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Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2023

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Contents

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Contact information:

For further information contact Falls.ManagementWA@health.wa.gov.au.

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Overview

Introduction

Falls and falls-related injuries cause substantial morbidity and mortality among older Australians. The hospital setting is associated with an increased risk of falling among older people due to additional risk factors from both illness and being in an unfamiliar environment.

Falls were the second most frequently reported clinical incident in Western Australia (WA) hospitals in 2020-2021, with 5961 reported incidents. Falls incidents accounted for 17.3% of all clinical incidents reported in this period. 60% per cent were unwitnessed falls, with walking being the activity most frequently undertaken at the time of the fall.[1]

Severity Assessment Code (SAC) 1 falls incident notifications increased from 73 in 2018/19 to 88 in 2020-2021. Falls are the 2nd most likely of all clinical incident categories to report a patient outcome of death or serious harm (n=83; 19.0%). Falls in a health service are more than four times likely to involve serious harm (n=68) than death (n=15), a delay in recognising or responding to physical clinical deterioration was almost as likely to have a patient outcome of death (n=26) as a patient outcome of serious harm (n=27).[1]

A review of the Post Fall Management Guidelines in Western Australian Healthcare Settings 2018[2] was undertaken by a working party of health professionals from across public, rural, and private inpatient facilities in WA. Rigorous examination of patient safety, current evidence on all aspects of post fall care, and the roles of health professionals took place. The objective was to update the existing guidelines with current evidence and expert opinions, to continue optimising patient safety and care post fall. These revised guidelines also meet the National Safety and Quality Health Service Standards for Hospitals,[3] the Australian Commission on Safety and Quality in Health Care Delirium Clinical Care Standards,[4] Preventing Falls and Harm from Falls in Older People and Best Practice Guidelines for Australian Hospitals[5] and where appropriate Australian Commission on Safety and Quality in Health Care best practice guidelines for Residential Aged Care Facilities.[6]

Consultation with multidisciplinary health professionals, unregulated health care workers, and consumers from across WA has been undertaken. This yielded rich feedback, which has been incorporated in the document where considered appropriate.

The World Health Organisation's definition of a fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Falls, trips, and slips can occur on one level or from a height.[7] This definition includes

- All syncopal events.
- Controlled falls (the patient has not been expected to fall and required assistance to ensure their safety to a lower level).
- Rolls out of bed (equipment and bed safety requires review, patients should not be rolling out of a bed to a lower-level multiple times).
- Patient is suspected of having put themselves on the floor.

Purpose of the guidelines

The purpose of the *Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings* (the Guidelines) is to ensure the continued delivery of optimal patient care and patient safety following a fall. The Guidelines aim to reduce the risk of further falls and harm from falls along with the early detection of physical and cognitive deterioration. Guidelines for nursing, medical, occupational therapy, physiotherapy, and pharmacy are included to assist with directing multidisciplinary care for the patient post fall.

The intent of the Guidelines is to:

- Replace the current *Post Fall Management Guidelines in Western Australian Healthcare Settings 2018.*[2]
- Inform and complement falls management care, identify, and manage physical and cognitive deterioration, prompt utilisation of clinical escalation policies, and procedures within WA hospitals and health services.
- Identify key clinical interventions for all inpatients/residents who sustain a fall in WA hospitals, health services, and multi-purpose sites. The term ‘patient’ when used in these guidelines refers to this group of individuals.
- Target an audience that includes medical staff, nursing staff, occupational therapists, physiotherapists, pharmacists, and other relevant clinical staff. The Guidelines may also be useful for unregulated health workers including aboriginal health care workers, patient care assistants, assistants in nursing, and allied health assistants in WA hospitals, health services and multi-purpose sites.
- Assist the health professional’s decision-making about appropriate treatment and care for specific clinical circumstances. The Guidelines do not replace clinical judgment. It is acknowledged that there will be case-by-case circumstances where exceptions to these guidelines will be necessary for best patient care. Clinicians are encouraged to justify and document these exceptions within the patient’s health care record.
- Follow the principles of comprehensive care.[3]
- Prompt consideration for specific patient cohorts such as paediatrics where these guidelines may need modifying to ensure their suitability.

These evidence-based guidelines provide the recommended care of the patient following a fall. It is acknowledged that facilities/areas may be unable to meet aspects of the guidelines, due, in part, to location and resources. There are opportunities for adaptation at a local level.

The appendices provide additional information to guide assessment and intervention for nursing staff, medical staff, occupational therapy, physiotherapy, and pharmacy. Included is material and advice about post fall huddles, interprofessional assessment, clinical investigation, and several tools that may be beneficial for staff.

Staff and Patient Falls

What the Guidelines do not provide is information for assisting a patient during a fall. It is expected that staff will be familiar and proficient with best practice manual handling principles as per their local policies.

Because of the breadth of areas these Guidelines follow, local policy should detail how to safely move a patient from the floor with equipment that is available within the facility. This is not within the scope of this Guidelines but will be considered for the next review in 2026.

Applicability

These guidelines are intended for use by all health professionals employed in inpatient facilities and multi-purpose sites in WA. They are also available for use by private health care facilities.

A community guideline for post-fall care is available on request (see contact e-mail).

Guidelines' requirements and use

- Approval to implement these guidelines should be sought from the relevant governance committee prior to implementation in health care facilities.
- Communication with the patient's family/carer must be undertaken with the full consent of the patient unless clinical assessment indicates otherwise.
- It is expected that health professionals (and unregulated care workers) will have at least minimum knowledge of the post-fall process and responsibilities.
- Implementation among and education of relevant staff is the responsibility of individual facilities.
- These guidelines can be divided into the post fall pathway and individual disciplines for easy accessibility by the multidisciplinary health professionals.
- When a patient falls the immediate post-fall process should be followed.
- The post fall pathway is ideally kept with the patient's bedside health care record, with the date and time of the fall documented.
- Pathways are presented to cover various situations for example witnessed/unwitnessed falls and patients receiving palliative care. The accompanying observations should be completed as advised.
- The guidelines recommend actions at 4, 6, 24, and 48 hours. These actions are undertaken for all falls regardless of whether the fall was witnessed or unwitnessed.
- It is not recommended that the post fall process is less than 48 hours but could be up to 72 hours if wished by individual facilities.
- Throughout the 48 hours and beyond it is essential to continue to monitor for physical, behavioural, cognitive clinical deterioration and report to a medical officer if this occurs.
- Communication is a vital component and should be considered at each step.
- Medical and allied health professionals are advised to conduct their reviews and care as per their discipline-specific guidelines.
- Multiple resources have been shared in the Appendices. These have been developed by health professionals and are all currently being used in varying WA hospitals. The resources are recommended by the health professionals that use them and those within the Post Fall Guideline Review Working Group.

Further information can be sought by emailing Falls.ManagementWA@health.wa.gov.au.

Nursing Guideline

DATE & TIME OF FALL:

NURSING/MULTIDISCIPLINARY 48 HOUR POST FALL PATHWAY

Stop and Consider: Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy (e.g. alcohol-dependent persons) are at an increased risk of intracranial, intrathoracic and/or intra-abdominal haemorrhage

IMMEDIATE POST FALL PROCEDURE

Complete DRSABCDE actions prior to moving the patient from the floor

- Provide reassurance and comfort to patient and call for assistance.
- Patient not to be moved if any physical injuries identified (unless airway is compromised) and fast track Medical Officer (MO) review within 30 minutes. (Regional sites consider Emergency Telehealth).
- Activate Medical Emergency Team (or local process) if the patient meets criteria.
- Immobilise cervical spine if the patient is unconscious or reports head or neck pain.
- The patient's movement to be guided by clinical assessment and local policy/guideline.
- Minimum investigations include:
  - Blood glucose level
  - ECG
  - Cognitive impairment screening using the Abbreviated Mental Test (AMT4), Rapid Clinical Test for Delirium (4AT) or Confusion Assessment Method (CAM) (as per local policy/guideline).
- Identify immediate pre-fall symptoms e.g., dizzy, feeling unsteady, etc. and consider other investigations as indicated by the pre-fall symptoms.
- Notify MO of patient fall and request review. (If no apparent injury, this can occur within 4 hours or as per local policy).
- Notify Ward/Area/Facility/ Senior Registered Nurse (SRN)/After Hours Clinical Nurse Specialist/Manager/MO.
- Depending on type of fall, commence observations and care delivery as follows:

WITNESSED FALL (NO HEAD STRIKE) →	Commence neurological and baseline physical observations as per Medical/SRN's clinical judgment and document rationale.
PATIENT ON ANTICOAGULANTS / ANTIPLATELETS **AND/OR** **WITNESSED FALL (HEAD STRIKE) or UNWITNESSED FALL** →	• Neurological observations: ○ Half-hourly for a minimum of 2 hours until GCS of 15 or patient considered back to their normal level of cognition achieved. ○ Continue if GCS remains < 15 or patient not considered at a normal level of cognition. Report to MO and continue as per instructions. • If the patient has GCS of 15 or patient considered back to their normal level of cognition, then continue observations: ○ Hourly for 4 hours. ○ Two-hourly 4 hours. ○ Four-hourly until a total of 48 hours from the time of fall has occurred). ○ At 48 hours if clinically assessed as stable, no clinical deterioration, document in medical record and return to observations pre-fall.
PATIENT ON PALLIATIVE PATHWAY →	• Patients at the end-of-life that are no longer having observations: • The consultant or senior registrar must document in the patient's health care record whether observations are to restart or not.
GOALS OF CARE CHECK →	• Review patients' goals of care to identify post fall care. The patient's treating Consultant or General Practitioner must guide this. • Patients on multipurpose sites may not need to be transferred to hospital for review.

RECOMMENDED ACTIONS WITHIN 4 HOURS:

- Medical review of patient has occurred.
- Identify the contributing factors to the fall and implement interventions to reduce the risk of another fall/injury.

