Falls Ngā hinga



The information in this guide is accurate to the best of our knowledge as of June 2023.

Definition

A fall is any unintentional change in position where the person ends up on the floor or at another level lower than their previous position. It includes slips, trips and falls that occur while others are helping (World Health Organization 2021).

Key points

- Falls can indicate an underlying acute event, exacerbation of a chronic condition or frailty progress. Unwitnessed falls may be a syncopal event.
- Fall prevention programmes that address a range of different risk factors (multifactorial) can reduce the risk of falling and prevent many falls (Gulka et al 2020).
- Preventing and reducing the risk of falls is everyone's business. It includes individual and population approaches (Cameron et al 2018; Health Quality & Safety Commission 2022f).
- Post-fall assessment is an important part of reducing future falls for the individual (Health Quality & Safety Commission 2022e).

Why this is important

Falls are the leading cause of unintentional injury in older people and are often a consequence of frailty (Health Quality & Safety Commission 2022a, 2022b). They can result in significant injury, functional decline (often related to a loss of confidence) and death (Health Quality & Safety Commission 2022e).

Key point

• In aged residential care (ARC), residents most at risk of falling are those needing help to transfer, those with impulsivity and people new to the facility.

Implications for kaumātua*

A Māori world view of ageing is based on a strength rather than a deficit model. Traditionally, kaumātua have a lot of **mana** (are held in high esteem).

Kaumātua may experience a sense of <u>whakamā</u> (shame, embarrassment) about their changing mobility and loss of independence. To avoid burdening others, they may not disclose falls, deny mobility challenges or be reluctant to use mobility aids or accept help.

^{*} Kaumātua are individuals and their connection with culture varies. This guide provides a starting point for a conversation about some key cultural concepts with kaumātua and their whānau/family. It is not an exhaustive list; nor does it apply to every person who identifies as Māori. It remains important to avoid assuming all concepts apply to everyone and to allow care to be person and whānau/family led.

If you encounter these kinds of responses, try reframing the situation to reflect a strength-based perspective (focusing on abilities, not deficits). An approach such as the following may be helpful.

We know how important your independence is to you and we would like to support you to be independent for as long as possible. We also want you to have everything you need to keep yourself safe. Would you like to try this (mobility aid) to see if it helps you feel more comfortable/steady?

<u>Whānau</u>/family can be a useful source of valuable, culturally informed (mana-enhancing) interventions as they are invested in keeping their loved one safe. Involve them in care planning wherever possible.

See the Guide for health professionals caring for kaumātua | Kupu arataki mō te manaaki kaumātua for more information.

Assessment

Standard falls risk assessment tools are available (see your facility's policy or procedure). However, almost all people living in ARC are at risk of falling (Health Quality & Safety Commission 2022c).

Treatment

At the individual level

- Focus on identifying and managing the individual's risk of falling (physical environment and holistic).
- Provide strength, balance and gait training. Research shows it reduces the overall number of falls and fall events in people who have repeated falls in ARC (Gulka et al 2020).
- For kaumātua, consider culturally relevant and appealing activities that improve strength, balance and gait. These may include **kapa haka** (Māori performing arts), **tītī tōrea** (Māori stick game) and activities that contribute to the community they live in.

At the population level

Implement a facility-wide falls prevention programme. As part of the programme, consider the built environment, equipment, staff education, exercise programmes and access to allied health professionals (Health Quality & Safety Commission 2022d).

Care planning

- 1. Plan individual care based on risks identified in falls risk assessment (see decision-support flowchart on the next page).
- 2. Optimise management of chronic conditions.
- 3. Remain alert for acute deterioration. (Falls can be a sign of acute deterioration.)

Decision support

Falls risk assessment (Cameron et al 2018; Health Quality & Safety Commission 2022c)

N	Assess risk of falling: ✓ on admission ✓ at routine reviews ✓ after fall event		 □ Standard falls assessment tools □ Everyone in ARC is at risk of falling
	Check for resident-centred risk (data collected in interRAI)		Non-modifiable ☐ Depth perception deficit ☐ Chronic conditions ☐ Impaired balance ☐ Impulsivity ☐ Severe dementia ☐ Functional disability ☐ Postural hypotension ☐ Bladder/bowel urgency ☐ Dehydration ☐ Toxin (ADE/alcohol) ☐ Vision, hearing
	Holistic considerations		For all
	Check for risks in the physical environment		Resident-related risks Footwear Clutter, other trip hazards Lighting/glare Personal items in reach Glasses, hearing aids Restraints Facility-related risks Clutter, other trip hazards Lighting/glare Proximity to toilet and staff Call bell location Room size function Furniture position, brakes
	₩		
	Assess and manage medication-related risks and benefits		Medication-related risks ☐ Psychotropics ☐ Diuretics and urgency - plan toileting resources ☐ Hypoglycaemics - monitor blood glucose ☐ PRN sedatives - minimise use ☐ Analgaesics - balance pain and sedation ☐ Recent changes - monitor for ADE
	Any new risks noted to		Potentially beneficial medication (discuss with prescriber) ☐ Alendronates for osteoporosis ☐ Vitamin D
	resident, environment or medication?		☐ Supplements for deficiencies
	Y V		Potential factors to include in care plan ☐ Physical activity (consider culturally relevant and appealing activities for kaumātua) ☐ Consider hip protectors ☐ Falls alerts in view ☐ Referral to specialist services
	Update care plan Update staff, resident, whānau/family Referral as required		

ADE = alcohol deprivation effect

ARC = aged residential care

PRN = as needed ('pro re nata')

Post-fall assessment (Hampshire County Council 2015; Health Quality & Safety Commission 2022e)

Resident falls or reports falling	If resident is still on floor: make comfortable (pillow, blanket, privacy) and assess before moving					
↓						
Gather history of fall from resident and eye witnesses	Fall incident history includes ☐ How and why they fell ☐ Whether they remember falling ☐ Trauma to head					
↓						
Primary survey	☐ Airway ☐ Breathing☐ Consciousness☐ ☐ Acute co☐ ☐ Bleeding ☐ Limb def	onfusion Head injury				
	☐ Bleeding ☐ Limb def	ormity Significant new pain				
▼						
Major injury? (found in primary survey)	 □ Do not move resident (except for CPR) □ Call 111 □ Vital signs and brief documentation of injury □ Contact NOK or EPoA □ Incident reporting 					
N						
Secondary survey	\square Bruising \square Wounds \square Mi	ld pain or discomfort 🏻 Swelling				
+						
Minor injury? (found in secondary survey)	 □ Reposition for comfort (hoist/mobility aids) □ Treat injuries and pain □ Vital signs and compare with baseline □ Incident reporting and notify NOK or EPoA 	with baseline				
	☐ GP/NP post-fall review	☐ Observe for 24–72 hours:				
	If resident has change in level of consciousness OR severe pain on standing OR refuses to stand, seek immediate GP/NP review					
N↓						
No physical injury detected	□ Alert □ No mobility changes	\square No pain or swelling \square No observable injury/wounds				
↓						
Consider holistic impact	- □ Whakamā (shame/embarrassment)	☐ Mana (dignity) ☐ Loss of confidence				
 Reposition for comfort (hoist/mobil Check vital signs and compare with Report incident and notify NOK or E GP/NP post-fall review Observe for 24-72 hours 	baseline PoA Review fa prevention	alls on strategies ite care plan				
If resident has change in level of consciousness OR severe pain on standing OR refuses to stand, seek immediate GP/NP review						
CPR = cardiopulmonary resuscitation						
	nurse practitioner	- ·				

References | Ngā tohutoro

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