

## Frequently Asked Questions

### GENERAL

**Q: *Why were these falls tools developed?***

**A:** The Falls Injury Prevention Program (FIPP) conducted consultation which demonstrated a high demand from clinicians in Queensland to improve the prevention and management of falls. A survey revealed a plethora of falls risk assessment tools were being used across the state and identified strong support for a standardised approach to the assessment of falls risk and post fall management across Queensland (87% of respondents, n=353).

Review of clinical incidents that resulted in serious harm and root cause analysis showed that the actions of staff to prevent falls were not clearly documented and communicated. Therefore these tools were developed. The aim of these tools is to improve the implementation of the actions tailored to each risk factor, the communication and documentation of the falls prevention care that you provide and to ensure appropriate post falls clinical care is provided for unwitnessed or witnessed falls.

**Q: *How have these tools been developed and reviewed?***

**A:** These tools have been developed through an extensive consultation process with clinical experts and site coordinators such as Nurse Educators or Falls CNCs. They were also designed using current evidence-based scientific literature and falls prevention guidelines.

The tools were implemented and evaluated across a variety of Queensland Health hospitals, residential aged care and community care facilities. This included a four month clinical trial of the Falls Assessment and Management Plan and Post Fall Clinical Pathway which involved a chart audit (n = 821 records), staff and client feedback and education. Documentation in randomly sampled charts was reviewed to determine whether the use of the tools led to changes in documentation regarding falls risk factors assessed and preventative actions taken.





These tools have recently undergone an extensive review in consultation with clinical and human factors experts from around the state. This review resulted in an update of the falls tools content and the format of the form was changed in response to feedback from the expert clinical group requesting a multiple day Falls Assessment and Management Plan and a tool that will align to ieMR.

**Q: *Why is there no stratification of risk of falls in these tools?***

**A:** The Falls Assessment and Management Plan (FAMP) is not a risk assessment scoring tool and thus a test for scoring is not required. There is debate on the value of formal falls risk-predicting tools, particularly if no interventions are subsequently put in place to modify patient risk factors (Oliver, 2008).

The FAMP tool assumes that all patients, residents and clients receiving care are comprised and therefore at a risk of falling. The FAMP takes a risk factor based approach leading to specific evidence based interventions to match identified risk factors. Key falls risk factors and interventions from the scientific literature have been included on the FAMP.

**Q: *If I find a patient screens 'no' to the initial screening box on the Falls Assessment and Management Plan, why do I need to continue to assess the patient?***

**A:** Although a patient may not indicate a positive screen ie. has not fallen in the last 6 months, an assessment of the key risk factors listed on the Falls Assessment and Management Plan (FAMP) still needs to be completed. Results from the trial's chart audit revealed 87% in-patients and 95% residents had a least one falls risk factor. Thus the majority of individuals in these populations are considered at risk of falling.

The FAMP tool takes a risk factor based approach ie. key risk factors for falling have been included on the tool and are matched to specific evidence based interventions or actions which currently is the most effective approach to falls prevention in the literature.

**Q: *Clients who are immobile but still have risk factors, what are they classed as because at the moment we class them as low risk as the only falls risk is during patient handling?***

**A:** As mentioned above, the new Falls Assessment and Management Plan does not stratify the level of falls risk as low, medium or high like in previous tools that you are have used. This tool identifies individual risk factors and the recommended interventions.

**Q: Can the Falls Assessment and Management Plan be completed by an Enrolled Nurse?**

**A:** Enrolled Nurses contribute to formulating the care plan in collaboration with a registered nurse and the Registered Nurse authorises the plan of care by signing the form. Enrolled Nurses contribute to the development of a care plan. They collect data and undertake actions within their scope of practice and sign and date accordingly

**Q: Is the Acute Resuscitation Plan (ARP) affected by the Post Fall Clinical Pathway?**

**A:** No. The ARP overrides the Post Fall Clinical Pathway in terms of managing a patient's treatment plan. Staff would still complete some sections of pathway ie. Notify Doctor and family.

**Q: What are the benefits of the new tools?**

**A:** Results from the trial showed:

- Increased identification of key falls risk factors
- A statistically significant change in prevalence of initial interventions documented
- Increased documentation of actions and falls prevention interventions to mitigate identified falls risk factors
- Increased frequency of initial post-fall observations
- Increased frequency of neuro observations for suspected head injuries and/or unwitnessed falls
- Improvements in time taken to notify medical staff of a fall
- Increased frequency of falls documentation

**Q: Can the tools be used in mental health areas?**

**A:** Currently there are no validated falls assessment tools developed for use in mental health. The tools were not designed with this setting in mind as they are based on current evidence in falls prevention. The application of tools in mental health areas needs to be researched, monitored and evaluated to determine potential issues.