RECOMMENDED ACTIONS WITHIN 6 HOURS:
Continue observations as indicated by fall type

- Notify Next of Kin (NOK)/carer and document commencement of open disclosure processes (form or sticker) in the medical record.
- Monitor for physical, behavioural, cognitive, and clinical deterioration. Report to MO if this occurs.
- MO to have reviewed any urgent results of tests.
- Refer/notify Occupational Therapist, Physiotherapist and Pharmacist of the fall.
- Arrange referral to other health professionals as per clinical assessment.
- Ensure contributing factors to the fall have been identified and interventions implemented.
- Rescreen, (using local endorsed falls risk assessment tool), review current falls prevention interventions and implement additional interventions as required.
- Document the fall in the medical record.
- Complete official reporting via local system e.g., RiskMan, DATIX.
- For an injurious fall that may be considered a SAC 1 injury – complete notification as per local clinical incident management policy.

RECOMMENDED ACTIONS WITHIN 24 HOURS:
Continue observations as indicated by fall type

- Notify Medical Officer immediately if any changes in observations including visual changes, speech/language disturbance or focal motor/sensory changes.
- Review of results of bloods, imaging, microbiology, and observations has occurred and been actioned.
- Review fall, identify and implement interventions required for the patient's falls management care.
- Patient and family/carer to receive information and education. Ongoing falls management care developed in partnership with patient and family/carer.
- The multidisciplinary team members have collaboratively discussed the fall and identified any further risks and interventions required and these have been implemented.
- Consider a structured multidisciplinary Post Fall Safety Discussion.

RECOMMENDED ACTIONS WITHIN AND AT 48 HOURS:

- At 48 hours post fall, review observations and if no clinical deterioration, return to appropriate observations.
- Completion of all actions within the guidelines.
- Conduct a comprehensive review of patient care.
- Document in the inpatient record and communicate any outstanding actions and date/time completion required by multidisciplinary team members.
- Consider a structured multidisciplinary Post Fall Safety Discussion within 48 hours of the fall.

COMMUNICATION:

- Ensure patient consents to discussion of care with family/carer (where clinically appropriate).
- Interpreter is always to be utilised where appropriate (and as per local policy).
- Primary nurse to ensure documentation in patient's health care record and local reporting database.
- Medical and allied health reviews documented in the patient's health care record.
- Patient and family/carer to receive information/education about the fall and ongoing instructions if discharged within 48 hours of the fall. (Provide "Health Information After a Fall "leaflet).
- All disciplines involved are to partner with the patient and family and share decisions to develop ongoing plan of care.
- Communication may require different approaches depending on disability/cultural requirements.
- Documentation of the fall to occur on nursing, medical, allied health handover sheets, and all transfer and discharge documentation. Inclusion of the fall in verbal handovers: nursing, medical, allied health.
- All staff involved in the care of the patient to be informed of incident outcome and revised care plan.
- Visual flagging that the patient is at high risk of falls (and as per local policy).
- Contact Ward/Area/Facility/SRN/After Hours Clinical Nurse Specialist (and as per local policy)

ALLIED HEALTH ASSESSMENT: OCCUPATIONAL THERAPY, PHYSIOTHERAPY, PHARMACY

- Complete assessments as per specific discipline guidelines within 2 working days of the fall (and as per local policy).
- Work collaboratively with the wider multidisciplinary team.

Medical practice guidelines (Inpatient falls)

Introduction – the facts

- Once a patient has had one fall in hospital, they are at 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.
- Even relatively minor falls in older people can lead to death or significant injury.

Protocol

- Every patient experiencing a fall in hospital requires a timely medical review (urgent if deteriorating, within 30 minutes if injured, and within 4 hours for most other falls).
- Services without resident medical staff should follow local escalation processes including use of the Emergency Telehealth Service (ETS).
- Responding to the fall incident requires the provision of immediate first aid, longer-term care, and active addressing of falls risk factors to prevent future falls.
- Consider using a proforma to assist with meeting examination requirements (See Appendix 2).

History

- Talk to the patient about the fall and symptoms arising from the fall.
- Review medical entries in the patient's health care record and medication chart to identify factors that may put the person at risk of falling, or of having an injury from the fall.
- Establish the patient's baseline mobility and cognitive state and determine whether it has changed post fall.
- Specifically, document whether the person is on Warfarin, Enoxaparin (Clexane), Heparin, Apixaban (Eliquis), Rivaroxaban (Xarelto), Dabigatran (Pradaxa), Prasugrel (Effient) and Ticagrelor (Brilinta), Fondaparinux, Lepirudin, Bivalirudin, Aspirin, Clopidogrel, Aspirin and Dipyridamole (Asasantin®) or other anticoagulant/antiplatelet medication.
- Patients with chronic liver disease or haematological disorders may also be coagulopathic.

Examination

- Examination should always take place, even if you must wake the patient.
- The examination should identify any injury sustained. When examining a patient, be aware that they may not draw attention to all their injuries (particularly if cognitively impaired).
- Do not allow the patient to be moved until head, cervical spine and hip injuries have been ruled out. Spinal precautions must be used if the patient has GCS <13 or a neck injury is suspected.
- The examination should also seek to identify the immediate underlying causes of the fall (infection, arrhythmia, stroke, hypotension, other acute illness).

- The examination should include:
    - Check pulse and blood pressure (when appropriate check postural drop).
    - Assess level of consciousness and document Glasgow Coma Scale.
    - Talk to the patient – assess for confusion (delirium or dementia). Document AMT4 (age, DOB, current year, place).
    - Examine the head, neck, spine, hips, and limbs to identify sites of tenderness/swelling/deformity (for example a shortened, externally rotated leg may indicate a hip fracture).
    - Neurological examination including speech, pupil size, eye movements, facial asymmetry, power, sensation, and plantar responses.
        - If there are no obvious features of hip fracture, ensure hip range of movement is pain free, and as soon as is practicable ensure weight bearing is also pain free.
        - Assess post-fall mobility.

Investigations

- Order relevant investigations and ensure the results are checked and documented in the patient's health care record.
- Exclude intracranial haemorrhage and fractures.

1. Is a CT head scan required?

a). If the patient has hit their head?[8]

This decision should be individualised and based on their risk of injury. There is no specific research determining the optimal pathway for inpatients. The National Institute for Health Care and Excellence (NICE) guidelines developed for Emergency Departments provide useful criteria for clinicians to assist decision-making. These are reproduced below in Figures 1 and 2.

Sites without available CT scanning should utilize local pathways and consultation services. Deterioration in neurological observations undertaken by nursing staff is a trigger for CT scanning.

Fig 1. When to perform a CT head scan within 1 hour[8]

For adults who have sustained a head injury and have any of the following risk factors, perform a CT head scan within one hour of the risk factor being identified:

- *GCS less than 13 on initial assessment.*
- *GCS less than 15 at 2 hours after the injury on assessment.*
- *Suspected open or depressed skull fracture.*
- *Any sign of basal skull fracture (haemotympanum, 'panda eyes', cerebrospinal fluid leakage from the ear or nose, Battle's sign).*
- *Post-traumatic seizure.*
- *Focal neurological deficit.*
- *More than one episode of vomiting.*

Fig 2. When to perform a CT head scan within 8 hours[8]

*For adults with **any** of the following risk factors who have experienced some loss of consciousness or amnesia since the injury, perform a CT head scan within 8 hours of the head injury:*

- *Age 65 years or older.*
- *Any history of bleeding or clotting disorders.*
- *Current anticoagulation treatment.*
- *Dangerous mechanism of injury (a pedestrian or cyclist struck by a motor vehicle, an occupant ejected from a motor vehicle or a fall from a height of greater than one metre or five stairs).*
- *More than 30 minutes' retrograde amnesia of events immediately before the head injury*.

b). If patient had a witnessed fall and did NOT hit their head and they do NOT need a CT head scan?

- CT Head required if signs of neurological impairment develop.

c). Unwitnessed fall with no signs of head injury?

Consider CT head scan within 8 hours if:

- Cognitively impaired.
- Neurological deterioration on nursing observations.
- On current anticoagulant treatment.

Whether a CT head scan will alter patient management and patient/carer preferences should be considered; for example, would the patient be considered appropriate for neurosurgical intervention? This dialogue should be documented in the patient's health care record and discussed with the treating specialist.

2. Is a CT cervical spine scan required?[8]

a) For patients with a head injury:

NICE guidelines[8] make the following recommendations in relation to cervical CT requests:

Fig 3. Risk factors indicating CT cervical spine within 1 hour[8]

A cervical spine CT should be arranged within one hour for all adults who have sustained a head injury and have any of the following risk factors:

- *GCS less than 13 on initial assessment.*
- *The patient has been intubated.*
- *Plain X-rays are technically inadequate (for example the desired view is unavailable).*
- *Plain X-rays are suspicious or abnormal.*
- *A definitive diagnosis of cervical spine injury is needed urgently (for example before surgery).*
- *The patient is having other body areas scanned for head injury or multi-region trauma.*
- *The patient is alert and stable, there is clinical suspicion of cervical spine injury and any of the following apply:*
  - *Age 65 years or older.*
  - *Dangerous mechanism of injury (fall from a height of greater than 1 metre or 5 stairs).*
  - *Focal peripheral neurological deficit.*
  - *Paraesthesia in the upper or lower limbs.*

Fig 4. Assessing range of neck movement safely[8]

For adults who have sustained a head injury and have neck pain or tenderness but no indications for a CT cervical spine scan, perform three-view cervical spine X-rays within one hour if either of these risk factors are identified:

- *It is not considered safe to assess the range of movement in the neck.*
- *Safe assessment of range of neck movement shows that the patient cannot actively rotate their neck to 45 degrees to the left and right.*

Be aware that in adults who have sustained a head injury and in whom there is clinical suspicion of cervical spine injury, range of movement in the neck can be assessed safely before imaging only if there are no high-risk factors and at least one of the following low-risk features apply. The patient:

- *Was involved in a simple rear-end motor vehicle collision.*
- *Is comfortable in a sitting position.*
- *Has been ambulatory at any time since injury.*

Treatment

- Implement treatment as appropriate (for example resuscitation, immobilisation, pain relief).
- If patient has sustained significant injuries, inform the patient's consultant (or on call consultant after hours). If intracranial haemorrhage is confirmed, also urgently consult the neurosurgical registrar or consultant on call.
- If patient is unstable, return as often as deemed clinically appropriate to review.
- Implement appropriate actions to prevent a recurrence of a fall and communicate these to relevant staff.
- Review for high-risk medications. If clinical evidence for head injury, withhold anticoagulants until CT head scan is available.
- Inform the relevant medical team for follow-up.
- In the case of significant injuries, the doctor should inform the Next of Kin (NOK) if patient consents. Nursing staff will inform NOK about less serious falls.
- Consider referral to relevant members of the multidisciplinary team for further assessment and interventions as required

Stop and consider

- Have head, cervical spine and hip injuries been adequately ruled out? Do not allow patient to be moved until you have done so.
- Spinal precautions need to be used if the patient has GCS <13 or a neck injury is suspected.
- Has a new medical problem, for example sepsis, been adequately ruled out or treated?
- Does the patient have delirium or dementia, and is management in accordance with best practice?

