South Canterbury
District Health Board
Enhancing the health & independence of the people of South Canterbury.

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5 September 2014

David Nicholas

By email: fyi-request-1879-6918245d@requests.fyi.org.nz

Dear Mr Nicholas

Thank you for your request on 11 July 2014 under the Official Information Act. In reply to your question:

1. *A month by month ward by ward breakdown in the number of patient falls going back 5 years?*

Data prior to Aug 2012 has been reported as historical data (in different format i.e. not broken down to each individual area – service level).

Assessment Treatment & Rehabilitation

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Aug-12	3	600	Aug-12	9	600
Sep-12	4	470	Sep-12	9	470
Oct-12	3	560	Oct-12	3	560
Nov-12	5	467	Nov-12	4	467
Dec-12	2	270	Dec-12	3	270
Jan-13	1	372	Jan-13	3	372
Feb-13	3	496	Feb-13	5	496
Mar-13	0	478	Mar-13	6	478
Apr-13	2	534	Apr-13	16	534
May-13	3	602	May-13	18	602
Jun-13	3	530	Jun-13	2	530
Jul-13	3	539	Jul-13	5	539

Aug-13	1	548	Aug-13	8	548
Sep-13	1	523	Sep-13	6	523
Oct-13	0	522	Oct-13	2	522
Nov-13	1	332	Nov-13	5	332
Dec-13	0	240	Dec-13	3	240
Jan-14	2	404	Jan-14	3	404
Feb-14	1	424	Feb-14	5	424
Mar-14	0	457	Mar-14	7	457
Apr-14	1	555	Apr-14	4	555
May-14	0	555	May-14	2	555
Jun-14	1	553	Jun-14	6	553
Jul-14	1	535	Jul-14	7	535

Medical

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Aug-12	3	711	Aug-12	9	711
Sep-12	4	611	Sep-12	9	611
Oct-12	3	599	Oct-12	4	599
Nov-12	4	606	Nov-12	6	606
Dec-12	2	605	Dec-12	2	605
Jan-13	1	612	Jan-13	3	612
Feb-13	1	530	Feb-13	3	530
Mar-13	2	630	Mar-13	2	630
Apr-13	4	642	Apr-13	7	642
May-13	4	675	May-13	5	675
Jun-13	0	640	Jun-13	5	640
Jul-13	1	663	Jul-13	2	663
Aug-13	5	674	Aug-13	5	674

Sep-13	1	607	Sep-13	3	607
Oct-13	2	618	Oct-13	4	618
Nov-13	0	234	Nov-13	0	234
Dec-13	1	631	Dec-13	3	631
Jan-14	3	607	Jan-14	3	607
Feb-14	2	509	Feb-14	3	509
Mar-14	1	571	Mar-14	3	571
Apr-14	2	619	Apr-14	5	619
May-14	3	599	May-14	1	599
Jun-14	3	650	Jun-14	4	650
Jul-14	2	609	Jul-14	2	609

Surgical

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Aug-12	2	1084	Aug-12	6	1084
Sep-12	0	919	Sep-12	4	919
Oct-12	0	728	Oct-12	2	728
Nov-12	4	818	Nov-12	2	818
Dec-12	0	957	Dec-12	5	957
Jan-13	1	794	Jan-13	2	794
Feb-13	2	757	Feb-13	2	757
Mar-13	1	802	Mar-13	4	802
Apr-13	0	925	Apr-13	3	925
May-13	1	1063	May-13	0	1063
Jun-13	2	902	Jun-13	2	902
Jul-13	2	881	Jul-13	1	881
Aug-13	2	964	Aug-13	0	964
Sep-13	1	717	Sep-13	2	717

Oct-13	1	764	Oct-13	1	764
Nov-13	2	811	Nov-13	1	811
Dec-13	3	903	Dec-13	2	903
Jan-14	1	926	Jan-14	3	926
Feb-14	0	738	Feb-14	4	738
Mar-14	2	850	Mar-14	2	850
Apr-14	0	846	Apr-14	7	846
May-14	2	937	May-14	4	937
Jun-14	0	914	Jun-14	4	914
Jul-14	1	825	Jul-14	5	825