**Q: Why aren't anticoagulants listed as a risk factor for falls?**

**A:** Anticoagulant therapy alone is not a risk factor for falls however anticoagulant therapy does increase the risk of patient harm if they fall therefore:

- Anticoagulant/antiplatelet therapy are included in the Management Plan under the Communications section on the FAMP (page 2) as a prompt for MO/ Pharmacy to review the risk versus benefit of this medication for patients at risk of falling.
- Anticoagulants are included in the Medical Assessment section of the Post Fall Clinical Pathway.
- The current evidence base is limited in terms of quantifying the extent of this risk which also varies depending on the agent in question ie. aspirin versus warfarin.
- Use clinical judgement regarding stroke and myocardial infarct prevention and anticoagulant use when undertaking medication reviews as part of a falls assessment.

**Q: I have been asked to review our local falls assessment procedures and develop a form to comply with the National Safety and Quality Health Service Standards (NSQHSS) – can I just use the Falls Assessment and Management Plan (FAMP) and Post Fall Clinical Pathway (PFCP)?**

**A:** Yes. The FAMP and PFCP were both developed to be used across the state-wide in a variety of settings. The tools are based on current falls prevention evidence and were also designed to meet the NSQHSS. These tools have been tailored and validated in acute (hospital), residential aged care and community care (FAMP only) areas.

The Australian Commission on Safety and Quality in Health Care, Preventing Falls and Harm from Falls in Older People Best Practice Guidelines (2009) recommends using existing validated tools that have been developed for use in relevant settings eg. for a hospital use a tool that has been evaluated in a similar hospital. Many facilities use non-validated tools that they have developed themselves or simply adapt a validated tool ie. taking out sections of researched falls tools and combining these together which negates the validity of the original tools. Using non-validated tools may be detrimental ie. wasting staff time to complete a tool that has poor reliability and predictive value (ACSQHC National Best Practice Guidelines Hospitals 2009:31), putting patients at risk as historical Queensland Health Root Cause Analyses have indicated.

## HOSPITAL

**Q: *What is a variance?***

**A:** "Defined as any deviation from the proposed standard of care listed in the pathway". (Dalton et al).

**Q: *How do I document a variance?***

**A:** If a care outcome has not been achieved, a flag is noted in the variance column by writing a "v". The treating clinician is then expected to go to the back page of the Post Falls Clinical Pathway or the clinical events variance sheet to complete the entry. It is also essential to code, describe the variance, any actions taken and outcomes as they occur. Any variances must be recorded using V – variance, A-action, O-outcomes.

**Q: *Can I change the pathway?***

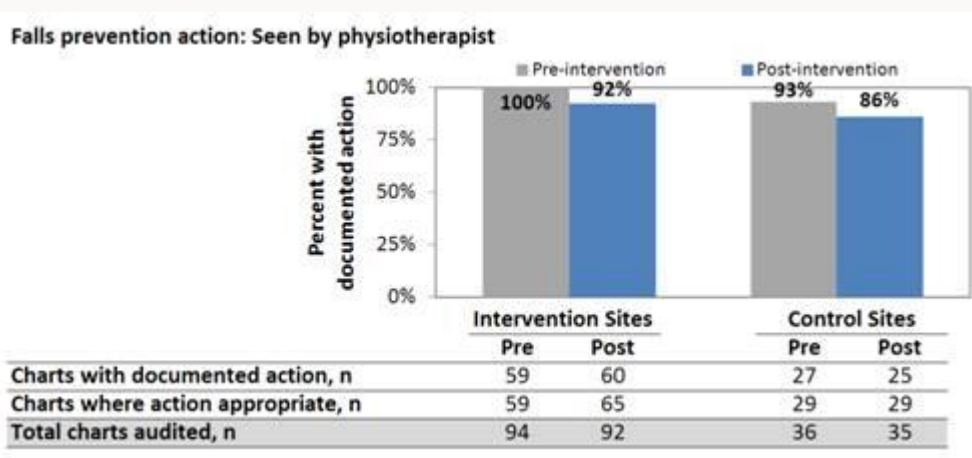
**A:** Yes. At the point of care, clients requiring individualised care for issues that are specific to them and may require alterations to their care. To alter the pathway, flag a variance and record details of the variance on the back page of the Post Falls Clinical Pathway or on a clinical event variance sheet.