Document and handover

- Documentation in the patient's health care record is vital. Sites may use a separate medical post-fall document, which should be used according to local policy.
- Communicate with relevant staff.

- If you have any doubts about appropriate investigations and management, contact the appropriate senior medical person and after hours, the afterhours registrar or medical officer on call.
- Consider using medical proforma for post fall assessment (see Appendix 2).

Medical treating team within 48 hours of the fall:

- Follow up any urgent investigations.
- Review medications e.g., on sleeping tablets – consider weaning off.
- Collaborate with the multidisciplinary team to identify all the patient's falls risk factors.
- Formulate an individualised management plan to address these.
- Assess for delirium and manage.
- Ensure the fall is mentioned on the discharge summary.

Discharge

The patient and carer should be provided with written and verbal information about falls. Discuss with the patient and carer about the risks of clinical deterioration, further falls and ensure that they have understood.

If discharged within 48 hours of a fall a "Health Information After a Fall" leaflet and discussion should be provided to ensure that the patient and carer have an understanding of the signs and symptoms of any clinical deterioration and where to seek help.

***Note: If the following occur, the fall must be reported to the coroner:**

- **a fall that resulted in the patient's death.**
- **a fall that was sustained within 48 hours prior to the patient's death.**

Occupational therapy guidelines

Introduction

Post inpatient fall the Occupational Therapist's role is to complete an analysis of the inpatient fall, identifying the patient's falls risk factors and how they contributed to the fall. Assessment, intervention, and recommendations should relate to the core Occupational Therapy areas of practice.

The Occupational Therapist, when completing an inpatient post fall assessment, focuses on:

- Patient's independence in Activities of Daily Living (ADLs);
- Patient's Vision;
- Patient's Cognition and;
- Review of the Environment (Hospital).

Additional supporting information can be found in Appendix 3. This is not an exhaustive list of assessments and interventions. They are a guide to what could be considered in the post fall analysis. Not all interventions are suited to all patients. Occupational Therapy specific interventions should be patient-centred and match individual needs.

Standard

The Occupational Therapist should assess all patients who have had a fall whilst an inpatient within two working days where possible or as per local policy.

These reviews can take place in person or via remote review on telehealth.

Referral process post inpatient fall to occupational therapy

Nursing/medical or allied health can refer to Occupational Therapy directly or via e-referrals for an inpatient post fall assessment. The Occupational Therapist can also obtain referrals via journey board meetings, screening processes or by liaising directly with nursing or medical staff.

Post fall occupational therapy assessment and interventions

The Occupational Therapy inpatient falls assessment needs to consider the following:

1. Falls Analysis:

    - Background information surrounding the fall, the mechanism of injury, where did the fall occur, when did the fall occur and what activity was being undertaken at the time of the fall.

2. Falls Risk Factor Identification, Stratification and Occupational Therapy Interventions:

    - The risk factors and interventions focus on the core occupational therapy areas (see above) and how they relate to the inpatient's day-to-day function on the ward. Each identified risk factor should be addressed.
    - All patients and their carers should be provided with written and verbal tailored falls prevention education.

- Intervention should also consider post-discharge needs and outpatient referrals especially for high-risk population i.e., adults experiencing frequent falls, adults with Parkinson's Disease, cognitive impairment etc. Please refer to Appendix 3.

Documentation

Complete the falls analysis and identify the falls risk factors/interventions in the areas of ADL including the effect of vision, cognition, and the environment. Document your findings clearly and concisely in the patient's health care record or as per local documentation requirements.

- Minimum documentation should include:
  - Date & time of fall (if known).
  - Date & time seen by Occupational Therapist.
  - Analysis of fall: including risk factors identified.
  - Interventions and recommendations for falls risk minimisation: including consideration of the impact of the environment, ADL, vision, and cognition on falls risk if appropriate.

- The Occupational Therapy sticker for the patient's health record (Appendix 3) provides an example of iSoBAR documentation that could be utilised.

- If any further intervention is required from an Occupational Therapist, ensure this is documented in the health care record as required.

Physiotherapy post fall guidelines

Introduction

The role of Physiotherapy is integral to the multidisciplinary management and care of patients who are at risk of falling or have fallen.

Supporting information and resources are available in Appendix 4

Referral process post inpatient fall to physiotherapy

Nursing/Medical or Allied Health can refer to Physiotherapy for a patient falls assessment following an inpatient fall. The Physiotherapist can also obtain other referrals via journey board meetings, screening processes or by asking nursing or medical staff.

Following the notification of an inpatient fall, a Physiotherapist should review the patient within two working days where possible or as per local policy.

These reviews can take place in person, or via remote review on telehealth.

The following guidelines are recommended:

Assessment

- Liaise with relevant nursing staff and refer to the patient's health care records to investigate details, nature of, and events preceding the fall.
- Determine if the patient has had a review by a Medical Officer, Senior Nurse, or Nurse Practitioner (NP).
- Review the results of any medical investigations performed (for example X-ray and CT scans).
- Confirm if the patient has medical clearance to mobilise or is restricted to 'Rest in Bed'. Ideally, the Medical Officer has documented this prior to assessing and mobilising the patient. However, to prevent delays, a verbal approval may be sought. Document the name and designation of the Medical Officer providing the orders in the patient health care record.

As a minimum the following should be assessed:

Subjective Assessment

- If not known from a prior Allied Health Assessment, include previous level of functioning and mobility (including level of assistance required, walking aid use, cognition).
- Involve carers (with patient consent where possible) in assessments, especially for patients with cognitive impairment.
- Identify any previous falls history and/or current fall risk factors.
- Home environment.
- Discuss the fall with the patient, if they can recall the fall, to determine their insight into what happened and to gather information regarding their cognition.

Comprehensive Objective Assessment

- When medically stable, the patient should receive a comprehensive assessment. This may include a mobility, strength, vestibular, balance assessment and any other assessment as determined appropriate at that point in care.
- If the patient is unable to participate in the assessment due to pain, difficulty in weight-bearing, acute confusion, or another reason, the Physiotherapist should refer to the Medical Officer for further review/investigations. A comprehensive Physiotherapy review to occur post results of relevant medical investigations.

Comprehensive Physiotherapy assessment should include the following:

- Consider assessment of postural Blood Pressure if this is a possible contributing factor to the fall.
- Consider basic cognition screen such as Abbreviated Mental Test (AMT)4.
- Current mobility and level of assistance required, including walking aid requirements.
- Balance assessment as appropriate
    - As a minimum standard, sitting and standing balance.
    - If the patient is unable to stand, an assessment of sitting balance should be completed.
    - Standing balance should be assessed in progressively more challenging positions e.g., timed unsupported stance with eyes open and closed, with feet apart, feet together, step stance, tandem stance, and single leg stance.
    - Dynamic standing balance should also be assessed, if appropriate.
- Assessment and outcome measures determined appropriate at that point in care (e.g., manual muscle testing, Timed Up and Go, Berg Balance Scale, De Morton Mobility Index, repeated sit to stand and step tests, vestibular assessment).
- The 2022 World Falls Guideline[7] recommend using Gait Speed (GS) for predicting falls risk. For risk stratification they recommend use of GS, with a cut-off value of < 0.8 m/s based on its predictive ability and simplicity. This is measured at usual pace over 4 metres, with a cut off value, of < 0.8 m/s indicative of a falls risk.

Intervention

- According to assessment findings, and in collaboration with the multidisciplinary team, eliminate/control risk factors to reduce the risk of falls and harm from falls.
- In partnership with the patient and their carer/family, provide information about falls risk factors, risk reduction strategies, physiotherapy treatment, and the ongoing management plan. (Ensure patient consents to family/care involvement if possible).
- Supply equipment if required (e.g., walking aids).
- If the patients' shoes/slippers do not meet the criteria of a 'safe shoe', request safe footwear or the patient is to wear non slip socks if possible. Check for local footwear guidelines/policy.
- Continue/commence patient rehabilitation (if indicated) incorporating specific balance and muscle strengthening components.
- Monitor for any behavioural or thinking changes during subsequent interactions with the patient that could indicate a delirium. Escalate any concerns to the Medical Officer.
- Where indicated, support staff with the new mobility/manual handling recommendations.

- Communicate your interventions and recommendations, including level of assistance required to relevant staff (to enable the updating of nursing care plans and to highlight the patient as a Falls Risk).
- Ensure the “At risk of falling” alert sign above the patient’s bedside as per local guideline/ policy.
- Consider providing appropriate “Stay on Your Feet WA” written resources, or available local resources on relevant falls risk prevention.

Documentation

- Document the patient has medical clearance to mobilise or is restricted to ‘Rest in Bed’. Ideally, the Medical Officer has documented this prior to assessing and mobilising the patient. However, to prevent delays, a verbal approval may be sought. Document the name and designation of the Medical Officer providing the orders in the patient health care record.
- Clearly and concisely document:
    - Clinical assessment findings and interventions completed.
    - Falls risk status.
    - Strategies and recommendations to reduce risk and harm from further falls.
    - Falls prevention education that was provided.
    - Handover of the patient’s mobility falls risk status and falls prevention recommendations that were provided to nursing staff and relevant multidisciplinary team.
- Update the locally endorsed Falls Risk Assessment Tool including the patient’s falls risk status.
- Where applicable, update patient’s mobility chart, local post fall checklist, and any other site-specific communication tools, as per local guideline/policy.

