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leading quality in community services

Falls Management in the Community

PRACTICE GUIDELINES

COMPETENCIES

SCOPE

This guideline applies to the provision of paid support services in the community. They are relevant Australia-wide or when a participant is travelling overseas with their Australian team of support worker/s.

DISCLAIMER

This guideline is provided to help guide best practice in the disability, aged care and community support industry. This information does not in any way replace legislative, regulatory, or contractual requirements. Users of this document should seek appropriate expert advice in relation to their circumstances. ACIA does not accept any liability on the use of this guideline.

PURPOSE

This guideline is to assist:

- ensure each Client has a mobility plan which is developed with input from the client, the client's representative and health professional;
- ensure all clients are assessed for Falls risk; and
- provide a framework for ensuring appropriate measures are implemented and regularly reviewed to reduce the risk of client Falls and subsequent harm.

DESIRED OUTCOME

- To maintain a quality and safe standard of service delivery support
- To reduce a negative or adverse outcome to a fall.
- Implement support strategies to assess falls risk in a timely manner and facilitate strategies as aligned to client's goal and needs.
- To ensure the appropriate level of assistance and/or supervision is provided to each client.

BACKGROUND

Falls are not something that should just be expected nor are they a reason for restraint to be implemented. Each client should be individually considered in relation to their risk factors, the timing and type of fall and a range of approaches considered. Whilst many assessments of the client are undertaken by the RN and physiotherapist, Carers are well placed to "know the client" and these insights are valuable tools in preventing a fall.

Clients on anticoagulant medication:

- All unwitnessed and witnessed falls (where a client has hit their head) will require medical review in hospital.

DEFINITIONS & SUPPORTING INFORMATION

Community Supports and/or Services is defined as the provision of paid supports and services in a service user's home or community. It includes but is not limited to, the following activities of daily living:

- personal care or support
- housework or domestic assistance
- transport assistance
- community access
- social support
- nursing services
- clinical supports
- gardening and home maintenance
- palliative care
- respite care

Support Worker - A paid person who assists people to perform tasks of daily living so as to participate in social, family and community activities in the person's home and their community. Support Workers have been commonly known in the past as attendant care worker, disability worker, aged care worker, community worker, homecare worker, care worker or paid carer.

Service Provider - Organisation or person accountable for the delivery of supports to Clients.

Carer - a person that provides supports to the Client at no cost (generally family or friend).

Support Worker Competency - trained and assessed as competent by a Registered Nurse or a person deemed competent by the provider to safely and appropriately perform a specified task as a support worker.

Client means the service user, participant, user, care recipient, consumer or person receiving the nursing or support services.

Plan means a Service Plan, Support Plan or Individual Plan (however titled – the plan) is a document developed in response to a request for service. It is developed by a Registered Nurse or a person deemed competent by the provider from the service provider, prior to the commencement of service delivery. It outlines the expected outcomes of the requested care/services and the tasks, duties and interventions required to meet the care and service needs of the client (within the parameters of the funding program). The plan guides and directs the individual support worker or Registered Nurse in their day-to- day delivery of the services.

Registered Nurse means a person who has completed the prescribed educational preparation, demonstrated competence for practice, and is registered and licensed with the Australian Health Practitioner Regulation Agency (AHPRA) as a Registered Nurse.

Competent means having been trained and assessed by a registered nurse or enrolled nurse or approved assessor as competent to safely and appropriately perform a specified task.

Fall has the meaning given by the World Health Organization, being an event which results in a client coming to rest inadvertently on the ground or floor or other lower level or a sudden, unintentional change in position, causing a client to land at a lower level on an object, the floor, the ground or other surface, and includes:

- slips and trips;
- falling into other people;
- being lowered;
- loss of balance;
- Found on the floor;
- legs giving way.

All instances where a client is found on the floor should be treated as a Fall.

FRAT means the Falls Risk Assessment Tool developed by the Peninsular Health Falls Prevention Service, as updated from time to time.

Full Physical Assistance means one on one physical effort from another person or persons is required throughout the walking or transfer or bed movement task.

Standby Assistance means standby in case physical effort or verbal cues from one person is required during the specified activity of walking or transfers or bed movement. This involves a commitment of support workers on a one to one basis and setting-up activities for a client is required to enable a task of walking or transfer or bed movement in a safe manner. These activities may involve but are not limited to locking wheels on a wheelchair or adjusting foot plates or side arm plates, handing the client a mobility aid, setting up/checking the bed pole or monkey bars, guiding with bed mechanism, fitting of callipers, leg braces or lower limb prostheses.

Supervision means setting-up activities for a client is required to enable a task of walking or transfer or bed movement in a safe manner. These activities may involve but are not limited to locking wheels on a wheelchair or adjusting foot plates or side arm plates, handing the client a mobility aid, setting up/checking the bed pole or monkey bars, guiding with bed mechanism, fitting of callipers, leg braces or lower limb prostheses. Supervision also comprises of verbal prompts needed to enable safe walking or transfers or bed movement.

Therapist means a physiotherapist, occupational therapist or allied health therapist.