**Q: *I am concerned the Falls Assessment and Management Plan (FAMP) will result in a sharp rise of physiotherapy referrals, of which a large proportion will be inappropriate?***

**A:** Firstly, each tool clearly indicates at the top that the form does not replace clinical judgement. For example if clinical judgement determines the patient is not indicated for referral to physiotherapy, then this is appropriate, or if in a location where there are other practitioners who may manage mobility issues such as OT or nursing due to lack of physios, or a referral is usually made to other services, then this is appropriate, and a variance can be completed. These types of clinical decisions are documented in the patient notes.

Evaluation of the clinical trial showed that using the forms did not change the number of physiotherapy referrals – most people for whom using the form was deemed appropriate were already being seen by a physio.

As one of the hundreds of outcomes, we determined the proportion of patients seen by a physiotherapist pre and post trial – to see if using the forms had an impact on the number of patients being seen by a physiotherapist. Following the tools trial there was a marginally significant finding that fewer patients in the intervention group (the group that used the forms) that required physiotherapy were seen (100% of cohort pre vs. 92% post,  $p = 0.049$ ), with no difference found over time for the control group (continued with usual care) ( $p = 0.668$ ) (this data is for the FAMP – hospital).



## COMMUNITY

**Q:** *Can I photocopy the completed tool for the client to take a copy with them to their GP?*

**A:** The following advice is from the Community Health Information Manager: There is no problem giving a copy of this form to the client to pass on to their GP. Our Client Consent & Information Checklist has a section allowing for client consent to share their assessment information "for the continuation of health care provision". Even without a consent being signed, if the client takes the information to their GP, then consent for the sharing of the information is implied.

There should be some notation in the client record, or on the Falls Assessment Form that the client has been provided with a copy.

**Q:** *Some parts of the Falls Assessment and Management Plan duplicates the Ongoing Needs Identification (ONI)?*

**A:** The Community Care Falls Assessment and Management Plan (FAMP) tool does not replace the ONI. This tool is supplementary to the ONI. From our understanding and meetings with other Community Health Managers; some

Community Health sectors are using a falls assessment tool once the ONI has identified clients at falls risk.

Our tool (FAMP) would replace any specific falls related assessment tools. It does not replace the integrated ongoing needs identification tool. Our tool is the next step in planning specific interventions for those identified at risk of falls from the ONI. It would be great if the ONI flagged people who were at risk of a fall once certain tick boxes were marked. We suggest using the Community FAMP in conjunction with the Health Behaviours ONI Profile.

***Q: How are the tools used for Medical Aids Subsidy Scheme (MASS) applications?***

**A:** The MASS 20 DLA/MOB form assesses a client's falls history. If the MASS application is to request items to prevent future falls – the client is classified as an urgent assessment. The Community Falls Assessment and Management Plan can be attached to the MASS 20 DLA/MOB application form and the information gathered in the comments section can be used as evidence of the clients falls risk. The comments could include something like:

'Client has reported a fall in the past 6 months, and has decreased vision. Given that the toilet is down the hallway and there are concerns re her safety accessing this during the night, a bedside commode is recommended to minimise risk of falls.'

***Q: What is the difference between a home hazard assessment, environmental assessment and environmental audit?***

**A:** For older people who live in the community, about 50% of falls occur within their homes and immediate surroundings (ACSQHC National Best Practice Guidelines Community Care 2009:94). Environmental modification can help reduce these risk factors.

For older people with high falls risk, a home hazard assessment, modification and education that is professionally prescribed by an Occupational Therapist (OT) is recommended<sup>10,14</sup> (Community Good Practice Guidelines 2008:85; Delbaere and Lord 2011:4 ref 19). This process involves checking the older person's home for falls



hazards and then according to the person's abilities modifying the environment to remove or minimise these hazards.

This may include an environmental audit and/or assessment. An environmental audit specifically identifies what environmental risk factors for falls exist i.e. vision and illumination, furniture, equipment, flooring etc. An environmental assessment involves evaluating people and how they interact with their environment.

Environmental assessments should be completed by a health professional with experience and training in evaluating people and their environment ie. an occupational therapist (ACSQHC National Best Practice Guidelines Community Care 2009:94).