Discharge planning

- Ensure the history and management of the inpatient fall and falls risk is handed over and included on transfer and discharge documentation.
- Identify post-discharge rehabilitation and falls-prevention needs, completing timely referrals and handovers to appropriate local community services (including Physiotherapy, Occupational Therapy, Nursing, and Falls Clinics or as outlined as per local services discharge).

Further information is available at Appendix 4.

Pharmacy post fall guidelines

Introduction

Medications are recognised as a major contributor to falls, and pharmacists can play an active role in reviewing medication regimens to optimise therapy and minimise the likelihood of further falls.[9] Pharmacist-led medication reviews have an important role to play in improving prescribing safety. Medication reviews focused on falls prevention involve striking a balance between minimising medicines associated with falls and effectively treating medical conditions. This includes taking a comprehensive approach to reviewing the patient's clinical condition, screening for medications most likely to be implicated, and collaborating with Medical Officers (MO), patients and their caregivers to implement interventions to reduce the risk of falls and harm from falls.[9,10]

Pharmacists should review patients within two working days of a fall, which may occur in person or via remote review or telehealth. Pharmacists should also, if possible, attend the post-fall huddles (if facilities undertake these).

Please see Appendix 5 for resources that may assist pharmacists in their medication reviews.

Initial assessment and review

The initial assessment will consist of a clinical review covering at a minimum:[9-11]

- Review of patient's current clinical condition, medication and local falls risk assessment and plan.
- Review of documentation related to the patient's clinical condition at the time of the fall.
- Review of potential issues regarding falls-related medication management.
- Assessment for pharmacokinetic and pharmacodynamic medication interactions that could be contributing to increased falls risk:
    - Medications directly contributing to falls such as side effects of a medication, for example orthostatic hypotension, sedation, impaired balance/coordination/reaction time, cognitive changes, hypoglycaemia, or hypotension secondary to levodopa administration.
    - Medications indirectly contributing to falls such as symptoms of under- or un-treated conditions, for example tremor secondary to sub-optimal medication regimen in Parkinson's disease.
- Assessment of appropriateness of medication management for complications associated with the fall:
    - Bone integrity, including fracture and bone density (assess vitamin D and calcium status/consider supplementation).
    - Pain management.
    - Bleeding risk and anticoagulation management.
    - Fear of falling associated with medications.
    - Anticholinergic burden.[12]

The initial assessment and clinical review should include screening to determine the appropriateness and clinical need for a comprehensive falls medication review and be documented in the health care record of the patient.[10]

Comprehensive medication review

If a comprehensive medication review is needed, pharmacists may do this at the time of initial review or within two working days of the fall. Referral may alternatively be made for a timely medication review in the community, dependent on appropriateness and availability of services. The comprehensive medication review should include:

- Consideration of the patient's clinical condition, medication plan, and potential falls-related medication issues.[9-11] The approach outlined for 'the initial assessment and review' may guide this.
- Meaningful engagement with the patient or carers to guide recommendations if possible.[13]
- Development of appropriate evidence-based recommendations to the patient's medication plan.
- Communication of relevant changes to the medication plan to the MO, General Practitioner, patient, or carer, etc. documenting in health care record and educating of the patient or carer on medication self-management strategies.[10]

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Acknowledgements: WA Post Fall Guidelines Review Working Party

Name		Position	Facility	Health Service
Lead for WA Post Fall Guidelines Review Working party				
Su	**Kitchen**	**Clinical Nurse Consultant Falls Management**	**SCGOPHCG**	**NMHS**
Section Leads highlighted in bold				
Subgroup Working Parties				
Post fall care protocol (this also includes all members of the working party)				
Su	**Kitchen**	**Clinical Nurse Consultant**	**SCGOPHCG**	**NMHS**
Linda	Page	Regional Clinical Practice Improvement Coordinator	WACHS	WACHS-WB
Wendy	Singleton	Deputy Director of Nursing Inpatient Services	SJOG Murdoch	SJOG
Occupational Therapists				
Kristie	**Harper**	Research Coordinator | Occupational Therapy	**SCGOPHCG**	**NMHS**
Carli	Breur	Acting Senior Occupational Therapist	FSH	SMHS
Prue	Colkers	Occupational Therapist	FSH	SMHS
Ashleigh	Southall	Senior Occupational Therapist	Merredin	WACHS-WB
Katherine	Flett	Senior Occupational Therapist	Albany	WACHS-GS
Penn	Herbert	Occupational Therapist	FSH	SMHS
Ashleigh	Maconachie	Acting Senior Occupational Therapist	FSH	SMHS
Samantha	Williamson	Occupational Therapist	Geraldton	WACHS-MW
Nicky	Young	Senior Occupational Therapist	SCGOPHCG	NMHS
Physiotherapists				
Sandy	**Dumas**	Physiotherapy Head of Department	FSH	SMHS
Lisa	Campbell	Senior Physiotherapist	FH	SMHS
Alvin	Correia	Physiotherapist	RGH	SMHS
Jess	Davies	Physiotherapist Falls Specialist	OPH	NMHS
Madi	Rangaiah	Physiotherapist	SCGH/FSH	NMHS/SMHS
Chelsea	Schapel	Physiotherapist	Carnarvon	WACHS- MW
Pharmacists				
Julie	Lin	Pharmacist	SCGH	NMHS
Karolina	Golebiewski	Pharmacist	GLH	NMHS MH
Alix	Makrides	Clinical Pharmacist	OL	NMHS MH
Medical				
		Expert opinion sought, multiple sources.		
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Abbreviation Key to Health Services, Hospitals, and Districts			
AHC	Albany Health Campus	**OPH**	Osborne Park Hospital
CHC	Carnarvon Health Campus	**RGH**	Rockingham General Hospital
DOH	Department of Health WA	**SCGOPHCG**	Sir Charles Gairdner & Osborne Park Care Group
FH	Fremantle Hospital	**SCGH**	Sir Charles Gairdner
FSH	Fiona Stanley Hospital	**SJOG**	Saint John of God Health Care
GLS	Graylands Hospital	**SMHS**	South Metropolitan Health Service
GS	Great Southern	**SW**	South West
MH	Merriden Health Service	**WACHS**	Western Australian Country Health Service
MW	Mid-West	**WB**	Wheatbelt
NMHS	North Metropolitan health Service		

Appendices

Appendix 1: WA Post Fall Guidelines: Definitions and explanatory notes

Definition of a Fall

A fall is defined as **an event which results in a person coming to rest inadvertently on the ground or floor or other lower level**. Falls, trips, and slips can occur on one level or from a height[7] This includes:

- All syncopal events.
- Controlled falls (the patient has not been expected to fall and required assistance to ensure safety to a lower level).
- Rolls out of bed (equipment and bed safety require review, patients should not be rolling out of a bed to a lower level).
- Patient is suspected of having put themselves on the floor.

Falls Risk Assessment Tool: This is a document that is used to screen for a patient's risk of falling, identify their risk factors and may include interventions to reduce those risks. These will vary and it is essential to use the one guided by local policy

Working Day: Any day that is not a public holiday or Saturday or Sunday

Procedure	Definition
Notify Next of Kin (NOK). Refer to local 'Open Disclosure' policy.	Notification of the patient's NOK of any unplanned event that results in or has the potential to result in injury is to occur as soon as possible following the event or within 4 hours of occurrence.
Reassess falls risk status Complete the Falls Risk Assessment (as per local guideline) and refer to relevant staff, for example Physiotherapist, Occupational Therapist, and Pharmacist, 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 and delirium 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 MO and Senior Nurse when a patient falls.	To continue post-fall management of the patient, all staff need to be aware of the fall and the new interventions put in place.

Interpreter to be utilised where appropriate. Communication with the patient/carer/family is to be adapted to meet individual health literacy needs. Cultural needs and preferences must also be considered.	Interpreter use will assist in increased communication with the patient re: the fall and ongoing risks/treatment and reassurance. Where possible, prior to involving family/carers, obtain patient consent that they agree to this intervention. Information and discussion with patient/carer/family must be delivered in a manner that meets their health literacy, any learning disabilities, and/or cultural needs. Partnership with the patient is required to develop plan of care.
Reviews by other relevant staff are recommended. This includes: • Physiotherapist within 2 working days post fall. • Occupational Therapist within 2 working days post fall. • Pharmacist review within 2 working days post fall.	This will assist in identifying further risk factors and interventions required to reduce the risk of falls, harm from falls and changes in cognition. Reviews are undertaken according to local policy.

Appendix 2. Medical Post Fall Assessment Proforma

The clinical assessment of a patient post fall needs to be thorough to ensure that the patients' injuries are identified and treated, that risk factors for further falls are considered and mitigated as far as possible.[13] Junior or inexperienced doctors often undertake this assessment.

The proforma below has been developed to assist in guiding a complete and comprehensive assessment of the patient post fall that meets the best practice guidelines within the Post Fall Multidisciplinary Management Guidelines for Western Australian Care Settings 2023.

The template is currently being utilised in hospitals in Western Australia.

The template may require adaption to suit different specialties.

More information and the template can be obtained via Falls.ManagementWA@health.wa.gov.au.