ICU/CCU

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Jul-12	0	175	Jul-12	0	175
Aug-12	0	175	Aug-12	0	175
Sep-12	1	131	Sep-12	0	131
Oct-12	0	133	Oct-12	0	133
Nov-12	0	117	Nov-12	0	117
Dec-12	0	157	Dec-12	0	157
Jan-13	0	118	Jan-13	0	118
Feb-13	0	93	Feb-13	0	93
Mar-13	0	148	Mar-13	0	148
Apr-13	0	162	Apr-13	0	162
May-13	0	150	May-13	0	150
Jun-13	0	118	Jun-13	0	118
Jul-13	0	136	Jul-13	0	136
Aug-13	0	147	Aug-13	0	147
Sep-13	0	114	Sep-13	0	114

Oct-13	0	138	Oct-13	0	138
Nov-13	0	151	Nov-13	1	151
Dec-13	0	112	Dec-13	0	112
Jan-14	0	111	Jan-14	0	111
Feb-14	0	124	Feb-14	0	124
Mar-14	2	152	Mar-14	0	152
Apr-14	0	129	Apr-14	0	129
May-14	0	136	May-14	0	136
Jun-14	0	121	Jun-14	0	121
Jul-14	0	137	Jul-14	0	137

Day patient Services

Month	Number of Injury Falls	Month	Number of Non-Injury Falls
Jul-12	0	Jul-12	0
Aug-12	0	Aug-12	0
Sep-12	0	Sep-12	0
Oct-12	0	Oct-12	0
Nov-12	0	Nov-12	0
Dec-12	0	Dec-12	0
Jan-13	0	Jan-13	0
Feb-13	0	Feb-13	0
Mar-13	0	Mar-13	0
Apr-13	0	Apr-13	0
May-13	0	May-13	0
Jun-13	0	Jun-13	0
Jul-13	0	Jul-13	1
Aug-13	1	Aug-13	0
Sep-13	0	Sep-13	0

Oct-13	0		Oct-13	0	
Nov-13	0		Nov-13	0	
Dec-13	0		Dec-13	0	
Jan-14	0		Jan-14	0	
Feb-14	0		Feb-14	0	
Mar-14	0		Mar-14	0	
Apr-14	0		Apr-14	0	
May-14	0		May-14	0	
Jun-14	0		Jun-14	0	
Jul-14	0		Jul-14	0	

Maternity Services

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Jul-12	0	223	Jul-12	0	223
Aug-12	0	226	Aug-12	0	226
Sep-12	0	186	Sep-12	0	186
Oct-12	0	174	Oct-12	0	174
Nov-12	0	193	Nov-12	0	193
Dec-12	0	252	Dec-12	0	252
Jan-13	0	177	Jan-13	0	177
Feb-13	0	143	Feb-13	0	143
Mar-13	0	222	Mar-13	0	222
Apr-13	0	203	Apr-13	0	203
May-13	0	151	May-13	0	151
Jun-13	0	162	Jun-13	0	162
Jul-13	0	189	Jul-13	0	189
Aug-13	0	175	Aug-13	0	175
Sep-13	0	211	Sep-13	0	211

Oct-13	0	156	Oct-13	0	156
Nov-13	0	153	Nov-13	0	153
Dec-13	0	151	Dec-13	0	151
Jan-14	0	166	Jan-14	0	166
Feb-14	0	201	Feb-14	0	201
Mar-14	0	196	Mar-14	0	196
Apr-14	0	181	Apr-14	0	181
May-14	0	197	May-14	0	197
Jun-14	0	152	Jun-14	0	152
Jul-14	0	169	Jul-14	0	169

