Keeping older people safe in our care

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NSW Falls Prevention Program
Clinical Excellence Commission
September 2017
NSW has over 7.7 million people over an area three times the size of the United Kingdom.
### The NSW public health system is world class
It is the largest public health system in Australia

- **7.7 MILLION** NSW residents on 809,444 SQ. KM
- **230** Hospitals
- **1.9 MILLION** Inpatient Episodes
- **111,000** Dedicated FTE Staff
- **2.7 MILLION** Emergency Department Attendances
- **$20.7 BILLION** 2015-16 Budget
- **963,562** Ambulance Emergency Responses
- **218,942** Planned Surgical Cases Performed
- **16,208** CompCare Home Packages Delivered to Patients Being Discharged From Hospitals

### The NSW community

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>25.6%</td>
<td>Are 19 and under</td>
</tr>
<tr>
<td>35.6%</td>
<td>Live in regional or remote areas</td>
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<tr>
<td>31.4%</td>
<td>Were born overseas</td>
</tr>
<tr>
<td>14.7%</td>
<td>Are 65 and over</td>
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<tr>
<td>2.9%</td>
<td>Are of Aboriginal and Torres Strait Islander descent</td>
</tr>
<tr>
<td>24.5%</td>
<td>Households where two or more languages are spoken</td>
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2015/16
Calls for falls to ambulance = 97,572
median 8,131 /month
Fall-related hospitalisations by sex, persons of all ages and 65 years and over, NSW 2001-02 to 2014-15
Fall-related injury hospitalisations by sex, Overnight stay, persons of all ages and 65 and over, NSW 2001-02 to 2014-15

Rate per 100,000 population

2002-03 to 2014-15:
- Males, 65+: rising trend
- Males, All ages: rising trend
- Females, 65+: rising trend
- Females, All ages: rising trend

INICAL CELLENCE IMMISSION
Fall-related hip fractures in people 65 and over: hospitalisations by sex, NSW 2001-02 to 2014-15

Rate per 100,000 population


Males, Fall-related hip fractures
Males, Total hip fractures
Females, Fall-related hip fractures
Females, Total hip fractures
Quarterly fall rate per 1,000 hospital separations by sub-category, NSW public hospitals, 65 years and over

- Intracranial injury
- Fractured neck of femur
- Other fractures
- Total falls

Intracranial injury: 0.2
Fractured neck of femur: 0.4
Other fractures: 0.6
Total falls: 1.0

Fall rate per 1,000 separations

- Jul-Sep 2015: 1.8
- Oct-Dec 2015: 1.6
- Jan-Mar 2016: 1.4
- Apr-Jun 2016: 1.2
- Jul-Sep 2016: 2.0
- Oct-Dec 2016: 1.8
- Jan-Mar 2017: 1.6
Figure 11 and 12: Falls by SAC1 & SAC2 and SAC3 & SAC4, July 2012 - December 2016

Caveat:
* SAC1 data obtained from CEC RIB database, SAC2-4 data obtained from IIMS
IMS Data


- 09.00 – 10.30
- 13.00 – 14.30
- 16.00 & 18.00
KEY FINDINGS THIS YEAR INCLUDE:

74% OF HOSPITALS REPORTED HAVING A HIP FRACTURE PATHWAY. 51% ACROSS THE WHOLE ACUTE HIP FRACTURE PATIENT JOURNEY AND 23% IN THE EMERGENCY DEPARTMENT ONLY.

56% OF HOSPITALS RESPONDED THAT THEY HAD A PATHWAY FOR PAIN MANAGEMENT IN HIP FRACTURE PATIENTS. 36% ACROSS THE WHOLE ACUTE PATIENT JOURNEY AND 20% IN THE EMERGENCY DEPARTMENT ONLY.

60% OF HOSPITALS REPORTED A DAILY ORTHOPAEDIC SERVICE FOR OLDER HIP FRACTURE PATIENTS. 32% UTILISING A DAILY GERIATRIC MEDICINE LIASON SERVICE. 24% UTILISING A SHARED-CARE ARRANGEMENT WITH ORTHOPAEDICS. AND 4% UTILISING A MEDICAL LIASON SERVICE FOR DAILY REVIEW.

27% OF HOSPITALS REPORTED PROVIDING WRITTEN, INDIVIDUALISED INFORMATION ON DISCHARGE THAT DESCRIBES ONGOING PATIENT CARE AND THE GOALS OF THIS CARE, AND RECOMMENDATIONS FOR PREVENTION OF FUTURE FALLS AND FRACTURES.