Date and time of assessment: **Date and time of fall:**

Was the fall witnessed or unwitnessed:

Critical injuries (consider signs of head injury, skull fracture, hip fracture, C-Spine exam): IMMOBILISE IMMEDIATELY

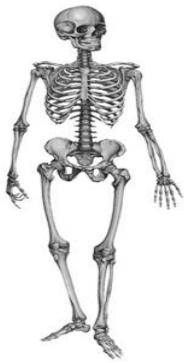
Does the patient meet MET criteria		Yes	No	If Yes- call MET now		
Did they hit their head		Yes	No	Unknown		
Does the patient report pain	**Hip**	Yes	No	**Neck:**	Yes	No
Explain:						
Current observations	HR:	BP:	RR:	SpO2:	Temp:	
Is cognitive impairment present	Yes	No	If yes: new / pre-existing / uncertain			
Neurological Examination	GCS:		AMTS 4 (age, DOB, place, year) score = /4			
External evidence of head injury	Yes	No	Describe:			

Pupil size/reactivity	**Eye ROM**	**Facial symmetry**	**Speech**

	Left Upper Limb	**Right Upper Limb**	**Left Lower Limb**	**Right Lower Limb**
Power				
Sensation				

ECG Results:		Coagulopathy	Yes	No
• On warfarin or other anticoagulants (heparin, enoxaparin, dabigatran, rivaroxaban, apixaban etc)			Yes	No
• On antiplatelet medication (Aspirin, Clopidogrel, Ticagrelor, Dipyridamole etc)			Yes	No
• Dual antiplatelet therapy (Aspirin and Clopidogrel)			Yes	No

Musculoskeletal Assessment (Tenderness/Range of Movement)

Cervical Spine: Thoracic /lumbar spine:		Facial Bones:
Wrist: Elbow: Shoulder:		Ankle: Knee: Hip/pelvis:

Can the patient walk free of pain post fall?	Yes	No
If yes, document why the patient cannot be walked		

Assessment: What was the patient attempting to do at the time of the fall? Contributing factors for the fall:			
Injuries sustained:			
Superficial injuries (bruises, cuts etc.) :			
Investigations ordered:			
CT Head (+/_ neck): *See post fall guidelines for indications*		Yes	No
Time/Date of review: Results:			
X-Rays:		Yes	No
Time/Date of review: Results:			
Blood tests:		Yes	No
Time/Date of review: Results:			
Patients Medical Team notified of the fall		Yes	No
Patient cleared to mobilise	Yes / No	Review post Xray/CT	
Goals of Care checked/reviewed		Yes	No
Initial Management Plan -			
i.			
ii.			
iii.			
iv.			
v. Stop & consider whether patient has an underlying delirium or sepsis			
vi. Consider withholding anticoagulants if head injury likely. Speak to senior doctor			
Name: (print):	**Name:** (sign)		
This is an initial assessment only. If you are concerned, or if the clinical condition changes from the above assessment, please contact the medical team immediately			
Patients team RMO to complete the next working day: Checklist of Falls Management			
Any urgent investigations to follow up?	Yes	No	Results:
Hospital fall is to be documented on discharge summary	Yes	No	
Postural drop >20mmHg) present?	Yes	No	If yes: Management?
Patient on medication that causes sedation. *(e.g., Temazepam, Oxazepam, Diazepam etc)*	Yes	No	If yes to these, slowly wean if appropriate
Patient on anti-psychotics? *(e.g., Risperidone, Haloperidol, Olanzapine etc)*	Yes	No	
If patient is at risk of low Vitamin D, has the level been checked?	Yes	No	Already on Vitamin D Yes/No
Is the patient delirious?	Yes	No	
Does the patient have dementia?	Yes	No	
Name (Print):	**Name** (Sign):		

Appendix 3: Occupational therapy supporting information

These guidelines direct your intervention following an inpatient fall. The role of the Occupational Therapist is to undertake an analysis of the fall and identify targeted interventions to address risks relevant to key Occupational Therapy areas comprising of ADL, vision, cognition, and the environment. These risk factors and interventions are evidence-based and aim to reduce the risk of falls and harm from falls.

3.1.1. Occupational therapy: Activities of daily living (ADL)

Risk factors for falls	Recommendations

• Decreased independence with Personal ADLS (PADL):
  o Showering.
  o Dressing.
  o Toileting.
  o Grooming.
  o Eating.
  o Transfers in ADL context.
• Incontinence/urgency/ nocturia.
• Decreased standing balance in functional activity.
• Pain/ fatigue/ breathlessness when participating in PADL.
• Postural hypotension.
• Impact of high-risk medication, polypharmacy, or medication changes on function.
• Low haemoglobin/blood related disorders.
	<u>Occupational Therapy-Specific Interventions:</u>
	• Work with the patient to locate and keep frequently used items within reach to prevent awkward postures.
	• Patient may sit whilst dressing/showering and provide or educate regarding small aids.
	• Encourage use of grab rails in the bathroom and educate regarding the benefits and purpose of the rails.
	• Educate patient, staff, and family/carer about the need for urinal bottle or commode chair to be within reach at bedside.
	• Educate and support patient to negotiate regular toileting plan with nursing staff.
	• Determine required assistance and/or supervision with PADL (identify which PADL tasks need to be addressed).
	• All patients and their carers should be provided with written and verbal falls prevention education.
	• Grade and adapt functional activity that the patient is completing as appropriate to reduce hospital functional decline and manage falls risk.
	• Educate about and facilitate non-pharmacological symptom management, for example fatigue management, energy conservation, stress management.
	• Encourage patient to dress in own clothing. Ensure clothing and footwear are well-fitting and appropriate for the ward setting. Educate in dressing strategies that are safe and promote independence.
	• Provide written and verbal education addressing identified falls risks and consider use of a falls management action plan.

3.1.2. Occupational therapy: Effects of vision on ADL

Risk factors for falls	Recommendations
• Visual Impairment (for example visual field loss, macular degeneration cataracts, diabetic retinopathy, glaucoma). • Visual-perceptual issues/changes. • Wearing glasses (bifocal/multifocal).	<u>Occupational Therapy-Specific Interventions:</u> • Ensure patient's own glasses are available in hospital for use. • Minimise bed moves to retain familiar environment. • Position frequently used objects close by patient's visual field. Work with patient to determine optimal position. • Educate patient to request frequently used objects be repositioned in the same place. • Remove clutter and obstacles from room. • Allow patient adequate time to adjust to lighting changes before engaging in ADL. • Educate patients of risk when using bifocal and multifocal glasses i.e., increased time taken with visual adjustment and impacting vision with steps, etc. • Ensure visual impairment sign above bed. • Facilitate orientation of patient to time and place through environmental prompts and/or daily prompts from staff and family.

3.1.3. Occupational therapy: Cognition

Patients with cognitive impairment are at risk of falls. If cognitive impairment is suspected, a cognitive assessment is recommended to help identify any impairments that may impact on the patient's function. Please follow the local area guidelines/policy regarding cognitive review/assessment. Consider an assessment if delirium is present and escalate as appropriate to medical team for review.

Risk factors for falls	Recommendations
Acute/short-term diagnosis (contributing to admission and causing cognitive impairment): • Delirium, encephalopathy, post-ictal, acute vascular event or stroke, concussion. **Chronic/long-term diagnosis** (may not be reason for admission, but cognitive impairment may be pre-existing): • Past stroke, acute brain injury/traumatic brain injury, dementia diagnosis (Lewy body, Alzheimer's disease, Vascular dementia, Fronto-temporal dementia), past neoplasm, intellectual impairment, alcohol-related brain impairment, neurodegenerative disease, for example Multiple Sclerosis, Parkinson's disease. **Mood:** • Depression, anxiety, bipolar, schizophrenia, mental health issues affecting cognition. **Behaviour:** • Wandering, restlessness, agitation, aggressive. • Fear of falling/loss of confidence.	<u>Occupational Therapy-Specific Interventions:</u> • Orientation to and assessment of call bell use and provision of alternative as required. • Reorientation: calendar, environmental prompts, clocks, day clothes, use of 'sunflower' tool. • Encourage patients to use sensory aids. • Investigate and prompt usual ADL routines: when/how do they shower/dress, usual toileting/nocturia practices, usual meal routines. • Communicate patient routine to all staff with timetable at bedside. • Educate and work in partnership with patient and family to address cognitive issues, their impact on falls risk and strategies that can be put in place. Provide written education. • Advise Multidisciplinary Team as appropriate on individualised falls risk factors, for example need for environmental signs, regular checks on patient, and call bell use. • Determine if assistance and/or supervision with PADL (specify which tasks require assistance). • Minimise bed moves to ensure consistent environment. • Ask family to bring in familiar items for the patient, for example pillow, blanket, and clothes. • Set up inpatient environmental signage to label commonly used areas, such as the toilet, shower, etc. • Address fear of falling, consider further assessment (Falls Efficacy Scale International) and intervention (education, grading activity, follow-up care).

3.1.4. Occupational therapy: Environment

Risk factors for falls	Recommendations
• Patient out of immediate sight of nursing staff (single room or away from nursing station). • Distracted or coerced by others within shared room. • Difficulty managing distance from bed to bathroom. • Inability to re-locate own bed within shared room. • Difficulty locating commonly used areas, for example toilet, sink, shower. • Clutter around bed space or within corridors. • Inappropriate bed or chair height. • Over bed/bedside table too high or low for use by patient. • Inappropriate lighting/lack of control over lighting. • Poor floor surface integrity. • Floor surface hazards, for example spills, water, food. • Pressure reduction (for example alternating air), mattress impacting on ability to transfer. • Commonly used items not within reach. • Use of unfamiliar equipment i.e., commode rather than over toilet frame. • Foot stool in environment.	<u>Occupational Therapy-Specific Interventions:</u> • Negotiate moving patient to visible area or shared room if required. • Negotiate moving patient to bed space near bathroom to assist with access and orientation. • Provision of clock and/or calendar to assist with orientation to date and time. • Clearly label bed space with patient's name and use belongings to make it a familiar space. • Check patient equipment needs in room and bathroom removing unnecessary or unfamiliar pieces to reduce clutter. • Check heights of equipment and ensure seat heights are between 100 to 120% of floor to knee height when patient's feet are flat on the ground. • Set up appropriate inpatient environment signage labelling commonly used areas (patient bed space, and bathroom/shower/toilet). • Adjust or replace over bed/bedside table to ensure appropriate height. • Review appropriateness of bed rail. • Ensure patient can reach and use available light switches. • Inform shift coordinator/nursing manager if repair of the floor surface is required. • Ensure floor surface is clean and dry. • Ensure static setting used for transfer on/off alternating air mattresses. • Keep frequently used items within reach. • Educate regarding need to position frequently used objects within patient's visual field or positioned in the same place.

