Post-Fall Management Guidelines: Supplementary Discipline Specific Guidelines

Falls Prevention Health Network

March 2015
This document is a supplement to the Post-Fall Management Guidelines in WA Healthcare Settings and should be read in conjunction with the main guidelines.

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Supplementary Guideline 1: Medical Officer Guidelines on Post-Fall Management

The Facts
- Relatively minor falls in older people can lead to death and significant injury and/or result in increased levels of anxiety and social withdrawal.¹
- Once a person has had one fall in hospital, they are at greater risk of having more falls.
- All falls are to be treated seriously by staff as often a fall is an indication of an underlying problem that can be treated.

Protocol
- Every person experiencing a fall in hospital requires an urgent medical review by a Medical Officer (MO) or Nurse Practitioner (NP).
- Responding to the fall incident requires the provision of immediate first aid, medium and longer term care, and documentation.

History
- Talk to relevant staff about the nature of the fall.
- Talk to the patient about the fall and symptoms arising from the fall.
- Review medical notes and medication charts to identify factors that may put the person at risk for falling, or for having an injury from the fall.
- Establish the patient's baseline mobility and cognitive state to determine whether it has changed post fall.
- Specifically note whether the patient is taking aspirin, clopidogrel, aspirin plus dipyridamole (Asasantin), warfarin, heparin, enoxaparin (Clexane), dalteparin (fragmin), rivaroxaban, dabigatran, apixaban or other antiplatelet drugs or anticoagulants. Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.

Examination
- Examination should always take place, even if you have to wake the patient.
- The examination should identify any injury sustained. When examining a patient, be aware that they may not draw attention to all of their injuries (not wanting to be a bother or cognitively impaired).
- The examination should also seek to identify the immediate underlying causes of the fall (arrhythmia, stroke, hypotension, other acute illness).
- The examination should include:
  - Assessment for confusion (delirium or dementia)
  - Assessment of level of consciousness
  - Neurological examination including speech, eye movements, facial asymmetry, muscle power, reflexes and plantar responses
  - Check pulse and blood pressure (preferably lying and standing)
  - The head, neck, clavicles, shoulders, wrists, hips and ankles should be examined
  - Identify sites of tenderness/ swelling/ deformity (e.g. a shortened, externally rotated leg may indicate a hip fracture)
If no obvious features of hip fracture, ensure hip range of movement is pain free, and as soon as is practical ensure weight bearing is also pain free.
Examine other systems as required depending on circumstances.
Assessment of post-fall mobility.

Investigations
- Order relevant investigations and ensure the results are checked and documented in the notes.
- Exclude fractures and intra-cranial haemorrhage.
- A cranial CT (Computed Tomography) should be arranged urgently if:
  - There is suspicion of a head injury (altered level of consciousness, headache, amnesia, vomiting).
  - If the patient hit their head AND is coagulopathic (see history section).
  - See Canadian CT Head Rule2.
- Consider an urgent CT if the patient is difficult to assess because of dementia, sedation or 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/or focal motor/ sensory changes.
- Consider whether the patient management will be altered by CT head should be made, such as patient/carer1 preferences and whether the patient would be considered appropriate for neurosurgical intervention. This dialogue should be clearly documented and discussed with treating specialist.
- Consider checking serum vitamin D levels, and treatment given if deficient (see Australian and New Zealand Bone Mineral Society (ANZBMS) position statement)4.

Treatment
- Implement treatment as appropriate (e.g. pain relief, immobilisation, wound care resuscitation).
- Implement appropriate actions to prevent a recurrence of a fall, and communicate these with relevant staff.
- Inform the relevant medical team for follow up.

Document and handover
- Document your findings, treatment and plan in the medical notes as well as the Clinical Incident Form (CIF) and communicate with relevant staff.
- If you have any doubts about appropriate investigations and management contact the appropriate senior medical person e.g. after hours registrar.
- The patient’s medical team should lead a multidisciplinary team discussion to identify all the patient’s falls risk factors and formulate an individualised management plan to address these risk factors.


1 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.
Supplementary Guideline 2: Flow chart: Physiotherapy and Occupational Therapy Practice Guidelines on Post-Fall Management

Following the notification/identification of an inpatient fall, the patient must be reviewed within specified target periods outlined within the facility Occupational Therapy (OT) and Physiotherapy (PT) Department guidelines.