33% OF HOSPITALS REPORTED THEY HAD ACCESS TO A FRACTURE LIASON SERVICE (FLS) FOR THE SYSTEMATIC IDENTIFICATION OF FRACTURE PATIENTS WITH THE PURPOSE OF PREVENTING FURTHER FRACTURES.

OF THE 2041 PATIENTS FOLLOWED UP AT 120 DAYS, 21% AND 23% OF PATIENTS IN NEW ZEALAND AND AUSTRALIA RESPECTIVELY ARE REPORTED AS HAVING RETURNED TO THEIR PRE-FRACTURE MOBILITY AT 120 DAYS AFTER PRESENTATION TO HOSPITAL.

OF THOSE WHO TRANSITIONED FROM HOSPITAL CARE, AND WERE FOLLOWED UP AT 120 DAYS, 81% AND 76% OF PATIENTS IN NEW ZEALAND AND AUSTRALIA RESPECTIVELY, HAVE RETURNED TO THEIR OWN HOME AT 120 DAYS.

82% AND 77% OF PATIENTS IN NEW ZEALAND AND AUSTRALIA, RESPECTIVELY, ARE REPORTED AS BEING OPERATED ON WITHIN 48 HOURS OF PRESENTATION TO HOSPITAL.

90% AND 89% OF PATIENTS IN NEW ZEALAND AND AUSTRALIA, RESPECTIVELY, ARE OFFERED THE OPPORTUNITY TO MOBILISE ON THE FIRST DAY AFTER SURGERY.

95% OF HIP FRACTURE PATIENTS HAVE UNRESTRICTED WEIGHT-BEARING IMMEDIATELY AFTER HIP FRACTURE SURGERY.
From the patient’s perspective

- Don’t kill me
- Don’t harm me
- Don’t do things that cannot help me
- Reliably do things that can help me
- Relieve my pain – physical and emotional
- Don’t make me feel helpless
- Share information
- Don’t make me wait
- Don’t waste money
Clinical Excellence Commission

The Clinical Excellence Commission promotes and supports best practice clinical care, safety and quality across the NSW health system by:

• conducting high-level analysis and reviews that identifies risks and opportunities for improvement

• providing expert support, advice, tools and information

• working collaboratively with patients, clinicians, managers, health service partners and the broader community.
Building blocks

- Learning organisation: building capability by training in leadership and quality improvement
- Real time data for improvement
- Development of high reliability patient care teams to improve culture
- Ward based essentials of safety
- Moving from projects and programs to systems of care
- Statewide systems for incident monitoring and intelligence
Care of the older person in hospital

- Quality markers: **falls**, cognition, continence, pressure care, medications and nutrition
- Integrated approaches to care
- Caring environments – design

Leadership and Culture - Facilitators for success

- **Boards**: leading through strategic direction, governance, risk management, financial and quality and safety

- **Executive**: building capability and supporting frontline teams in improvement – whole of hospital targeting

- *Engagement with patients, families and carers*

- **Expert clinical/improvement leads and teams**: nursing, medical and allied health improve clinical processes

- **All ward staff**: practice reliable falls prevention/care
Risk factors for falls

Medical Conditions
- Stroke
- Incontinence
- Parkinson’s disease
- **Dementia**
- **Delirium**

Medications
- Psychoactives
- Polypharmacy

Psychosocial & Demographic
- History of falls
- **Depression**
- Advanced age
- Living alone
- ADL limitations
- Female gender
- Inactivity
- Poor nutrition

Sensorimotor & Balance
- Muscle weakness
- Impaired vision
- Reduced peripheral sensation
- Poor reaction time
- Impaired balance

Environmental
- Poor footwear
- Home hazard
- External hazard
- Inappropriate spectacles

Neuroscience Research Australia 2012

Falls
CEC support

What are the contemporary skills required to deliver safe care?