Appendix 3.2: Occupational therapy: A sticker for patient's health care record

Actual size 13cm x 10cm.

Occupational Therapy Inpatient Falls Assessment and Intervention Summary	
Identify	3pt ID confirmed: ☐
Situation (details of fall, time location and mechanism)	Date of fall: Informed by: Ward: _____ _____
Observations:	Clearance to mobilise from medical team: Y ☐ N ☐ Current Function:
Background (Previous Falls Hx)	Previous Falls Hx: _____
Assessment (falls risk factors)	ADLS (including impact of vision): _____ _____ Cognition: _____ _____ Environment: _____ _____
Recommendations (OT specific falls prevention interventions)	_____ _____ _____ _____ _____ Falls education provided with: _____ Further OT input required: _____ Name: Signature: Date: Page:

Further details and template can be obtained via
Falls.ManagementWA@health.wa.gov.au

Appendix 4: Physiotherapy: Supporting information and resources

Appendix 4.1 post fall guidelines cue card

These are pocket size and can be put with your ID badge for handy reference

POST FALL PHYSIOTHERAPY GUIDE
1. R/v within 2 working days post fall 2. Medical team clearance to mobilise verbally or documented 3. Comprehensive Physio Ax and Mx of falls risk patient (flip lanyard) **4. Document:** - Previous level of mobility - Clearance to mobilise - Assessment findings: - Current mobility status - Mobility chart completed - H/o mobility & falls risk relevant to MDT/Nursing - Provided patient/carer education - Individualised fall prevention strategies 5. Fall risk on h/o and consider referral to OP falls clinic 6. Liaise with Nursing staff re: updates on local falls risk Ax document/commence post fall protocol/checklist REFER TO POST FALL PHYSIOTHERAPY GUIDELINES AS NEEDED

ASSESSMENT & MANAGEMENT FOR FALL RISK PATIENTS
ASSESSMENT 1. Fall history and post fall details 2. Review imaging 3. Determine previous level of mobility 4. Identify fall risk factors 5. Objective- balance, vestibular, strength, mobility as indicated 6. Monitor & report changes in cognition or pain **INTERVENTION** 1. Eliminate/control fall risk factors 2. Prescribe Walking aid if needed 3. Update Mobility chart & check falls risk sign above bedside. 4. Commence Post Fall Checklist as per local policy 5. H/o fall risk & mobility to relevant to MDT/Nursing 6. Patient/carer edn re: mobility status & fall prevention recommendations 7. Individualised interventions commenced and education documented on local Falls Risk Ax document. 8. Post D/c referral for falls Mx. 9. Document all the above.

Further details and template can be obtained via
Falls.ManagementWA@health.wa.gov.au

Appendix 4.2. Physiotherapy: Post fall documentation guide

The below are guides/proformas to assist with assessment and documentation of a patient post fall that meets these guidelines. These include **ISOBAR** and **SOIER.** Please refer to guideline for prompts as needed.

<table>
<tr><th colspan="2">PHYSIOTHERAPY POST FALL ISOBAR</th></tr>
<tr><td>Identify</td><td>3-point identification (Name, DOB, and address)</td></tr>
<tr><td>Situation</td><td>Date of Fall: Informed by:
Details of Fall:

Reason for Admission:

Medical review post fall: Yes/ No
Cleared to mobilise: Yes/ No
Details of Fall:</td></tr>
<tr><td>Observations</td><td>Imaging results:
Other relevant investigation results:
Cognition: (Consider AMT 4)
Delirium present: Yes/ No
Observations:</td></tr>
<tr><td>Background</td><td>Significant PMHx:

Preadmission mobility including walk aids, mobility, and levels of function:

Pre fall mobility:

Home environment:</td></tr>
<tr><td rowspan="2">Comprehensive Objective Assessment:</td><td>Identify risk factors (Consider below)</td></tr>
<tr><td>• Age> 65
• Acute medical condition Behaviour e.g., wandering/impulsive
• Cognition Impairment/Dementia
• Environment/ lighting
• Footwear
• Incontinence
• Malnutrition
• Medications: Polypharmacy>5 medications/psychoactive/other
• Alcohol and other drug use
• Past medical history
• Previous falls
• Vision impairment
• Other (state)

Current mobility:
• Bed Mobility:

• Sit to stand:

• Ambulation:</td></tr>
</table>

	Falls Risk Status: Balance assessment as appropriate: Sitting Balance: Standing Balance: Other relevant outcome measures:
Physiotherapy Interventions:	Interventions included: • Mobility review and walk aid provision: • Falls education provided to patient and carers: • Handovers provided to nursing and other staff: • Falls Risk Management plan and mobility charts updated and falls risk updated: • Other
Recommendations:	Mobility recommendations: Falls Risk status is: Falls education provided to patient and carers: Handovers provided to nursing and other staff: • Follow up Physiotherapy is required: • Post discharge falls prevention and management plan and handovers include:

PHYSIOTHERAPY POST FALL SOIER	
	Seen by PT for post-fall review. 3-point ID checked. Consent obtained. **PC:** Date of Fall: Informed by: Medical review post fall: Yes/ No Cleared to mobilise: Yes/ No Details of Fall: Reason for Admission: Imaging: **Significant PMHx:** **Preadmission function/mobility:**
Subjective	History of fall obtained from patient/caregiver:
Objective **(Comprehensive Objective Ax)**	Cognition: Observations/Cardiovascular/respiratory status: Current mobility: • Bed Mobility: • Sit to stand: • Ambulation: • Balance assessment as appropriate • Other: Falls risk status:
Intervention	1. Mobility review and recommendations: 2. Interventions include:

<table>
<tr><td></td><td>3. Falls education provided to patient and carers:

4. Handovers provided to nursing and other staff:

5. Falls Risk Management plan and mobility charts updated and falls risk sign displayed:

6. Other</td></tr>
<tr><td rowspan="2">Evaluation:</td><td>Identify risk factors (Consider below)</td></tr>
<tr><td>• Age> 65
• Acute medical condition Behaviour e.g., wandering/impulsive
• Cognition Impairment/Dementia
• Environment/ lighting
• Footwear
• Incontinence
• Malnutrition
• Medications: Polypharmacy>5 medications/psychoactive/other
• Alcohol and other drug use
• Past medical history
• Previous falls
• Vision impairment
• Other (state)
Falls Risk Status:</td></tr>
<tr><td>Review</td><td>1. Follow up Physiotherapy is required:
2. Post discharge falls prevention and management plan and handovers include:</td></tr>
</table>

Appendix 5: Pharmacy post fall assessment

These are suggested resources for pharmacists.

5.1 Medication-related Falls Risk Assessment Tool (MFRAT)[15]

The table below enables the categorisation of falls risk that is related to medication use. It provides recommended actions to be considered because of the categorisation.

Abbreviations: FRIDs= Falls Risk Increasing Drugs; QUM = Quality Use of Medicines

<table>
<tr><th>Risk category</th><th colspan="3">Identification criteria</th><th>Action required</th></tr>
<tr><td>High</td><td colspan="3">Patient's FRAT category indicates at high risk of falls

AND

The patient is prescribed (or has had temporarily withheld during hospital admission)
2 or more FRIDs.</td><td>Referral for a hospital- based medication review. Other further medication-related interventions may also be appropriate.</td></tr>
<tr><td>Moderate</td><td>Patient's FRAT category indicates at high risk of falls

AND

The patient is prescribed (or has had temporarily withheld during hospital admission)
1 FRID.</td><td>OR</td><td>Patient's FRAT category indicates low or no risk of falls

AND

The patient is prescribed (or has had temporarily withheld during hospital admission)
2 or more FRIDs.</td><td>Medication-related interventions such as medication review may be appropriate.</td></tr>
<tr><td>Low</td><td colspan="3">The patient is NOT on any FRIDs
(nor is any FRID on a temporary withheld medication list).</td><td>Non-medication-related interventions for falls reduction may still be applicable.</td></tr>
<tr><td colspan="5">FRIDs include medicines causing adverse effects such as postural hypotension, drowsiness, dizziness, blurred vision, or confusion. See accompanying table for a list of medicines commonly associated with falls risk.

If further risk stratification is required due to limited resources for intervention, the addition of risk factors such as frailty, age over 75 years, previous ADR, recent and/or frequent hospitalisation may be added to the risk assessment.

NSW TAG QUM Indicator 8.2 provides further information about identifying risk of and preventing medication-related falls in older hospitalised patients (https://www.nswtag.org.au/polypharmacy-qum-indicators-and-resources/).

Acknowledgment: NSW Therapeutic Advisory Group</td></tr>
</table>

5.2 Common Falls Risk Increasing Drugs (FRIDs)

This list is not exhaustive. Please consider consulting other medication reference texts.