Note: The flowchart on page 6 adapted from: Sir Charles Gairdner Hospital (June 2012). Multidisciplinary post inpatient fall guidelines summary: Occupational therapy and physiotherapy. Perth, WA should be used in conjunction with the pathways and any specific department Post Inpatient Fall Policy and Procedures.
Inpatient fall

Patient referred by nursing/medical staff. (Relevant ward staff to complete a Clinical Incident Form (CIF) within specified time period following patient fall)

Investigate specific details, nature of, and events preceding patient fall

Patient reviewed by Medical Officer

Medical Officer clears and documents patients ability to mobilise
(Note: This MUST be documented by Medical staff)

**Multidisciplinary Assessment**

Investigate patient’s pre-admission level of mobility and function.
Identify all relevant individual falls risk factors (including those directly contributing to the current fall as well as potential future falls).
Please refer to profession-specific pathways for PT and OT clinical assessment guidelines.

- **Physiotherapy Guidelines**
- **Occupational Therapy Guidelines**

**Multidisciplinary intervention**

Intervention should include inpatient rehabilitation (as required), comprehensive falls education to the patient and/or the patient’s carer/family. Clearly identify and document the patient as a FALLS RISK and liaise with relevant ward staff. Ensure recommendations for patient’s mobility are clearly documented and communicated to the ward team. Eliminate/minimise falls risk factors where possible (profession specific). Please refer to profession-specific pathways for PT and OT intervention guidelines.

- **Physiotherapy pathway**
- **Occupational Therapy pathway**

**Multidisciplinary discharge planning**

Liaise with relevant team members, the patient, and/or the patient’s carer/family. Consider post-discharge rehabilitation and falls prevention needs as part of the discharge planning process. For example, referral to Falls Clinic or Day Hospital, outpatient therapy, Rehabilitation-In-The-Home, or community therapy programs.

- **Physiotherapy pathway**
- **Occupational Therapy pathway**

*For Rest in bed (RIB)*

Medically unstable, awaiting medical investigation/results, injury resulting in mobility restrictions.

Ongoing monitoring and formal therapy review when medically appropriate.
Supplementary Guideline 3: Physiotherapy Practice Guidelines on Post-Fall Management

- In the event of a patient’s fall, the patient must receive a mobility and balance assessment within the first 24 hours, if medically stable. The appropriate interventions and recommendations should be documented to reduce the risk of recurrence.
- There is strong evidence to suggest that multi-factorial interventions reduce falls and risk of falling in hospitals. Physiotherapy is integral to this multidisciplinary input.
- Following notification of a fall from nursing staff and/or patient incident, the physiotherapist receiving the referral should see the patient as soon as is practicable. A target of less than 24 hours post incident is recommended.
- Liaise with relevant nursing staff and refer to patient notes to investigate details, nature of, and events preceding the fall.
- Determine if the patient has been reviewed by a MO/NP. If so, determine and review results of medical investigations performed. For example, X-ray, CT scans etc.
- Confirm if the patient is medically cleared to mobilise or if the patient is restricted to ‘Rest In Bed’ activity. This must be clearly documented by the medical staff. If it is not, liaise with the appropriate medical staff and request documentation prior to assessing and mobilising the patient.
- If not known from prior assessment, investigate the patient’s preadmission level of mobility and function (e.g., level of assistance required, use of walking aid etc.); identify any preadmission and/or current falls risk factors. Involve carer in assessment if applicable.
- Examine the patient’s falls history and document the frequency (≥2 falls in past 6 months or 1 fall and gait or balance difficulty = HIGH FALLS RISK).
- Determine if the patient has been previously assessed by a physiotherapist on this admission.
- Ensure recommendations and prevention strategies have been made and check that the patient’s mobility chart is up to date (if applicable).
- If the patient is medically stable, conduct a comprehensive assessment. This may include but is not limited to: Timed unsupported stance, Rhomberg/Sharpened Rhomberg, Timed Up and Go (TUG), step test, repeated Sit-to-Stand (STS), Berg Balance Scale.
- According to your assessment finding eliminate/control for risk factors where possible.
- Supply equipment, if required (e.g. walking aids).
- Update the patient’s mobility chart (if applicable) and liaise with the nursing coordinator to update the Stay On Your Feet® Falls Risk Assessment and Management Plan (SOYFWA® FRAMP), nursing care plan and nursing handover and identify the patient as a FALLS RISK.
- Clearly and concisely document assessment findings and subsequent recommendations to ensure safety when mobilising and prevent manual handling risks to other staff.
- Educate the patient (and/or patient’s carer/family members where applicable) about falls risk factors, falls prevention, and the treatment and management recommendations.
- Continue/commence patient rehabilitation (if required) incorporating specific balance and muscle strengthening components.
- Consider post-discharge rehabilitation and falls prevention needs as part of the discharge planning process (e.g., sub-acute rehabilitation facility, referral to appropriate local community services including physiotherapy, occupational therapy, nursing and Falls Clinics).