Paediatric Service

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Jul-12	0	174	Jul-12	1	174
Aug-12	0	158	Aug-12	0	158
Sep-12	0	149	Sep-12	0	149
Oct-12	0	79	Oct-12	0	79
Nov-12	0	96	Nov-12	0	96
Dec-12	0	117	Dec-12	0	117
Jan-13	0	95	Jan-13	0	95
Feb-13	0	54	Feb-13	0	54
Mar-13	0	131	Mar-13	1	131
Apr-13	0	131	Apr-13	0	131
May-13	0	125	May-13	0	125
Jun-13	0	120	Jun-13	0	120
Jul-13	0	139	Jul-13	0	139
Aug-13	0	112	Aug-13	0	112
Sep-13	0	136	Sep-13	0	136

Oct-13	0	166	Oct-13	0	166
Nov-13	0	114	Nov-13	0	114
Dec-13	0	109	Dec-13	1	109
Jan-14	0	74	Jan-14	0	74
Feb-14	0	92	Feb-14	1	92
Mar-14	0	134	Mar-14	0	134
Apr-14	0	113	Apr-14	0	113
May-14	0	139	May-14	0	139
Jun-14	0	91	Jun-14	0	91
Jul-14	0	122	Jul-14	0	122

Mental Health and Addiction Services Inpatient Unit

Month	Number of Injury Falls	Number of Occupied Bed Days	Month	Number of Non-Injury Falls	Number of Occupied Bed Days
Jul-12	0	264	Jul-12	2	264
Aug-12	0	170	Aug-12	0	170
Sep-12	0	162	Sep-12	0	162
Oct-12	0	304	Oct-12	0	304
Nov-12	1	189	Nov-12	0	189
Dec-12	0	242	Dec-12	0	242
Jan-13	3	304	Jan-13	3	304
Feb-13	0	230	Feb-13	1	230
Mar-13	0	273	Mar-13	0	273
Apr-13	0	231	Apr-13	0	231
May-13	0	264	May-13	0	264
Jun-13	0	278	Jun-13	0	278
Jul-13	0	287	Jul-13	0	287
Aug-13	1	295	Aug-13	0	295
Sep-13	0	246	Sep-13	2	246

Oct-13	0	220	Oct-13	2	220
Nov-13	0	244	Nov-13	0	244
Dec-13	1	171	Dec-13	0	171
Jan-14	0	231	Jan-14	1	231
Feb-14	1	215	Feb-14	1	215
Mar-14	0	217	Mar-14	0	217
Apr-14	0	194	Apr-14	0	194
May-14	0	175	May-14	1	175
Jun-14	1	211	Jun-14	0	211
Jul-14	0	130	Jul-14	0	130

Historical Data

From Incident Reporting Monthly Summary Report

October 2009

Fall- Injury

Surgical Group	11
Medical Group	3
AT&R/ Mental Health Group	15
Support Group	

Falls – Non injury

Surgical Group	
Medical Group	
AT&R/ Mental Health Group	
Support Group	

November 2009

Fall- Injury

Surgical Group	3
Medical group	1
AT&R/ Mental Health Group	

Support Group

Falls – Non injury

Surgical Group	2
Medical group	4
AT&R/ Mental Health Group	
Talbot	26

December 2009

Fall- Injury	
Surgical Group	2
Medical group	
AT&R/ Mental Health Group	3
Falls – Non injury	
Surgical Group	1
Medical group	10
AT&R/ Mental Health Group	7

January 2010

Fall- Injury	
Surgical Group	3
Medical group	3
AT&R/ Mental Health Group	2
Falls – Non injury	
Surgical Group	3
Medical group	7
AT&R/ Mental Health Group	9

February 2010

Fall- Injury	
Surgical Group	1

Medical group	
AT&R/ Mental Health Group	
Falls – Non injury	
Surgical Group	2
Medical group	
AT&R/ Mental Health Group	8

March 2010

Fall- Injury	
Surgical Group	3
Medical group	1
AT&R/ Mental Health Group	3
Falls – Non injury	
Surgical Group	3
Medical group	2
AT&R/ Mental Health Group	7

April 2010

Fall- Injury	
Surgical Group	1
Medical group	1
AT&R/ Mental Health Group	4
Falls – Non injury	
Surgical Group	4
Medical group	2
AT&R/ Mental Health Group	5
Support Grp	1