Due to the differences in firewall restricitions across the state many staff may be unable to follow the links provided below. So, it is advised that all disciplines use the Australian Medicines Handbook (July 2022 edition) to access the information required on the below medications.[16]

More information can be found at https://www.nswtag.org.au/polypharmacy-qum-indicators-and-resources/

<table>
<tr><th colspan="4">Psychotropic medicines</th></tr>
<tr><td>Antidepressants</td><td>• Monoamine oxidase inhibitors
• SSRIs
• SNRIs
• Other antidepressants
• Tricyclic antidepressants
• Comparative adverse effects</td><td>Antipsychotics</td><td>All

Comparative adverse effects</td></tr>
<tr><td>Anxiolytics/ Sedatives/ Hypnotics</td><td colspan="3">• Benzodiazepines
• Z-drugs
• Other: Suvorexant</td></tr>
<tr><th colspan="4">Cardiovascular medicines</th></tr>
<tr><td>Antiarrhythmics</td><td>• Amiodarone
• Digoxin
• Flecainide
• Sotalol</td><td>Antihypertensives</td><td>• ACE inhibitors
• Sartans
• Beta-blockers
• Calcium channel blockers
• Thiazide & Related Diuretics
• Other antihypertensives
  • Clonidine
  • Methyldopa
  • Prazosin</td></tr>
<tr><td>Heart failure medicines</td><td>• Aldosterone antagonists
• Loop diuretics
• Other HF medicines
  • Ivabradine
  • Sacubitril with valsartan
  • Sodium-glucose co-transporter 2 inhibitors - Australian Medicines Handbook (health.wa.gov.au)</td><td>Nitrates and other vasodilators</td><td>• Nitrates
• Pulmonary hypertension medicines
• Other vasodilators</td></tr>
<tr><th colspan="4">Other medicines</th></tr>
<tr><td>Anticholinergics</td><td>• Numerous drugs have anticholinergic effects
• Hyoscine (butylbromide & hydrobromide)
• Inhaled bronchodilators</td><td>Antihistamines</td><td>• Sedating antihistamines
• Less sedating antihistamines</td></tr>
</table>

Parkinsonism Medicines	• Dopamine agonists
	• Monoamine oxidase type B inhibitors
	• Anticholinergics
	  •Benzatropine
	  •Trihexyphenidyl
		Opioids	All, alone or in combination

Beta-blocker eye drops	• Betaxolol • Timolol	**Genitourinary**	• Selective alpha blockers • Phosphodiesterase inhibitors • Anticholinergics
Hypoglycaemics	• Sulfonylureas • Insulins • Sodium-glucose co-transporter 2 inhibitors - Australian Medicines Handbook (health.wa.gov.au)	**Other**	• Prochlorperazine

***Alcohol can depress the central nervous system and the effects may be increased if taken with drugs with similar effect. Alcohol can interact with a range of medicines and increase unwanted side effects, including higher risk for falls.**

5.3 STOPPFall (Screening Tool of Older Persons Prescriptions in older adults with high fall risk) [16]

There can be a reluctance to deprescribe FRIDs and the above study considers that a lack of skills and knowledge can form a barrier to deprescribing. To support clinicians, the STOPPFall deprescribing tool was developed through a Delphi process. This is comprehensive, practical, and recommended for use by global researchers in the World Guidelines for Falls.[7] Please refer to the tables below.

Deprescribing guidance for STOPPFall items			
	Fall-risk assessment: In which cases to consider withdrawal?	**Is stepwise withdrawal needed?**	**Monitoring after deprescribing**
Always	• If no indication for prescribing		• Fall incidence and change in symptoms e.g., OH, blurred vision, dizziness • Organise follow-ups on individual basis
Benzodiazepines (BZD) and BZD-related drugs	• If daytime sedation, cognitive impairment, or psychomotor impairments • In case of both indications: sleep and anxiety disorder	In general, needed	• Monitor: anxiety, insomnia, agitation • Consider monitoring: delirium, seizures, confusion
Antipsychotics	• If extrapyramidal or cardiac side effects, sedation, signs of sedation, dizziness, or blurred vision • If given for BPSD or sleep disorder, possibly if given for bipolar disorder	In general, needed	• Monitor: recurrence of symptoms (psychosis, aggression, agitation, delusion, hallucination) • Consider monitoring: insomnia

Opioids	• If slow reactions, impaired balance, or sedative symptoms • If given for chronic pain, and possibly if given for acute pain	In general, needed	• Monitor: recurrence of pain • Consider monitoring: musculoskeletal symptoms, restlessness, gastrointestinal symptoms, anxiety, insomnia, diaphoresis, anger, chills
Antidepressants	• If hyponatremia, OH, dizziness, sedative symptoms, or tachycardia/arrhythmia • If given for depression but depended on symptom-free time and history of symptoms or given for sleep disorder, and possibly if given for neuropathic pain or anxiety disorder	In general, needed	• Monitor: recurrence of depression, anxiety, irritability, and insomnia • Consider monitoring: headache, malaise, gastrointestinal symptoms
Antiepileptics	• If ataxia, somnolence, impaired balance, or possibly in case of dizziness • If given for anxiety disorder or neuropathic pain	Consider	• Monitor: recurrence of seizures • Consider monitoring: anxiety, restlessness, insomnia, headache

Deprescribing guidance for STOPPFall items: Continued			
	Fall-risk assessment: In which cases to consider withdrawal?	**Is stepwise withdrawal needed?**	**Monitoring after deprescribing**
Always	• If no indication for prescribing		• Fall incidence and change in symptoms e.g., OH, blurred vision, dizziness Organise follow-ups on individual basis
Diuretics	• If OH, hypotension, or electrolyte disturbance and possibly if urinary incontinence • possibly if given for hypertension	Consider	• Monitor: heart failure, hypertension, signs of fluid retention
Alpha-blockers (AB) used as antihypertensives	• If hypotension, OH, or dizziness	Consider	• Monitor: hypertension • Consider monitoring: palpitations, headache
AB for prostate hyperplasia	• If hypotension, OH, or dizziness	In general, not needed	• Monitor: return of symptoms
Centrally-acting antihypertensives	• If hypotension, OH, or sedative symptoms	Consider	• Monitor: hypertension
Sedative antihistamines	• If confusion, drowsiness, dizziness, or blurred vision • In case of all indications: hypnotic/sedative, chronic itch, allergic symptoms	Consider	• Monitor: return of symptoms • Consider monitoring: insomnia, anxiety

Vasodilators used in cardiac diseases	• If hypotension, OH, or dizziness	Consider	• Monitor: symptoms of Angina Pectoris
Overactive bladder and incontinence medications	• If dizziness, confusion, blurred vision, drowsiness, or increased QT-interval	Consider	• Monitor: return of symptoms
Abbreviations: BPSD = Behavioural and Psychological Symptoms of Dementia; OH = Orthostatic Hypotension			

Other resources

Deprescribing tools - NSW Therapeutic Advisory Group (nswtag.org.au)

An online interactive version of the STOPPFall deprescribing tool may be available (depending on setting): https://www.eugms.org/research-coope ration/task-finish-groups/frid-fall-risk-increasing-drugs.html

Appendix 6: Interprofessional post fall assessment

Interprofessional post fall assessment is where instead of individual physiotherapy and occupational therapy reviews of the patient; one discipline completes the assessment for both disciplines**.**

This has been mostly developed by Fiona Stanley Hospital, and many resources are available on the WA Health Post Fall Website.

Please ensure that Fiona Stanley Hospital is acknowledged if any of the materials are utilised. For copyright permission/concerns please contact via email address below

Further details can be obtained via
Falls.ManagementWA@health.wa.gov.au

Appendix 7: Post fall multidisciplinary huddle / safety huddles

The following information is a guide only, identified from literature and experiences of inpatient facilities across Western Australia (WA) that have implemented this practice. It includes a brief background, example of the process, team members, and a checklist that can aid the discussion and tools that may assist with documentation.

WA facilities who have already implemented Post Fall Multidisciplinary Huddles (PFMH) are happy to share their experiences and lessons learned. Details can be obtained from Falls.ManagementWA@health.wa.gov.au

Background

PFMH is a recommended and structured format where staff gather to discuss a patient fall.[7] 'It is a professional dialogue after an event that focuses on performance standards and enables team members to identify what happened, why it happened, and how to prevent future incidents.'[17] Patients and families are also involved where possible. This continues to demonstrate the partnership between health professionals and patients/families/carers.

The multidisciplinary (MD) team receive immediate communication and feedback regarding the incident, identify interventions to reduce the risks and ensure implementation of these. While comparable to MD meetings, the distinction is that only **one** patient is the focus, and it is brief.[17]

Staff can perceive increasing awareness, team collaboration, and encourage a culture of increased efficiency and planning.[18,19] Team effectiveness can also expand by >20% by utilising this process.[17]

Complex health care facility systems can impede the ability to deliver reliability in the PFMH.[20] Challenges include added pressure on staff time but following the embedding of the practice, the challenges reduce.[18,19] Senior leadership is key to success.[17]

Purpose of PFMH: [17]

- Improve patient outcomes (reducing falls risk, risk of injuries, falls and injuries), and promote improved quality of optimal care provision.
- Increase/enhance MD communication/collaboration post fall.
- Clarify safety concerns.

- Identify interventions required.
- Identify referrals required.
- Develop an individualised plan of care for the patient.
- Identify barriers to progress and create strategies to address these barriers.

Process

Ideally, the PFMH should take place as soon after the fall as possible; however, this is often impractical. It is suggested that the PFMH needs to take place within 24 hours of the fall, at a time that is considered appropriate for each area (depending on area/facility and local policy).

It is not considered appropriate to be part of the patient journey meetings but as a separate focus and kept as brief and succinct as possible. Length of time will vary due to the complexity of the patient health situation and the fall, but the recommendation is to keep the PFMH to less than ten minutes.

- PFMH members include as a minimum (where possible):
    - Clinical Nurse Specialist/Clinical Nurse Manager/Shift Coordinator.
    - Physiotherapist.
    - Occupational Therapist.
    - Pharmacist.
    - Medical Officer from treating team.
    - Primary nurse during that shift.
    - Other (consider patient).
- The PFMH team choose the lead.
- Gather in an identified area, preferably the patient bedside if deemed appropriate.
- Discuss the fall, with the team and patient, identifying the contributing factors and interventions to be implemented by the MD team.
- It is essential to ensure full support for the patient/family/carer during the discussion.
- The huddle leader has the responsibility to keep the huddle short and focused, ensuring each necessary topic is discussed.[17]
- The Lead of the huddle documents the results in the patient's health care record along with allocated interventions.
- All handovers are to include interventions employed.
- Patient and family advised of the outcome, if possible, by a previously identified MD team member present at the huddle.
- Interventions are allocated to appropriate team members.
- The Lead will need to follow up to ensure implementation of interventions has occurred.