Adapted from: Physiotherapy Department, Sir Charles Gairdner Hospital (2012). Physiotherapy Practice Guideline: Hospital Inpatient Post Fall Management. Perth WA.
Supplementary Guideline 4: Occupational Therapy Practice Guidelines on Post-Fall Management

Policy statement

All patients, who present with or who have a fall whilst a hospital inpatient, are at a higher risk of further falls. There is strong evidence to suggest that a multidisciplinary approach targeting multifactorial interventions reduce falls and risk of falling.5

Background information

The occupational therapist works as part of the multidisciplinary team. The primary role is to identify falls risks and provide intervention for falls risks.

The occupational therapist will specifically focus on:

- cognition
- activities of daily living (ADL) (including Personal Activities for Daily Living (PADL) and Instrumental Activities of Daily Living (IADL))
- environment (both ward and home).

Standard

All patients who present with a fall or fall-related injury and/or who have a fall whilst an inpatient will be assessed by an occupational therapist within as soon as is practicable. A target of two working days is recommended.

Patient groups

There are four patient groups:

- Group 1: Patients who present to an Emergency Department (ED) with a fall, age >65yrs, have fallen or have a fall-related injury and are then discharged
- Group 2: Patients who present to ED with a fall, age >65yrs, have fallen or have a fall-related injury and are then admitted
- Group 3: Patients who fall whilst an inpatient
- Group 4: Patients who are at risk of falling - Inpatient admitted for other reasons but identified as ‘high risk’ of falling.

Method of referral

Group 1:

- All patients >65yrs, presenting to ED with a fall or fall-related injury, will have falls assessment/interventions/recommendations completed depending on discharge destination. This can be carried out by the Care Coordination Team, where available.
Groups 2, 3, 4:

- All patients admitted to a ward will have a SOYFWA® FRAMP completed by nursing staff. Nursing staff will refer to an occupational therapist if a patient is at a high falls risk as identified by a positive response to the following criteria:
  - has had a slip, trip or fall in the past 6 months
  - unsafe when walking or transferring
  - is confused.
- For inpatients that sustain a fall the patient will be referred by nursing staff for an assessment by the occupational therapist.
- The occupational therapist as part of daily practise must also screen for patients through team meetings, patient lists and liaison with team members for patients that have presented with a fall or fall-related injury, had a fall whilst an inpatient, or are at risk of falling. This should be done on a daily basis where practicable.

Communication

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 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. Refer to the Communication section in Dementia: Osborne Park Hospital Guide for Occupational Therapists in Clinical Practice for more information.

Documentation

The Occupational Therapy Falls Assessment Form or the Care Coordination Team Falls Assessment Form will be used to document falls specific information for all groups of patients (see above definition) that have fallen or are at high risk of falling.