Reliable & sustained interventions

- Cognitive impairment – dementia /delirium
- Mobility – safe mobilisation
- Medication review, reconciliation and reduction
- Intentional Rounding /toileting plan
- Multi-disciplinary team collaboration
- Huddles/team talks and clinical handover
Falls in hospital

Falls Prevention in Hospitals

Patient on admission in Hospital
- Falls Risk Screen: Ontario Modified Stratify (Sydney Scoring)
  - Complete on all patients within 24 hours of admission
- No Falls Risk
  - Continue with admission
- Falls Risks Identified
- Long Stay Patients/Residents
  - On admission & at a minimum 6 monthly or change of patients condition
- Falls Risk Assessment and Management Plan (FRAMP)
  - Identify Fall risks in FRAMP and choose relevant interventions, implement and document
- Engage with Patient/Family/Carer
  - Provide patient/carer with falls prevention information
  - Engage patient/carer in development of the care plan and provide information
- If Patient Falls
  - Post Fall Management
    - Use CEC Post Fall Guide
    - Complete and document all interventions

Serious Incident Investigation
- SAC 1 - Follow RCA guidelines
- SAC2 or repeat fall
  - Complete SAC2 Falls Incident Investigation form
  - Clinical team will be formed
  - Fall to be investigated & recommendations implemented

Discharge and Refer
- Ensure GP, family/carer, RACF and other relevant care providers are informed of:
  - Patients falls risks
  - Interventions
  - Recommendations for further assessment

Consider referrals to falls prevention exercises:
- www.activeandhealthy.now.cov.ca
- Tai Chi, Stepping On, Occupational Therapist/Physiotherapist groups, Otago

Fall Risk Screen

Fall Risk Assessment & Management Plan

Improving communication

Clinical Handover
Few people with dementia are admitted for dementia-related reasons

Common reasons for admission are:

- **Falls-related injuries** e.g. hip fractures & head injuries (3 times as common)
- **Infections** e.g. UTIs, pneumonia
- **Circulatory problems** e.g. stroke, dehydration
ACI Aged Health Network

Key Principles for Care of Confused Hospitalised Older Persons

**Key Principles for Care of the Confused Older Hospitalised Person**

1. **Principle 1: Cognitive screening**
   - Patients aged 65 years and over will be screened for confusion on admission or within 24 hours of admission using a validated screening tool.

2. **Principle 2: Delirium risk identification and prevention strategies**
   - Older people will be assessed for delirium risk.
   - Interventions will be put in place for prevention of identified risks.
   - Identified risks will be communicated to the older person, their carer, family and staff involved in their care.

3. **Principle 3: Assessment of older people with confusion**
   - Older people who are confused will be assessed.
   - The cause of their confusion will be investigated to determine the appropriate management.

4. **Principle 4: Management of older people with confusion**
   - NSW hospitals will have programs in place for older people with confusion that align with these principles.
   - The implementation will be in partnership with the older person, their carer and family.

5. **Principle 5: Communication processes to support person centred care**
   - Communication processes and tools will support person-centred care for the older person throughout their hospital journey and at their transfer of care to the community.

6. **Principle 6: Staff education on caring for older people with confusion**
   - Staff are supported through training, education and leadership to enable them to deliver skilled, timely and knowledgeable care to the older person with confusion.

7. **Principle 7: Supportive care environment for older people with confusion**
   - NSW hospitals will provide a supportive care environment for the older person with confusion.
1st April 2015

APRIL FALLS DAY

Don’t let confusion cloud the risk of falls

Patients with Dementia and/or Delirium are at higher risk of falls

If your patient becomes more confused e.g. sudden, fluctuating changes of confusion, increased agitation, disorientation or changes in levels of consciousness

Be alert to DELIRIUM
Recognise and Respond

Falls Prevention is everyone’s business

Is my patient more confused?

YES

NO

A patient with confusion is a high fall risk

Be alert to DELIRIUM
Recognise and respond to patients with dementia

What is the clinical cause of confusion?

? UTI / infection

? Dehydration

? Constipation / urinary retention

? Post anaesthetic

? Acute

Temperature, pulse, BP are Vital Signs

Level of cognition is a Vital Sign

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

Be alert to DELIRIUM
Recognise and respond to patients with dementia / delirium
Why are confused older people falling?