May 2010

Fall- Injury	

Surgical Group	3
Medical Group	2
AT&R/ Mental Health Group	2
Support group	1
Falls – Non injury	
Surgical Group	5
Medical Group	7
AT&R/ Mental Health Group	9

June 2010

Fall- Injury	
Surgical Group	1
Medical group	5
AT&R/ Mental Health Group	3
Falls – Non injury	
Surgical Group	2
Medical group	5
AT&R/ Mental Health Group	13

July 2010

Fall- Injury	
Surgical Group	
Medical group	1
AT&R/ Mental Health Group	
Falls – Non injury	
Surgical Group	
Medical group	8
AT&R/ Mental Health Group	16

August 2010

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	
Talbot	
Primary Care	
Falls – Non injury	
Surgical Services Group	3
Medical & Ambulatory Group	10
Mental, Allied & Health of Older Persons	5

September 2010

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	1
Mental, Allied & Health of Older Persons	2
Primary Care	
Falls – Non injury	
Surgical Services Group	3
Medical & Ambulatory Group	12
Mental, Allied & Health of Older Persons	9

October 2010

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	1 W10 3- ATR
Primary Care	
Falls – Non injury	
Surgical Services Group	3
Medical & Ambulatory Group	12

Mental, Allied & Health of Older Persons	ATR -6

November 2010

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	
Mental, Allied & Health of Older Persons	2
Primary Care	
Falls – Non injury	
Surgical Services Group	2
Medical & Ambulatory Group	
Mental, Allied & Health of Older Persons	7
Talbot	20

December 2010

Fall- Injury	
Surgical Services Group	6
Medical & Ambulatory Group	
Mental, Allied & Health of Older Persons	3
Primary Care	
Falls – Non injury	
Surgical Services Group	5
Medical & Ambulatory Group	
Mental, Allied & Health of Older Persons	5

January 2011

Fall- Injury	
Surgical Services Group	3
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	1

Talbot	6
Primary Care	
Falls – Non injury	
Surgical Services Group	5
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	7 1 wd10

February 2011

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	2
Primary Care	
Falls – Non injury	
Surgical Services Group	5
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	12

March 2011

Fall- Injury	
Surgical Services Group	
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	6
Primary Care	
Falls – Non injury	
Surgical Services Group	2
Medical & Ambulatory Group	8
Mental, Allied & Health of Older Persons	6

April 2011

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	3
Primary Care	
Falls – Non injury	
Surgical Services Group	7
Medical & Ambulatory Group	9
Mental, Allied & Health of Older Persons	5

May 2011

Fall- Injury	
Surgical Services Group	3
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	
Primary Care	
Falls – Non injury	
Surgical Services Group	
Medical & Ambulatory Group	10
Mental, Allied & Health of Older Persons	6

June 2011

Fall- Injury	
Surgical Services Group	3
Medical & Ambulatory Group	1
Mental, Allied & Health of Older Persons	2
Primary Care	
Falls – Non injury	
Surgical Services Group	9
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	5

Talbot	12

July 2011

Fall- Injury	
Surgical Services Group	
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	8
Primary Care	
Falls – Non injury	
Surgical Services Group	4
Medical & Ambulatory Group	4
Mental, Allied & Health of Older Persons	5
Primary Care	
Service Support Group	1

August 2011

Fall- Injury	
Surgical Services Group	5
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	2
Primary Care	
Falls – Non injury	
Surgical Services Group	6
Medical & Ambulatory Group	8
Mental, Allied & Health of Older Persons	29

September 2011

Fall- Injury	
Surgical Services Group	4
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	3

Primary Care	
Falls – Non injury	
Surgical Services Group	6
Medical & Ambulatory Group	10
Mental, Allied & Health of Older Persons	15
Talbot	21

October 2011

Fall- Injury	
Surgical Services Group	3
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	9
Primary Care	
Falls – Non injury	
Surgical Services Group	3
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	12