Occupational therapy falls assessment

Much information surrounding falls background, mechanism of injury, and falls risks may already be identified and documented by medical, nursing and other allied health staff. To avoid patients being asked the same types of questions, the occupational therapist sources information from medical notes/ team meetings etc where appropriate.
The Occupational Therapy Falls Assessment includes the following:

1. Presenting medical condition
2. Past medical history
3. Living arrangements
4. Falls analysis - including location, falls history, task at time of fall
5. Assessment focusing on:
   5.1 Cognition
       Establish baseline cognitive function; include history from carer/family and past medical notes. Establish and document whether cognitive changes are acute or gradual in nature. Complete formal cognitive assessment as appropriate such as Mini Mental Status Examination (MMSE), Rowland Universal Dementia Assessment Scale (RUDAS), and Confusion Assessment Method (CAM). Always complete a functional cognitive assessment, e.g. self-care, kitchen assessment. In addition, document patients' normal routine and interests. Refer to the Dementia: Osborne Park Hospital Guide for Occupational Therapists in Clinical Practice for more information.  
   5.2 Activities of daily living
       Document pre-admission and current practices that increase falls risks. Conduct functional activities of daily living (ADL) assessments such as the Assessment of Motor and Process Skills (AMPS) the Falls Risk for Older people in the Community (FROP COM) and/or kitchen assessment.
   5.3 Environment
       Assessment of (ward and home) environment to identify potential hazards and ADL practices that contribute to the individual's falls risks. Use existing materials including the Stay On Your Feet WA® Home Safety Checklist and other Stay On Your Feet WA® education materials.
5. Identification of individual risk factors
   As part of the multidisciplinary team the occupational therapist must identify individuals’ risk factors that are impacted by cognition, environment and ADLs. Individuals’ risk factors must be documented by the occupational therapist. Falls risks include:
   6.1 Other medical conditions
       - E.g., Stroke, Parkinson Disease, Peripheral Neuropathy
   6.2 Previous falls
   6.3 Lives alone
       - Does the patient still have a carer, either a visiting family member or friend/neighbour whose support is quite significant to the person’s health status? If yes, include the carer in care planning.
6.4 Environmental hazards, ward and home (see OT Assessment and Intervention)

6.5 Cognitive impairment (see OT Assessment and Intervention)

6.6 Polypharmacy (4+meds)

- Does the patient have a good understanding of their medications?
- Does their cognition impact on their understanding and compliance with their medications?
- Is the patient compliant in taking medications?
- Physically, do they have the upper limb strength, dexterity and vision to manipulate pill containers or cut pills in half?
- Are they orientated to day of week and time and able to identify on dosette box?
- Do they need assistance with managing medications due to any of the above - webster pack, dosette box?
- Refer to Pharmacist/MO for medication review.

6.7 Visual impairment

- Patients with a visual impairment are more at risk of falls when placed in an unfamiliar environment.
- Patients with visual impairment are more at risk at night time, especially when toileting.
- Return to familiar environment wherever possible and/or minimise bed moves.
- Identify patient’s level of visual impairment.
- Ensure patient have their glasses with them they are able to access them; they are clean and labelled with their name.
- Establish when the patient had their last eye check-up. Do they need a referral to an optician if vision has not been checked in the last 12 months?
- Does the patient wear bifocals or single lens? Discuss risks of wearing bifocals on steps and uneven surfaces (e.g., outdoors).
- Assessment of environment in relation to decreased vision.
  - Ward: Be aware of environmental risks in an unfamiliar environment, e.g. use of bed rails on hospital bed. Does the ward environment leave the bathroom light on? Are their environmental cues for patients with low vision in the unfamiliar environment, e.g. toilet signage, has the patient with low vision been orientated to their current environment on more than one occasion?
  - Home: Is their home environment clutter-free? Do they use night/sensor lights? All high falls risk patients with a visual impairment benefit from an OT home visit.
- Does the patient with low vision have the cognition (i.e., new learning) to adapt to a different environment? A patient with decreased vision may require several ADL retraining sessions in an unfamiliar environment to develop safe practices. Consider use of bedside commode for night time toileting.
6.8 Continence issues
- Assess the patient's continence and any related toileting issues.
- Does the patient experience incontinence (stress or urge).
- How do they currently manage their continence issues? Wear pads. How far is the toilet? Are they rushing? Do they use a bottle/bedside commode?
- How many times do they need to get up at night?
- Are they able to manipulate their clothing and manage perineal hygiene?
- Is their mobility compromised? Are they able to get in/out bed, chairs? Are they able to open the toilet door and manipulate a frame?
- Are they able to mop up urine spills if they occur?
- Is their safety compromised due to balance issues when attempting to change underwear, trousers, clean up spills?
- Does the patient restrict fluids due to problems with toileting overnight?
- Does the patient suffer from constipation because of this?
- At night do they leave on light to toilet?
- Do they need environmental aids to assist with continence e.g. bed rail/over toilet frame?
- Cognitively are they able to adapt to toileting changes e.g. new techniques, new equipment, and unfamiliar environment. Patient may require several ADL interventions in order to adopt new techniques/use equipment safely.
- Refer to continence nurse.