Environment is different from home
Post Fall

Immediate response
(Assessment & observations)

Ongoing observations & monitoring

Communicate

Document

Key conditions to be on alert for:
- Delirium
- Head injury – monitor patients on anticoagulants
- Sepsis

Post Fall Huddles
**SAFETY HUDDLE – PREVENTING FALLS**

**INFORMATION FOR CLINICIANS & HEALTH PROFESSIONALS**

<table>
<thead>
<tr>
<th>Safety Risks</th>
<th>Things to consider</th>
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<tbody>
<tr>
<td>Which patients are at risk of fall?</td>
<td>Have interventions been implemented e.g. regular mobility plan, toileting plan, medication review</td>
</tr>
<tr>
<td>Which patients have confusion?</td>
<td>Has a cognition and delirium screen been attended?</td>
</tr>
<tr>
<td>Has a delirium screen been attended?</td>
<td>Note: Delirium is identified as a medical emergency</td>
</tr>
<tr>
<td>Has the patient been reviewed?</td>
<td>Has a clinical review been conducted?</td>
</tr>
<tr>
<td>Common causes of delirium include: infection (including UTI), constipation, dehydrated, pain etc</td>
<td></td>
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<tr>
<td>Note that patients who are sleepy/not eating/not drinking could have a delirium and will require special care needs in regards to eating and drinking – regular prompts to take fluids and toileting (rather than being left in incontinence pads).</td>
<td></td>
</tr>
<tr>
<td>Which patients have mobility issues?</td>
<td>What mobility requirements do they have? e.g. referral to P/T, level of assistance required, staff available to assist patient to meet their personal care needs</td>
</tr>
<tr>
<td>Has the patient been up and mobilising with assistance (rather than resting in bed waiting for the P/T)?</td>
<td></td>
</tr>
<tr>
<td>Which patients have had a fall in our care in the last 24hrs?</td>
<td>Has a post fall huddle been attended and care plan reviewed and implemented?</td>
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**IMPROVING PATIENT CARE THROUGH SAFETY HUDDLES**

Safety Huddles are brief, focused and structured to share information about potential or existing safety risks which may affect patients, staff and any person accessing the healthcare environment.

**What do Safety Huddles Look Like?**
- They are held at a consistent time
- Safety Huddles are brief, 5-10 minutes
- They are performed standing to assist with focus and efficiency
- There is a designated leader
- A unit-specific standardized script and structure is followed
- A process for action is followed after the Safety Huddle
- All staff (clinical and non-clinical) are encouraged to speak up
- They are imprisonment-focused and non-judgmental

**Where Should a Safety Huddle be Held?**
In a central location which is convenient to all team members ensuring workflow is not obstructed and confidentiality is ensured.

**Who Should Attend a Safety Huddle?**
All staff involved in the care of patients, clinical and non-clinical, including: medical, nursing, allied health, pharmacists/medical, clinical support officers and security staff.

Develop Your Script: Addressing 3 Focus Areas

1. Look back - and ask:
   - “Over the last 24 hours what safety incidences occurred and have we prevented them from being repeated?”
   - Celebrate successes
   - “Have there been any compliments or good news stories?”

2. Look forward - and ask:
   - “What patient safety issues do we need to be aware of today that will distract us from patient care?”
   - “Are there any staff safety issues that need to be considered such as tasks posed by patients?”
   - In other words, what are the emerging threats?

3. Finalise:
   - Document and follow the unit-specific plan for follow-up of safety concerns
   - Assign accountability

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**About the NSW Falls Prevention Program**

The CEO’s Falls Prevention program aims to reduce the incidence and severity of falls among older people and reduce the economic and emotional impact of falls on individuals, families and the community. For further information, please visit: http://www.clinicalexcellence.health.nsw.gov.au

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**Clinical Excellence Commission**

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**For further information regarding Safety Huddles, the team would like to acknowledge the support of the Clinical Excellence Commission.**

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**Clinical Excellence Commission**

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If you think that your patients are at risk of falls, then they probably are.

Falls risk screens and assessments will help you to individualise care plans.

MOVING AROUND SAFELY IN HOSPITAL

INFORMATION FOR PATIENTS, FAMILIES AND CARERS

We want you to be as safe as possible in hospital.

During your stay, staff will talk to you about:
- your risk of falling
- how much assistance you need when you are moving around
- ways to prevent falls in hospital.

Falls in hospital

There are many reasons you may be at risk of falling in hospital:
- Being unwell and in an unfamiliar place
- Poor mobility and balance (unsafe when walking)
- Badly fitting footwear and clothing
- Poor eyesight
- Urgent need to go to the toilet
- Medications that cause drowsiness or dizziness.

Most falls in hospital happen when people are moving around, including:
- Getting out of bed
- Walking, especially to the toilet
- In bathrooms and toilets
- Bending over or reaching for personal items.

