potential injuries.</td>
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<tr>
<td>o Vital signs observations.</td>
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<tr>
<td>o Neurological observations and assessments.</td>
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<tr>
<td>o Activated MET / or MER if patient met criteria for prompt assessment.</td>
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<tr>
<td>o Observed for delirium and new or worsening confusion, headache, amnesia, vomiting or change in level of consciousness.</td>
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<tr>
<td>o Cleaned and dressed wounds – considered immunisation status for tetanus.</td>
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<tr>
<td>o Patient movement was guided by local policy guidelines.</td>
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<tr>
<td>o Medical Officer (MO)/ Nurse Practitioner (NP) notified and review requested.</td>
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<tr>
<td>o Clinical Nurse Specialist/ Senior Nurse notified.</td>
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<tr>
<td>o Considered need for pain relief and offered analgesia as indicated.</td>
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<tr>
<td>o Conducted relevant investigations.</td>
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<tr>
<td><strong>Within 6 Hours Post-Fall</strong></td>
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<tr>
<td>o Recorded vital signs and neurological observations every 30-60 minutes for 4 hours then reviewed.</td>
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</tr>
<tr>
<td>o Any observations that fall outside acceptable parameters on the observation chart prompted an appropriate response according to the review criteria on the observation chart and following local clinical escalation procedures.</td>
<td></td>
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<tr>
<td>o MO/NP notified of any visual changes, speech disturbance and focal motor/ sensory changes.</td>
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<tr>
<td>o Continued investigation and treatment of injuries sustained.</td>
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<tr>
<td>o Notified Next of Kin and carer (where applicable).</td>
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<tr>
<td>o If not already identified as high risk of fall injury, flagged as per local guidelines.</td>
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</tr>
<tr>
<td>o Minimum standards as per SOYFWA® Falls Risk Assessment and Management Plan OD (FRAMP) are in place.</td>
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<tr>
<td>o Provided preliminary patient, family and carer education on falls risk management.</td>
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<tr>
<td>Time Frame</td>
<td>Events/Activities</td>
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<tr>
<td><strong>Within 6 Hours</strong></td>
<td>o Clinical Incident Form completed.</td>
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</tr>
<tr>
<td>Post Fall</td>
<td>o Fall documented in medical record.</td>
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<tr>
<td></td>
<td>o Stay On Your Feet® Fall Risk Assessment and Management Plan (FRAMP) completed</td>
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<td></td>
<td>and referrals made to relevant staff.</td>
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<td></td>
<td>o Individualised care plan, with post-fall management strategies, developed.</td>
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<td></td>
<td>o Incident, outcomes and care plan communicated to all relevant staff.</td>
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<tr>
<td><strong>6-12 Hours</strong></td>
<td><strong>Unwitnessed fall and/ or hits head</strong></td>
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<tr>
<td>Post-Fall</td>
<td>o Continued neurological observations based on patient’s condition; 30-60 minute</td>
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<tr>
<td></td>
<td>ly as indicated by the parameters on the Observation Chart; 4 hourly if stable.</td>
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<td></td>
<td>Referred variances to MO for indications of review.</td>
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<tr>
<td></td>
<td><strong>Witnessed fall and did not hit head</strong></td>
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<td></td>
<td>o Continued vital signs observations 4-6 hourly for 72 hours then reviewed.</td>
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<td></td>
<td>o MO/NP notified of any visual changes, speech disturbance and focal motor/ sensory</td>
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<td>changes.</td>
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<td></td>
<td>o Results of investigations reviewed with MO/NP for treatment options and abnormality</td>
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<td></td>
<td>flagged.</td>
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<td></td>
<td>o Environment modified to reduce falls.</td>
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<td></td>
<td>o Ensured referrals to relevant staff were made.</td>
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<td></td>
<td>o Continued patient, family and carer education on falls risk management.</td>
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<tr>
<td><strong>12-48 Hours</strong></td>
<td><strong>Unwitnessed fall and/ or hits head</strong></td>
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<tr>
<td>Post-Fall</td>
<td>o Continued neurological observations based on patient’s condition; 30-60 minute</td>
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<td></td>
<td>ly as indicated by the parameters on the Observation Chart; 4 hourly if stable.</td>
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<td></td>
<td>Referred variances to MO for indications of review.</td>
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<tr>
<td></td>
<td><strong>Witnessed fall and did not hit head</strong></td>
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<td></td>
<td>o Continued vital signs observations at least 4-6 hourly for 72 hours then reviewed.</td>
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<td></td>
<td>o MO/NP notified of any visual changes, speech disturbance and focal motor/ sensory</td>
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<td></td>
<td>change.</td>
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<td></td>
<td>o Ensured all tests results were reviewed by MO/ NP and actioned.</td>
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<td></td>
<td>o Continued investigation and treatment of injuries sustained.</td>
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<td></td>
<td>o Ensured care plan is in place and effective.</td>
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<td></td>
<td>o Ensured referrals to relevant staff were made.</td>
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<td></td>
<td>o Continued patient, family and carer education on falls risk management.</td>
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<tr>
<td><strong>48-72 Hours</strong></td>
<td><strong>Post-Fall</strong></td>
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<tr>
<td></td>
<td>o Returned to pre-fall level of observations, if patient was considered stable at 72 hours.</td>
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<tr>
<td></td>
<td>o All specialist and allied health review completed and care plan / treatment documented in the patient’s notes for falls risk management.</td>
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</tbody>
</table>
### Appendix E: Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>AMPS</td>
<td>Assessment of Motor and Process Skills</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>CAEP</td>
<td>Community Aids and Equipment Programme</td>
</tr>
<tr>
<td>CAM</td>
<td>Confusion Assessment Method</td>
</tr>
<tr>
<td>CIM</td>
<td>Clinical Incident Management System</td>
</tr>
<tr>
<td>CIF</td>
<td>Clinical Incident Form</td>
</tr>
<tr>
<td>CT</td>
<td>Computed Tomography</td>
</tr>
<tr>
<td>DOH WA</td>
<td>Department of Health Western Australia</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>FROP COM</td>
<td>Falls Risk for Older People in the Community</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>MER</td>
<td>Medical Emergency Response</td>
</tr>
<tr>
<td>MET</td>
<td>Medical Emergency Team</td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini–Mental State Examination</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi-purpose site - health care across the acute, residential care and community continuum</td>
</tr>
<tr>
<td>NoK</td>
<td>Next of Kin</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>PADL</td>
<td>Personal Activities of Daily Living</td>
</tr>
<tr>
<td>PT</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>RIB</td>
<td>Rest In Bed</td>
</tr>
<tr>
<td>RUDAS</td>
<td>Rowland Universal Dementia Assessment Scale</td>
</tr>
<tr>
<td>SAC</td>
<td>Severity Assessment Code</td>
</tr>
<tr>
<td>SOYFWA® FRAMP OD</td>
<td>Stay On Your Feet WA® Falls Risk Assessment and Management Plan Operational Directive</td>
</tr>
<tr>
<td>SQuIRe</td>
<td>Safety and Quality Investment for Reform</td>
</tr>
<tr>
<td>STS</td>
<td>Sit-to-Stand</td>
</tr>
<tr>
<td>TUG</td>
<td>Timed Up and Go</td>
</tr>
<tr>
<td>WA</td>
<td>Western Australia</td>
</tr>
</tbody>
</table>
Appendix F: Feedback Form – Post-Fall Management Guidelines in WA Healthcare Settings