November 2011

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	6
Mental, Allied & Health of Older Persons	
Primary Care	
Falls – Non injury	
Surgical Services Group	5
Medical & Ambulatory Group	4
Mental, Allied & Health of Older Persons	10

December 2011

Fall- Injury	
Surgical Services Group	
Medical & Ambulatory Group	1
Mental, Allied & Health of Older Persons	
Primary Care	nil
Falls – Non injury	
Surgical Services Group	5
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	

January 2012

Fall- Injury	
Surgical Services Group	3
Medical & Ambulatory Group	1 5
Mental, Allied & Health of Older Persons	3
Talbot	12
Primary Care	
Falls – Non injury	
Surgical Services Group	
Medical & Ambulatory Group	10
Mental, Allied & Health of Older Persons	11

February 2012

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	4
Mental, Allied & Health of Older Persons	1
Primary Care	
Falls – Non injury	
Surgical Services Group	3
Medical & Ambulatory Group	X5

Mental, Allied & Health of Older Persons	5

March 2012

Fall- Injury	
Surgical Services Group	6
Medical & Ambulatory Group	
Mental, Allied & Health of Older Persons	4
Talbot	11
Primary Care	1
Falls – Non injury	
Surgical Services Group	2
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	13

April 2012

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	3
Community	0
Falls – Non injury	
Surgical Services Group	2
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	6

May 2012

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	7

Community	
Falls – Non injury	
Surgical Services Group	6
Medical & Ambulatory Group	3
Mental, Allied & Health of Older Persons	11

June 2012

Fall- Injury	
Surgical Services Group	2
Medical & Ambulatory Group	2
Mental, Allied & Health of Older Persons	
Community	
Falls – Non injury	
Surgical Services Group	1
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons	5

July 2012

Fall- Injury	
Surgical Services Group	1
Medical & Ambulatory Group	4
Mental, Allied & Health of Older Persons	6
Community	
Falls – Non injury	
Surgical Services Group	1
Medical & Ambulatory Group	5
Mental, Allied & Health of Older Persons ATR falls non-injury	7

Please note falls with injury range from minor harm i.e bruising or skin tear to serious harm i.e fracture or death. Timaru Hospital has no reported falls with serious harm from July 2013 to current (5/9/14).

2. What is the purpose of the green band placed on a patient wrist?
The green band is utilised as an identifier for patients who are assessed as 'at risk' of falling.

In the Assessment, Treatment and Rehabilitation Ward staff are utilising a new risk assessment tool and care plan format. The green wrist bracelet is utilised to identify patients who are at 'high risk' of falling.

3. What is current SCDHB policy and procedures about patient falls, has this policy changed?
Current procedure as requested. All polices, protocols, procedures are reviewed every two years or sooner to meet legislative changes or changes to best practice. Falls Prevention and Management Procedure has been updated, currently in signoff process.

	South Canterbury District Health Board		
	CLINCAL SERVICE PRACTICE MANUAL		
Procedure: Falls Prevention / Management	**Author:** Suzanne Jackson S. Jackson	**Authorised by:** B Taine S Powell	**No. of Pages:** 13 **Date for Review:** June 2014
	Designation: Nurse Educator	**Designation:** Chief Medical Officer Director of Nursing, Midwifery & Allied Health	**Distribution:** Clinical Services Practice Manual
	Date: June 2012	**Date:** June 2012	**Number:** CSPM F6
	Date Original Document: March 2010		**Review Dates:** 06/12

Objective:

- to identify patients 'at risk' of falling using a systematic assessment of known risk factors
- to ensure appropriate communication and implementation of interventions are utilised to eliminate or reduce risk factors
- to reduce the social, psychological and economic impact of fall-related injuries on individuals, families/whanau and the community

Responsibility:

- Medical Staff
- Nursing Staff
- Allied Health Professionals

Frequency:

- a Falls Risk Assessment tool will be completed for all patients admitted to South Canterbury District Health Board.