Please tell a staff member if:
- You are worried about falling
- You have had a recent fall or have had a fall in hospital before
- You feel dizzy or unwell
- You need help walking or with things like showering and dressing
- You have problems with your balance
- You need to go to the toilet urgently
- You don’t feel safe or comfortable moving around.

Tips for getting around safely:
- Check with a staff member if it is safe to move around on your own
- Use your call bell and keep it in easy reach
- Use a walking stick or frame if this has been recommended for you
- Wear supportive, non-slip shoes or slippers
- Get up slowly from sitting or lying down
- Be alert for any spills or obstacles.

Bathroom safety tips:
- A staff member may need to stay with you for your safety
- Sit down to shower and use the rails to get up off the chair or toilet
- Remain seated in the bathroom and use the call bell if you need help moving around.
Mobility Resources
Introduction to balance & strength exercises

Safe use of mobilising equipment

- Rollator Frames
  - YouTube video (high resolution)
  - Length 4:57

- Forearm Support Frame
  - YouTube video (high resolution)
  - Length 4:41

- Walking Stick
  - YouTube video (high resolution)
  - Length 5:33
Mobility Resources

**MOBILITY TERMINOLOGY GUIDE**

**ASSISTANCE**
The patient requires hands-on assistance from one or two staff, guiding, touching, and/or slight lifting in order to move safely.

**STAND-BY ASSISTANCE**
Stand directly next to the patient at all times and be ready to assist.

**SUPERVISION**
The patient is not likely to require any hands-on help but may require prompting.

**INDEPENDENT**
The patient requires no supervision or assistance. They are physically set up to perform tasks safely on their own. A walking aid may be used.

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**BED MOBILITY**

**SIT-TO-STAND**

**WALKING**

**PERSONAL CARE AND TOILETING**

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Don’t leave the patient alone in the bathroom including toileting and showering. Clinical judgement is required.

Adapted with permission from Auckland District Health Board (ADHB), NZ.
GIVE IT A GO! GUIDE
HELP YOUR PATIENTS TO MOBILISE SAFELY

The patient is able to follow simple commands or gestures and is willing to participate.

- [ ] YES
- [x] NO

Can the patient change position or move around in bed?

- [ ] YES
- [x] NO

Can the patient safely sit on the edge of the bed?

- [ ] YES
- [x] NO

Can the patient safely stand upright?

- [ ] YES
- [x] NO

Can the patient lift one foot off the ground and then the other?

- [ ] YES
- [x] NO

Give it a go!
Mobilise right to stay upright.

CONSIDERATIONS
• The patient’s pain and need for analgesia.
• If progression is still not possible, reposition the patient in bed.
• Transfer for toileting and sitting out of bed may be possible using an appropriate mechanical device.
• Referral to physiotherapy and pressure relieving devices – seek advice.

These steps should not replace your own clinical reasoning or judgement.
Evaluation of Falls in Hospital - KPI

- Triple aim - improved patient and staff experience, outcomes (health of the public) and efficiency & effectiveness of care

- LBVC KPI: Aim: 5% reduction in hospital falls leading to intracranial injury, fractured neck of femur or other fracture per 1000 occupied bed days (ACSQHC Hospital Acquired Complication data set)

- From July 2018 ? no funding for Hospital Acquired Complications including from falls in hospital
Falls in Hospital
Timeline 2017/18

Other Workshops being held in 2017:
- 24th August - Mental Health and Falls Prevention
- 20th October - Aged Care Collaborative Forum
- 23rd October – Delirium Master class: Professor Sharon Inouye
- November – MNCLHD Rural Forum
- December – MLHD Rural Forum
CEC support


- Clinical practice improvement, basic and advanced measurement techniques and tools
- Includes training for staff on screening and assessment for falls risk, clinical team communication and teamwork and medication safety and reconciliation
Care of the older person in the community

Opportunistic case finding in primary and secondary care settings

- Older people in contact with health professionals are to be asked routinely whether they have had a fall in the past year and observed for balance and gait deficits – regardless of the health care setting in which they present.

- And are to be offered interventions to manage fall risk and in particular where they will benefit from balance and strength training as appropriate.

- Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance are to be offered multifactorial fall risk assessment & individualised interventions.
FROP-Com Fall Risk Screen

Falls Prevention for Community Care Settings

LOW RISK
Score: 0 - 3
- Discuss & provide fall prevention resources
- Notify GP of any fall risk factors e.g. Poor balance, mobility, medication issues

Problem with Balance and/or Mobility?
Referral to Physiotherapist, Exercise Physiologist and/or GP

Problem with ADL, home environment or functional issue?
Referral to Occupational Therapist and/or GP

FROP-Com Fall Risk Screen
Plan of care developed in consultation with Patient/Client or family carer

Conduct or refer for a multifactorial risk assessment:
- Cognitive Screen/Delirium screen
- Medication review
- Feet/foot pain and footwear
- Vision check or a referral for vision
- Vitamin D +/- Calcium
- Postural dizziness/postural hypotension
- Mobility
- Continence issues
- Nutrition status - under/overweight

Main concern balance related
Prioritise referral to Physiotherapist, Exercise Physiologist and/or GP for mobility/balance assessment

Main concern ADL/function related
Prioritise referral to Occupational Therapist and GP for ADL/functional assessment

Document Care Plan, actions and/or referrals made in patient notes

HIGH RISK
Score: 4 - 9

Fall risk assessment and intervention

Referral suggestions:
- General Practitioner
- Community Nurse
- Pharmacist
- ACAT
- Optometrist
- Podiatrist
- Dietitian
- Aboriginal Health
- Migrant health service
- Physiotherapist
- Occupational Therapist
- Continence Nurse
- Exercise Physiologist

*Research shows increasing balance and strength in lower limbs helps to prevent falls in over 65 year olds
**Active and Healthy website www.activeandhealthy.nsw.gov.au
Procedure Following a Fall

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

CLINICAL REVIEW - GP
Timely review of person by the General Practitioner

CALL AMBULANCE
Rapid Response: Dial Triple O (000)

If person requires basic life support
• Remain calm and reassure person and family members
• Immediate response: Apply DRSABCD (Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defibrillator if available)

Check for signs of injury
• Observe for unusual body posture, active bleeding, bruising, new pain, neurological signs
• Leg shortened, rolled outwards could indicate a broken hip
• Dilation/uneven pupils could indicate a fracture
• Bruising bleeding around the head could indicate concussion/hard injury
• Confusion: disorientation, agitation, restlessness and change in usual behaviour - could indicate head injury
• If the person is anti-coagulant? If yes - be alert for head injury, there is an increased risk of intracranial injury/internal bleeding
• If you have concern based on your clinical judgement, call for a clinical review/rapid response

Person has had a fall and is UNABLE to get to their feet/has an Injury/acute confusion and is unable to be treated and stabilised
• CALL an AMBULANCE Triple O (000)
• Take observations (BP, Pulse, Respiration, Neuro) if trained
• Contact support person and GP
• Make person comfortable and monitor for signs of shock or other change in condition
• DO NOT leave client unattended

Person is found on the floor - has no obvious injury and is able to get to their feet OR person reports that they have had a fall
• Where required assist person into a chair – as per procedure page 13 Staying Active and on Your Feet booklet or PCC Flyer How to get up from a fall
• Discuss the incident with the person and assess for any change in function (ACL/mobility)
• Contact person responsible or significant support person/carer - and if not available facilitate follow-up calls to check on condition
• Contact their GP to inform them of the fall and relay any relevant information
• Warn the person/family/carer of deferred signs - dizziness, blurred vision, headaches, confusion (disorientation, agitation, restlessness and changes in behaviour - be alert for head injury, sudden onset of pain or new pain, inability to weight bear
• Advise them to contact their GP and/or ambulance if any of these signs develop
• Gain consent from the person to make referrals to appropriate services for falls risk assessment and management if required
• Do not leave the person until stabilised, or, if possible, when a support person is with them

When you return to the office
• Complete an EMS report as appropriate
• Document actions/communicate fall information at Clinical Handover
• Make referrals to appropriate disciplines to conduct falls risk assessment and management

Information following a fall at home

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

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

After a fall, visit your GP to discuss:
• exercise that is best for you to reduce falls
• how to improve your mobility
• how to manage chronic health conditions
• your medications (that might lead to a fall)

Staying Active and on Your Feet booklet
• Health and lifestyle checklist
• How to get up from a fall
• Exercises to do at home
• Home safety checklist

For a copy of the booklet and to find an exercise program close to you
Visit: www.activeandhealthy.nsw.gov.au

Acknowledgement to Staying Active and on Your Feet booklet
2010 www.activeandhealthy.nsw.gov.au
Patients who are confused could fall when in hospital - Information for families and carers

People with confusion (memory or thinking problems) have an increased risk of falling when in hospital due to cognitive impairment, physical illness and being in unfamiliar surroundings. A patient's cognitive impairment may be due to dementia or delirium.