G U I D E L I N E

Risk Factors for Falls

Intrinsic - Personal factors

- History of falling
- Deterioration in health, mobility and strength associated with ageing
- Impaired gait and balance
- Certain medical conditions such as: Parkinson, Dementia, Depression, Osteoporosis, Cataract, Glaucoma, Low BP, Incontinence
- Lack of exercise linked with poor muscle tone and low bone density
- Alcohol use
- Polypharmacy, diuretics and / or medications that affect balance, vision, alertness e.g. sedatives, antipsychotics, anti-Parkinson's, antihypertensive medications
- General fatigue or associated with wandering / pacing behaviour
- Inadequate nutrition and diet
- Impaired cognition / confusion
- Diabetes mellitus
- Anticoagulants

Extrinsic - Environmental factors

- Uneven or loose surfaces such as: cracked footpath, loose pebbles.
- Inadequate lighting
- Slippery floors
- Activities of daily living
- Time of day
- Hospitalisation
- People traffic, crowds
- Poor steps / stairways design or repair
- Height of chairs
- Unfamiliar surroundings
- Unsecured covers such as carpets, rugs Inadequate footwear

The greater the number of risk factors, the greater their chance of falling. By reducing the number of risk factors we can also reduce the falling or the number of falls.

Assessing the risk - Optimal fall prevention will involve a care team approach from the GP, Physiotherapist and support worker.

Identification of falls risk factors - Provision of suitable furniture, lighting and environment for the client's safe negotiation and access. Education of support workers to ensure comprehensive knowledge of clients' requirements. Support workers must follow plan directions and report any changes to clients' mobility.

Medical & Medication review - Client's at risk of falls are to be referred to the GP for a comprehensive medical / medication review. This review may include review of medications by the Pharmacist. Long acting sedative-hypnotic medication should be avoided. Regular review of medication modifications may be needed at the time of intercurrent illness because of altered pharmacokinetics.

Sensory Evaluation (vision)- Referral to the optometrist to determine if a change in vision has occurred increasing the risk to fall.

Appropriate footwear - Initial assessment includes assessment of client footwear to ensure appropriateness.

Hip protectors – May be assessed as clinically required to reduce the risk of adverse outcomes following a fall.

Assistive devices - The plan should assess the client for any assistive devices necessary and consults with the Manager, client / representative.

Comprehensive continence management - Bladder control is a complex integration of psychological, social, environmental, physical and anatomical factors. Urgency needs to be addressed as it significantly increases the risk of falling.

Comprehensive behaviour assessment / strategies - Investigation and alleviation of causes of restlessness, agitation in high-risk individuals such as pain, discomfort, loneliness, hunger, thirst or environmental irritations (e.g. noise).

Exercises - Support worker can provide hands on exercises as per the care plan. Documentation that the program as assessed is followed. Changes to a client's ability to participate must be reported to the Manager.

Restraint – Can often cause more severe injuries so should be minimised, and ideally eliminated. Consider all other alternatives sensor mats, non slip mats, High/Low beds, fall out mat , increased observation, activity.

Observations post fall and why?

It is important post incident that a thorough assessment of the client is undertaken to ensure that no physical injury has occurred. The risk of head injury is a real consideration and can be harder to identify particularly in a client that may have cognitive changes already and poor pupil or limb movement before the fall.

A full set of neurological observations may be undertaken at structured intervals will assist us to identify the changes associated with an internal haemorrhage, and should be guided by clinicians / medical practitioner.

Likewise anticoagulant therapy can cause bleed from a shake to the brain rather than just being caused by direct contact so these clients should be considered to be at a higher risk.

What are you looking for?

Isn't it easy to have a special formula that says when this changes to that we know the client needs to be sent to hospital?

Unfortunately, that doesn't happen so our main goal is to identify the changes that signify something is different.

- Changes in the basic observations themselves (BP, Pulse, pupil size, etc.)
- Changes in the client's conscious state
- Changes in the client's ability to move/use their limbs to the extent they were before
- Unusual changes to their speech / thought patterns
- The client complaining of just not feeling right

Any change at all should be immediately reported to a Manager / Clinician who will fully assess the client and may call in medical intervention.

Remember these changes may occur in the day or so after the fall so support worker should be continuing to observe and report any changes in the few days following the fall.

The mobility assessment and mobility and/or rehabilitation plan should be included in a client's care plan and communicated to all support workers providing hands on mobility assistance to the Client by the Therapist and Care Manager at all handover meetings and/or operation meetings.

Even minor changes in the mobility status of a client can lead to fall. Early interventions in these cases are important for the maintenance of the client safety and wellbeing.

(Axmon et al., 2018; Cahill et al., 2014; Choo et al., 2021; Church et al., 2015; Craig et al., 2020; Francis-Coad et al., 2016; Gemmeke et al., 2021; Hemsley et al., 2019; Ho et al., 2018; Ho et al., 2020; Karlsson et al., 2013; Makino et al., 2018; Ng et al., 2019; Sherrington et al., 2020; Sugitani & Ito, 2021)

RESOURCE DOCUMENTS

- External ACIA Guidelines 002 – Care and Service Provision in the Community
- Australian Community Industry Standards (ACIS)
- Commonwealth Quality of Care Principles 1997 (Cth)
- Aged Care Quality Standards
- Falls Prevention Manual, Falls Prevention Service, Peninsula Health, 2005
- Axmon, A., Sandberg, M., Ahlstrom, G., & Midlov, P. (2018). Fall-risk-increasing drugs and falls requiring health care among older people with intellectual disability in comparison with the general population: A register study. *PLoS One*, *13*(6), e0199218. https://doi.org/10.1371/journal.pone.0199218
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