Consider the following questions:

1. Risk Factors:

    - Did we know the patient was at risk?
    - Has the patient had a previous fall while in hospital?
    - Were minimum interventions in place?
    - If interventions were selected on the Falls Risk Assessment Tool, were they in place?
2. Establish what patient and staff were doing and why:
    - What was the patient doing at the time they fell?
        - Be specific, for example transferring, going to the bathroom.
        - Ask why multiple times.
    - What were the staff caring for the patient doing when the patient fell?
        - Ask why multiple times.
3. Determine underlying root causes of fall:
    - What was different this time compared to other times when patient was engaged in the same activity?
        - Ask why multiple times.
4. Interventions for implementation:
    - How could we have prevented this fall?
    - What changes made in the patient's plan of care will decrease the risk of future falls?
    - What patient or system problems require communication to other departments or disciplines?

Outcomes

- Decrease in falls rates (this may not occur immediately but as the practice is embedded).
- Decrease in injuries from falls.
- Increased patient satisfaction.
- Increased staff satisfaction.
- Increased skills in the analysis of falls and identification of further interventions.

7.1: Examples of post fall management huddle (PFMH) documentation tools for the patient's health care record

Interprofessional Post Fall Huddle Plan	
Staff/patient present:	
Patient/family present:	
Fall Date and Time:	**Location:**
Two main contributing factors to the fall:	
Recommendations and Interventions with name of professional to complete this:	
Referral and Assessments required:	
Medical **o** SRN **o** Physio **o** OT **o** Pharmacy **o** Falls CNC **o** Other **o** Falls screen, risk and assessment updated correctly	
Signature: **Name and Designation: Date:**	

Acknowledgements: Sir Charles Gairdner Hospital, Osborne Park Hospital, Western Australia Country Health Services

MDT Falls Prevention Plan

People present:

Fall Date and Time:

Location:

Recommendations/Interventions

Updated: FRAT ☐ Nursing Care Plan ☐ Mobility Chart ☐ Individualised Care Plan ☐ Education to patient/family/carer ☐

Date: Name/Signature:

Acknowledgements: Osborne Park Hospital

Further Resources

- WA Post Fall Multidisciplinary Management Guidelines and Tools
- NSW Clinical Excellence Commission Safety Huddles

Further details and templates can be obtained via
Falls.ManagementWA@health.wa.gov.au

Appendix 8: Clinical incident investigation templates

Clinical incident reporting is an integral part of the organisation's commitment to improving patient outcomes and provision of a high-quality service. The principal objective is to limit potential or actual incident/event consequences and reoccurrence and manage risk to the organisation. To be effective, clinical incident management requires a "whole of organisation" approach that fosters a "no blame" reporting culture.

Staff are to follow the West Australian Clinical Incident Management Policy[21] and local area policy. WA Health provides a Clinical Incident Management Toolkit[22] and guidelines[23] that will assist in an investigation and developing suitable recommendations. It is strongly recommended that all staff involved in incident investigation have reviewed them.

Many facilities and areas will often have their own template to utilise for clinical investigation of falls. The following is an example that guides staff through the investigation of a fall incident, to identify contributory factors and make recommendations that address any system issues identified to prevent recurrence. It is available for use and is suitable for adaption to suit all areas/facilities.

Event Description – Clinical incident

Date of fall		Time	

Keep the description concise and factual.
What was the patient's activity at the time of the fall?
Recent relevant results, i.e., bloods, urine, vital signs, etc.
Any factors that may have increased risk of fall, i.e., recent bed move, low Hb, change of condition, etc.
Describe the fall.
Describe the location and any features of the location that may have contributed to the fall.
Was the fall witnessed by (designation)?
Observations immediately post fall including outcome if known.
Describe the outcome for the patient and any intervention required because of the fall including increased length of stay.

Patient information

Admission date and diagnosis	Age	
Co-morbidities		
Acute admission	Yes	No
Residential care	Yes	No
Community care	Yes	No

Risk Assessment

Falls Screen and Assessment Tool (local tool) complete	Yes		No
Falls Screen and Assessment Tool (local tool) is up to date (updated per screening criteria)	Yes		No
Identified as high falls risk	Yes		No
Falls risk documented in Nursing Care Plan	Yes		No
Shift handover identified high falls risk	Yes	No	N/A
All appropriate strategies to reduce falls risk implemented and documented in care plan	Yes		No
If no explain			
All minimum standards in place – refer to Falls Screen and Assessment Tool (local tool)	Yes		No
If "No", explain:			

Risk factors

Medications known to increase falls risk	Yes		No
Recent changes to medications	Yes		No
Recent change in condition	Yes		No
Evidence of infection	Yes		No
Recent change to cognitive state	Yes		No
Recent delirium screen	Yes		No
Recent change of location	Yes		No
If "Yes", was patient oriented to new location?	Yes	No	N/A
Restraint in use	Yes		No
If "Yes", explain:			
Mobility issues	Yes		No
Mobility aids used appropriately	Yes		No
Suitable level of supervision in place	Yes		No
If "No", explain:			
Continence issues	Yes		No
Recent changes to vision	Yes		No
Visual aids used appropriately	Yes		No
Footwear was appropriate	Yes		No
Environment	Yes		No
If "No", explain:			

Post fall intervention

Initial and focused assessment documented	Yes	No
Medical Officer notified	Yes	No
Medical Officer review in timely manner (as per local policy)	Yes	No
Post fall observations attended as per procedure	Yes	No
Appropriate investigations undertaken in timely manner	Yes	No
Appropriate treatment/transfer in timely manner	Yes	No
Fall screen, risk assessment (local tool) and care plan updated	Yes	No
Adequate handover to clinician/service accepting care	Yes	No
Occupational Therapist, Physiotherapist and Pharmacist notified within 2 working days	Yes	No

Consumer/patient consent

Family/carer notified	Yes	No
Open disclosure commenced with patient/family/carer	Yes	No
Consumer advised and informed of treatment, medication	Yes	No
Risks and benefits discussed including risk of receiving no care or treatment	Yes	No
Alternatives to treatment discussed	Yes	No
This discussion regarding treatment is documented	Yes	No

Identified issues/contributing factors

Causal Statement

Start with the root cause, add the immediate contributing factor/s and then state the result.

Recommendations – Specific, Measurable, Accountable, Realistic, Timely

Write specific, clear recommendations, and assign them to an accountable person.

Outcome Measures

How will you know that there has been an improvement? Outcome measures must have a reporting structure to monitor the progress of implementation.

Check for strength of recommendations	
Stronger Actions Eliminate (Highest Effect)	**Intermediate actions – Control (Intermediate Effect)**
Architectural/physical plant changes	Increase in staffing/decrease in workload
New device with usability testing	Software enhancement/modifications
Engineering control (forcing functions)	Enhanced documentation/communication
Simplify a process and remove unnecessary steps	Checklist/cognitive aid/clinical pathway
Standardise equipment and processes	Eliminate look and sound likes
Tangible involvement and action by leadership in support of patient safety	Eliminate/reduce distractions (sterile medical environment)
Weaker actions – Accept (Lower Effect)	Read back all actions
Double checks	
Warnings and labels	
New procedure/memorandum/policy	
Training and/or additional study/analysis.	
Acknowledgements: West Australian Country Health Service, Safety and Quality Unit.	

Appendix 9: Auditing questions

Each health service/facility may have adapted the Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings and thus the auditing will vary. Below are suggestions of auditing questions for each discipline.

Nursing

1. Date and time of fall recorded in patient health care record. YES / NO / NA
2. Minimum interventions completed as applicable? YES / NO / NA
   i.e., baseline observations, neurological observations, blood glucose level, ECG, cognitive impairment screening using theAMT4 / 4AT / CAM
3. Patient moved correctly depending on injury and manual handling policy? YES / NO / NA
4. Next of Kin notified within four hours of the fall? YES / NO / NA
5. Falls Risk Assessment (local tool) rescreened within six hours of the fall? YES / NO / NA
6. Multidisciplinary Post Fall Huddle took place within one working day of the fall? YES / NO / NA
7. Prior to the fall had a falls risk assessment been completed YES / NO / NA

Physiotherapy

1. Was the patient reviewed by a physiotherapist within two working days following their fall? YES / NO / NA
2. Was the patient cleared to mobilise by the medical team prior to the physiotherapist review? YES / NO / NA
3. Was education provided to the patient and/or carer regarding their falls risk and falls prevention strategies? YES / NO / NA
4. Was there a referral for follow up completed upon discharge? YES / NO / NA

Occupational therapy

1. Was the patient referred to Occupational Therapy post inpatient fall? YES / NO / NA
2. Was the patient seen within two working days of the inpatient fall by an Occupational Therapist? YES / NO / NA
3. Has at least one risk factor and one intervention been identified and documented by an Occupational Therapist in the post fall assessment? YES / NO / NA

Pharmacy

1. Was a pharmacist involved in reviewing the patient's medication regimen within two working days of a fall occurring? YES / NO / NA
2. Was there any documented evidence of pharmacist review and communication of suggested interventions to other healthcare professionals and patients/carers? YES / NO / NA

Medical

1. Is there documentation of hip examination? (For example, comment on position of leg (not shortened, externally rotated), hip movement, hip tenderness, or bruising) YES / NO / NA
2. Is there documentation of assessment for head injury? (For example did they hit their head, evidence of head bruising or laceration, assessment of mental state, assessment for focal neurological signs). YES / NO / NA
3. Was the patient assessed within 4 hours of falling? (aim for 90% compliance with this) YES / NO / NA

General – all disciplines

1. Is it documented that the patient/family/carer received information (customise to local practice for example received a certain booklet) about the fall:
    a. Nursing? YES / NO / NA
    b. Occupational Therapists? YES / NO / NA
    c. Physiotherapist? YES / NO / NA
    d. Medical? YES / NO / NA

Reviews

These guidelines will be reviewed and evaluated as required to ensure relevance and currency. This policy will be reviewed within the maximum time frame of three years.

Version	Effective from	Effective to	Amendments
1.0	2015	2018	Original version
1.01	2018	2021	Updated guidelines
1.02	2023	2026	Updated Guidelines

The review table indicates previous versions of the policy and any significant changes.

This document can be made available in alternative formats on request for a person with disability.