Exclusion:

- patients where potential to fall is an age appropriate developmental stage ie. toddlers
- women admitted to the maternity service who do not meet the criteria for completion of a falls action plan.

Definition:

Falls: an unexpected event in which the person comes to rest on the ground, floor or lower level. This definition includes factors such as:

- injuries that are due to a collision or external force
- injuries that happen through slips and trips that result in falls
- falling against something that is at the same level, like a wall.

Precautions/Alert:

- best practice indicates that all patients/clients/residents that fall should have a medical review following a fall. Medical officers are to be notified of all falls that result in an injury to the patient/client/ resident immediately. Non-injury falls – medical officers to be notified within 24 hours of the patient/client/resident falling.
- a mutually agreed plan between a medical officer and a registered nurse
- regarding the review process for D6 residents found on the floor with no apparent injury is to be documented in the residents care plan.
- there is an increase in manual handling risk for staff when patients are nursed on a mattress on the floor.
- Consider prescribing Vitamin D for patients over 65 and who are at risk of falls

Associated Documents:

Occupational Health & Safety	Public Folders
Hazard Register	Held in each department
Safer Patient Handling (Lifting) CSPMS2	Clinical Services Practice Manual
Incident Reporting and Management Policy QR8	Organisational Policy Manual
Restraint Minimisation and Safe Practice Policy CSPMR21	Clinical Services Practice Manual
ACC Guidelines for Head Injuries	Held in each department or http://www.nzgg.org.nz/guidelines/0129/ACC14261.pdf
Falls Action Plan	HSC067 (printed document, held in ward)
Inpatient Falls Assessment	Admission to Discharge Plan HSC211 or HSC211 Insert
South Canterbury Falls Prevention Referral Form	Public Folders – Clinical Forms
"Reduce the Risk of Falling" Brochure	HSC212 (printed document, held in ward)

Procedure:
Patients will be assessed for falls risk using:
- the Inpatient Falls Assessment
- completion of assessments by the physiotherapist i.e. Tinetti Balance and Gait Evaluation as appropriate

Patients will be assessed for falls risk:
- on admission / transfer from another department into an inpatient bed
- at day assessment in Assessment, Rehabilitation and Treatment Service
- on presentation to the Emergency Department by the domiciliary physiotherapist (as appropriate)
- on admission to District Nursing Service (as appropriate)

Patients will be re-assessed for falls risk following:
- transfer to another ward or facility
- following a fall
- a change in health status

Falls Action Plan:
A multi-disciplinary falls action plan is developed to address the falls risk factors identified during the assessment/treatment/review process. The outcome of the falls risk assessment is documented in the patient/client/residents clinical record. A plan is to be developed for all patients/clients/residents who:
- have been admitted to hospital following a fall
- have fallen while in hospital
- are admitted to AT & R unit
- try to walk alone when it is unsafe to do so
- express a fear of falling
- are confused & agitated
- have a neurological disorder
- are at risk of falls (using staff clinical judgement)

The Falls Action Plan includes:

- involvement from patients/clients/residents and/or family/whanau
- provision of education on falls prevention for patients/clients/residents and/or family/whanau
- appropriate use of falls prevention strategies: (see appendix A)
- discharge planning which includes appropriate provision of equipment, referral to appropriate agencies and provision of information to patients and/or family/whanau about how to prevent falls in a community setting.
- patient provided 'Reducing Risk of Falls' Brochure

Following a fall:
Please refer to flowchart: Managing a patient following a fall (Appendix B)

Additional Documentation in relation to fall:

- An Accident Compensation Corporation (ACC) form is to be completed for all patients who present with an injury from a fall
- all falls are reported as per the Incident Reporting and Management Policy QR8.

NB: In areas where the Releasing Time to Care Module has been introduced: update the patient status at a glance board to identify 'at risk' patients; floor maps 'at risk' areas in departments. Monthly action plans and evaluation reporting is required.