Did you know?
- People with dementia are at increased risk of a fall and developing delirium
- Delirium is common in older patients in hospital, and can lead to a fall

Dementia is a term for a number of conditions that affect memory, judgement, communication and the ability to carry out everyday activities. Alzheimer's disease is the most common cause of dementia.

Delirium is an acute condition and sudden. Patients may become agitated, disorientated or have changes in level of consciousness. Possible causes include: infection (including urinary tract infection), effects of medications, pain, dehydration, malnutrition, drug/alcohol withdrawal, urinary retention and constipation. Delirium can develop without dementia. Identifying delirium early, treating the cause, managing the symptoms and supportive care is very important to keep your family member safe.

Behavioural changes you may notice include:
- A change in “usual” behaviour
- Changes in sleep habits (awake during the night, sleepy during the day)
- Sudden onset of confusion, disorientation, forgetfulness, unable to pay attention, hyperactivity
- Agitation, sudden changes in emotions, feeling fearful or upset
- Short term memory loss
- Withdrawn, sleepy or unresponsive
- Hallucinations (seeing things that are not there)
- Changes to level of consciousness

How can you help?
Family members and carer may be in a better position to notice changes in behaviour and function. It is important to notify staff if you notice any change in “usual” behaviour.
OVER TOILET AID

These instructions are to be used in conjunction with the information that your Health Professional has discussed with you.

- An over toilet aid enables people who have difficulty getting on/off the toilet to do so safely and independently with a raised toilet seat and arms.
- They may be height adjustable.
- A ‘splash-guard” version is recommended for use by men to prevent urine from splashing on the floor.

TO INSTALL

- It is recommended that the OTA is height adjustable. The height should enable you to sit and stand with ease.
- To adjust the leg length, push the button in and slide the internal leg piece up or down to the appropriate notch. Your Occupational Therapist can advise you regarding the appropriate height.
- One leg has extra holes, which can be adjusted to help stabilise the OTA if the floor is uneven.

SHOWER CHAIR

These instructions are to be used in conjunction with the information that your Health Professional has discussed with you.

- A shower chair enables anyone who has decreased balance, physical strength or mobility difficulties to shower safely and independently while sitting.
- Shower chairs should have small seat drainage holes to minimise risk of genital entrapment. For chairs with larger drainage holes, a face washer, or towel can be placed on the seat to minimise this risk.

TO INSTALL

- It is recommended that the shower chair or shower stool is height adjustable. The height should enable you to sit and stand with ease.
- To adjust the leg length, push the button in and slide the internal leg piece up or down to the appropriate notch. Your Occupational Therapist can advise you regarding the appropriate height.
- One leg has extra holes, which can be adjusted to help stabilise the shower chair if the floor is uneven.

PRECAUTIONS & SAFETY

- Ensure that the shower surround is stable. It must not slide around when being used.
- Ensure that the toilet paper is easily reached.
- Ensure that you close both lids before you return to sit on the toilet, and push yourself up, so that the seat does not tip.
- MOPPING & CLEANING

- Ensure that the shower surround is clean. It must not be wet or dirty.
- Store all the equipment away from children and adults. It may be dangerous if left unattended.

Note: Plastic garden chairs are not recommended for shower use. This is due to poor strength and stability of the chair, size of drainage holes, non-adjustable in height and they may be considered a falls risk.
Patient, family & carer as integral team members

Refocusing care delivery around the patient improves the patient care experience & clinical & operational outcomes:

- **decreased adverse events** – including falls

36.4% reduction in falls by patients with dementia by the sixth month of using TOP 5

“We need to think of the patient and their family as integral members of the healthcare team. Once you’ve gotten mileage out of your systems, then the next level of improvement you can only do by engaging the patient”

Professor Tom Delbanco, Inaugural Chair, Picker Institute, BIDMC Physician, Boston Harvard Medical School
• Created by nurses at Guy's and St Thomas’
• Barbara's Story is a series of 6 films which has changed attitudes to dementia in hospitals across the world – see complete video at: http://www.guysandstthomas.nhs.uk/news-and-events/2014-news/20140331-barbaras-story-youtube.aspx
Patient stories

CEC YouTube VIDEOS

CEC - Falls Prevention - Suzanne Archer’s Fall Journey (Sep 2014)
Clinical Excellence Commission ⋅ 732 views ⋅ 2 years ago
Suzanne is an artist and shares her story following a fall at home.