6.9 Reduced muscle strength
- Be aware of functional decline from bed rest or reduced mobility.
- Assess the impact of reduced muscle strength on a patient's function and falls risk.
- Assess ADL function and implement intervention so that patient is encouraged to sit out of bed and partake in normal activities.
- Retrain patient in safe ADL practices and implement environmental changes to assist with independence and safety.
- Is a patient at risk when standing to shower; do they need to use a rail or sit to shower and dress, or dress in bedroom? Does the patient/carer require education and retraining in safe ADL practices?
- Develop muscle strength through participation and independence in ADL practices. Provide equipment and environmental cues to assist with this.
- Refer patient to relevant allied health staff (i.e. Physiotherapist) or functional maintenance programs, where available.

6.10 Fear of falling
- A patient's fear of falling can be assessed through the Falls Efficacy Scale.
- In the history-taking or during interventions does a patient express a reluctance to partake in normal activities?
- Does the patient avoid activities as they fear it will put them at risk of falling?
- Has a patient become socially isolated and no longer accessing the community?
- Look at suitability of pendant alarm, Telecross monitoring, use of hip protectors.
- Do they know how to get off the floor if they fall? Do they have an emergency plan in place with fall?
• Build confidence by providing falls education to address risk factors; engage the patient in normal routine at ward level and at home (independence in ADL activities); practise familiar tasks in a supported environment to address risk factors.
• Refer to inpatient and outpatient falls services, where available. e.g. functional maintenance programs, falls clinics, Falls Specialist Services education groups and day hospitals.
• For significant anxiety/fear of falling (i.e. fear does not diminish with the above interventions), refer to clinical psychology in falls clinic.

6.11 Foot or footwear problems
• Assess footwear used.
• Provide Stay On Your Feet WA® footwear information.
• Ask carer/family members to bring in appropriate footwear.
• Discourage use of socks as footwear as they are a slip hazard on the ward.
• Identify other foot issues (i.e. decreased sensation/corns/long toenails).
• Is patient able to reach feet to put on footwear?
• Does the patient secure shoes on correctly?
• Do they require assistive equipment to put footwear on safely? Implement ADL interventions to ensure carryover of safe techniques and reinforcement of correct footwear.
• Refer to Podiatrist. Encourage regular review by community podiatrist.

6.12 Balance impairment
• Assess the impact of decreased balance on patients' PADL and IADL function.
• Identify risk areas and provide intervention, e.g. equipment prescription and training in their use, safe ADL practices.
• Assess patients' cognition and insight, e.g. is the patient unsteady when dressing in standing; is the patient choosing to do activities which are too difficult for them?
• Does the patient remember to use new equipment and integrate these into their routine?
• IADL function and practise – is the patient able to safely reach low and high items? Does the environment need to be reorganised to reduce overbalancing?
• Refer patient to relevant allied health staff (i.e. Physiotherapist) or functional maintenance programs, where available.

6.13 Gait impairment
• Assess the impact of gait impairment on function and environment.
• Is patient able to safely negotiate environment with mobility aid.
• Review environment – floor surfaces, steps, and distance from toilet.
• Is the patient wearing appropriate footwear?
• Do they furniture walk?
• Are they able to carry items if they are using a walking aid? Do they use a kitchen trolley?
• Do they remember to use their mobility aid?
• How do they manage long distances? Does the quality of their gait deteriorate when tired (e.g. poor foot clearance and risk of tripping on own feet)?
• On the ward are they able to manage to get to toilet or do they need a bottle beside bed?
• How does gait impairment impact on fear of falling, e.g. walking in crowds, use of public transport?
• Does the patient have the ability to dual task i.e. walk and talk?
• Refer patient to relevant allied health staff (i.e. Physiotherapist) or functional maintenance programs, where available.