Please consider taking the time to provide feedback on these guidelines to inform future reviews.

Responses may be submitted via:

- email to healthpolicy@health.wa.gov.au
- facsimile on (08) 9222 2130
- mail to Health Strategy and Networks, PO Box 8172, Perth Business Centre, WA 6849.

If you have any queries, please contact the Health Strategy and Networks on 9222 0200. We look forward to receiving your feedback.

Section 1: Demographics

1. Please provide details of yourself and your organisation.

<table>
<thead>
<tr>
<th>Title e.g. Ms/ Mr/ Dr</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Full Name</th>
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</table>

<table>
<thead>
<tr>
<th>Organisation name</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Department</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Position title</th>
<th></th>
</tr>
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<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

2. Are you providing feedback on behalf of a group or organisation, or as an individual?

☐ Individual
☐ Group/ organisation – please specify below the group/organisation you represent

Name of group/organisation:

3. How are you involved in falls prevention and/or management? (Tick all that apply)

☐ I am not involved in falls prevention and/or management
☐ Service provision – CLINICAL
☐ Service provision – ADMINISTRATIVE
☐ Advocacy and/or information provision
☐ Policy and/or planning
☐ Education and/or training
☐ Research
☐ As a carer
☐ As a consumer
☐ Others - please specify below
Section 2: Feedback on Post-Fall Management Guidelines

4. To what extent do you believe the Post-Fall Management Guidelines are useful for:

<table>
<thead>
<tr>
<th></th>
<th>Not at all useful</th>
<th>Slightly useful</th>
<th>Moderately useful</th>
<th>Very useful</th>
<th>Extremely useful</th>
<th>Unable to judge/not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highlighting the importance of post-fall management</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Enabling a consistent and best-practice approach to post-fall</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>assessment, management and follow-up in WA hospitals and health services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Minimising harm from falls and falls-related injuries among</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>patients in WA hospitals and health services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>Guiding how to respond to a patient immediately post fall</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>Guiding how to monitor and care for a patient up to 72 hours</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>post fall</td>
<td>☐</td>
<td>☐</td>
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</table>

5. What, if any, do you believe are the strengths of the Post-Fall Management Guidelines?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. What, if any, do you believe are the limitations or gaps of the Post-Fall Management Guidelines?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

No Longer Applicable
Rescinded 17 Oct 2018
7. To what extent do you believe the Post-Fall Management Guidelines are clearly written, that is, easy to understand?

☐ Extremely clear
☐ Very Clear
☐ Moderately clear
☐ Slightly clear
☐ Not at all clear

Please provide any comment (if any)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. How, if at all, can the Post-Fall Management Guidelines be improved?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

9. What, if any, are the implementation barriers or issues that exist with the Post-Fall Management Guidelines?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10. Please provide any other comments you have concerning the Post-Fall Management Guidelines?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Section 3: Your contact details

11. Are you willing for us to contact you if necessary to clarify your responses to this survey?
☐ Yes - Please provide your details below  ☐ No

Phone: ________________________   E-mail: __________________________________

Thank you for your contribution
8. References

16. Department of Health Western Australia. Falls Prevention Model of Care for the Older Person in Western Australia. Perth: Health Networks Branch, Department of Health, Western Australia; 2008.