Clinical Excellence Commission uploaded a video

CEC - Falls Prevention - Staying Active and Healthy (Oct 2013)
Clinical Excellence Commission ⋅ 646 views ⋅ 2 years ago
Home-based balance and strength exercises to help prevent falls.
As of 30 June 2017, there were 825 program providers & 850 exercise programs.

- 785 of these are registered as fall prevention programs &
- 65 are registered as general physical activity programs.

### Google Analytics

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<th>Metric</th>
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<td>Number of sessions</td>
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<tr>
<td>Percentage of sessions accessed in NSW</td>
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Promoting active communities – (to prevent falls)

www.activeandhealthy.nsw.gov.au

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

DVD Home – based exercises

Strength and balance exercises that can be completed in the comfort of your own home.

Visit www.activeandhealthy.nsw.gov.au for more information on these exercises
• **2038** Stepping On programs have been delivered throughout the state in more than **12 languages**

• **21,954** participants have completed the program as at (June 2017)

(Stepping On © Clemson & Swann)
Support to Rural Volunteers to deliver Tai Chi and Physical Activity Programs

NSW Health - get healthy
Healthy Older People Partnership (HOPP)  
Project—WSLHD  

(A Combined Government and Non-Government Services)

Choices: (Take your pick of programs below)

1 Staying Active & Healthy Information Sessions
- Free professional advice about the importance of balance and strength exercises and healthy eating in older people
- Covers gentle exercise and presentation
- Interactive session and free resources
- One off 45 minute session

2 Fit & Strong Challenge
- This Challenge is for you to complete at home
  - Complete 4 healthy activities
  - Be Active for 30 minutes a day
  - Do Strength & Balance exercises
  - Get Vitamin D (sunlight before 10am or after 3pm)
  - Adequate calcium (dairy) intake
- Complete a short survey pre and post Challenge
- Commitment for 4 weeks at home

3 Home Based Strength & Balance Program
- 4 specific exercises focused on strength and balance you can do in the privacy of your own home
- Exercises include heel raises, half squats, walking sideways and knee lift
- Monitored by carer and tailored to individual abilities

4 Stepping On Program
- Free evidence based program to reduce risk of falling and maximise independence
- Run by health professionals
- Learning with peers in non-threatening environment
- Learn about nutrition for stronger bones
- Gets results – 31% reduction in falls
- Note: Inclusion criteria applies
- 2 hour sessions over 7 weeks

Aim:
To improve your health and well-being by improving strength and balance to enable you to live independently in your own home.

For further information, Please contact Trish Nove on 9840 3630
Healthy Older People Partnership (HOPP) Project
(To improve Health, Strength & Balance of Older people in WSLHD)

NGO & Other Services Partnership Forum
(40 People attended)

Steering Committee

Members report to relevant management structure

Multicultural Sub Group
Strategies to put CALD on the Agenda

HOP Communication /Media Sub Group
Strategies to Promote and Advertise Project

Planning & Evaluation Sub Group
Overall Planning and Evaluation Framework

Individual Package Sub Group
Collaborate with Partners to Develop an Individual Package for Older people living more isolated in their homes
Oldest Flash Mob - Blacktown
Care of the older person in residential aged care

Vitamin D supplementation

Medication review

Multidisciplinary intervention
Professor Lindy Clemson

Engaging a whole primary care “village” to prevent falls: general practice, allied health and patients

Dr Amy Tan
Prof Lindy Clemson
Assoc Prof Lynette Mackenzie
The iSOLVE team

Professor Lindy Clemson

Dr Kim Delbaere

Standing Tall – home based exercise program

NSW Falls Prevention Network

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

http://fallsnetwork.neura.edu.au
Take home message

- We all have a role to play in **Keeping Older People Safe in Our Care**

- Looking for clinical improvement in how we provide this care and work together

- Acknowledgement the great work already underway in this region
Thank you

Questions

For further information:

lorraine.lovitt@health.nsw.gov.au

www.cec.health.nsw.gov.au