6.14 Nutrition
• Does the patient report swallowing difficulties or non-intentional weight loss?
• Is the patient at risk of reduced muscle mass and strength due to malnutrition?
• Assess the patient’s ability to cook; how they obtain their meals; need for assistance with meals.
• Is their cognition impacting on their ability to cook, e.g. leaving stove on, unsure of how to reheat meals, forgets meals are in fridge?
• How do they get to the shops? Assess patients’ ability to prepare a light meal. Encourage patient to be independent preparing a hot drink on ward.
• Assess home environment/ layout of cupboards.
• Assess ability to manipulate cutlery take food to mouth. Review seating if eating or swallowing issues. Provision of assistive equipment if necessary.
• Refer to dietician and/or speech pathologist.

Occupational therapy falls interventions
This section outlines multidisciplinary interventions for generic risk factors as well as occupational therapy interventions for cognition, ADLs and environment. Additional occupational therapy interventions for these areas include:

1. Cognition
   Prevent cognitive decline through:
   • involvement of carer/family, establish familiar routine and ADL practices
   • referral to relevant allied health staff (i.e. Physiotherapist) or functional maintenance programs, where available, to encourage independence in all activities
   • maintaining normal sleep/wake cycle – familiar routine
   • regular toileting routine
   • use of protective equipment such as hip protectors, sensor alarms, hi-lo beds
   • daily orientation to time, place, person and reason for being in hospital
   • provision of orientation aids such as clocks and calendars
   • incorporating safe practices into daily routine particularly in unfamiliar environment
   • providing alternative methods of falls education (e.g., videos, SOYFWA® brochures and booklets).

2. Activities of daily living
   • Education and retraining of ADL practices.
   • Provision of equipment to decrease falls risks and improve patients’ independence.
   • Build confidence and decrease fear of falling through routine activities such as self-care and meal preparation.
3. Environment

- Adjustment and/or modification of ward environment, e.g. lighting in bathroom, bedside commode.
- Provide and train in use of assistive equipment at a ward level.
- Provision and implementation of assistive equipment in home environment.
- An OT home visit for all visually impaired or high falls risk patients.

**Occupational therapy falls-specific discharge planning**

May include:

- Recommendations for transition to home/residential care/rehabilitation facility.
- Liaising with care facility regarding patients falls risks and interventions.
- Referrals to:
  - Falls Clinic/Day Hospitals/Falls Specialist
  - Outpatient physiotherapy services/community physiotherapy
  - Rehabilitation in the Home
  - Department of Veterans’ Affairs – Home Front Program
  - Living Longer Stronger ProgramTM
  - Occupational Therapy Home visit
  - Silver Chain Personal Enablement Program or falls program.
  - Independent Living Centre
  - Community Aids and Equipment Programme (CAEP)
  - Complex Needs Coordination Team (CoNeCT).

Adapted from: Occupational Therapy Department, Sir Charles Gairdner Hospital (2012). Occupational Therapy Practice Guideline: Hospital Inpatient Post Fall Management. Perth, WA.
The guidelines in this document have been adapted from the following guidelines developed by Sir Charles Gairdner Hospital:

- Sir Charles Gairdner Hospital (June 2012). Multidisciplinary post inpatient fall guidelines summary: Occupational therapy and physiotherapy. Perth, WA.
- Physiotherapy Department, Sir Charles Gairdner Hospital (2012). Physiotherapy Practice Guideline: Hospital Inpatient Post Fall Management. Perth WA.
- Occupational Therapy Department, Sir Charles Gairdner Hospital (2012). Occupational Therapy Practice Guideline: Hospital Inpatient Post Fall Management. Perth, WA.

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References


## Acronyms and abbreviations

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<td>Home and Community Care</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<tr>
<td>MER</td>
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<td>MET</td>
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<td>Mini–Mental State Examination</td>
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<td>MPS</td>
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<tr>
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<td>NP</td>
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<td>PADL</td>
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<td>Stay On Your Feet WA® Falls Risk assessment and Management Plan</td>
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<td>SQuIRe</td>
<td>Safety and Quality Investment for Reform</td>
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<tr>
<td>STS</td>
<td>Sit-to-Stand</td>
</tr>
<tr>
<td>TUG</td>
<td>Timed Up and Go</td>
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<td>WA</td>
<td>Western Australia</td>
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