Interface with Primary Sector:
The emergency department (ED) may act as the primary health care provider to those who have fallen or are at risk of falling and are not admitted to hospital. Domiciliary physiotherapy is available in ED for the assessment of patients who have fallen or are at risk of falling (and for provision of walking aids, as appropriate). The decision regarding ongoing access to the domiciliary physiotherapy or referral through the ACC provider sits within the physiotherapy service. Patients who meet the access criteria may be referred to the AT & R Rapid Response Service.

SCDHB Community Based Services: complete a risk assessment for all patients who have fallen or are at risk of falling and have not been admitted to hospital. Refer to appropriate services i.e. therapy services, general practitioner for appropriate and timely intervention.

Home and Community:
Sport Canterbury is the coordinating agency for referrals to the Falls Prevention Programmes in the community. The 'Stay On Your Feet' programme includes a home based intervention as well as community classes that are run in South Canterbury. The aim of the programme is to reduce the incidence of falls among older people (65+) living in the community.

The home based falls prevention programme is led by either health professionals or trained volunteers in South Canterbury. The programme is based on the Otago Exercise Programme (OEP) which includes leg strength and balance retraining exercises. The 'Stay On Your Feet' community classes run for 10 weeks teaching the OEP exercises as well as education on risk factors. The classes are held in different areas of South Canterbury. Modified Tai Chi classes funded by ACC are available in some areas. There are also community Tai Chi classes and information is available from Sport Canterbury – South Canterbury.

To be eligible for either Stay On Your Feet or Modified Tai Chi (ACC funded), the patient must be 65 years of age or older and living in the community or an independent unit of a retirement village. If your patient is eligible complete a South Canterbury Falls Prevention Referral Form.

The programme is not suitable for people with significant cognitive impairment and individuals need to be motivated to complete the exercises at home.
Referral Pathway: Sport Canterbury – South Canterbury will receive all community based Falls Prevention Referrals for the programme and will forward the referral on to the designated provider. After completing a programme a person is offered a Green Prescription Referral to receive further support and information. The Green Prescription programme is run by Sport Canterbury – South Canterbury.

Stay On Your Feet
Home Based Programme

- Funded programme consisting of leg muscle strengthening and balance retraining exercises.
- Led by registered health professional or trained volunteer
- 5 home visits over a 6 month period with phone calls between visits

Stay On Your Feet
Community Classes

- Led by trained professional instructor
- 10 week programme consisting of leg muscle strengthening and balance retraining exercises
- Class location will vary – contact Falls Prevention Coordinator for details

Tai Chi Classes

- Community based classes using a specific set of Tai Chi exercises which focus on building strength and balance
- Classes meet weekly
- Contact Falls Prevention Coordinator or Green Prescription Advisor about Community Tai Chi classes

Green Prescription
Programme

- A Green Prescription is a referral from a GP or Practice Nurse for a person to be more physically active.
- The programme provides 3-4 months of support, information about community programmes and home exercise options.
- 10 week 'Be Active' programmes are held throughout South Canterbury.

References:

EQuIP4 Standard New Zealand Guide 2008 – Standard 1.5.4
Preventing Injury from Falls – The National Strategy 2005-2015
Department of Health Western Australia 2004
Sports Canterbury - Falls Prevention Project June 2007
Sport Canterbury – South Canterbury – Falls Prevention Project 2011 - 2013

Appendix A

Risk Factors	Potential Strategies for Patients at Risk of Falling (there may be alternative strategies apart from those listed, document strategies on Falls Care Plan)
Environmental Safety	• Equipment used is assessed as safe and appropriate for each individual, check for known falls risk factors i.e. space, lighting, floor surface • Keep area around bed, chair and toilet clear.
Orientation	• Orientate patient to ward, toilet, bathroom, call bell and meal times.
History Of Falls	• Obtain details about previous falls from patient, clinical record or family/carers to determine any pattern – time of day, after medication, activity at the time, environmental impact. • Document hx on Falls Assessment Tool and in clinical record. • Assess for fear, decreased confidence related to previous falls.
Altered Cognitive State and Impaired Judgement	• Address patient's anxieties / reassure patient, re-orientate patient to surroundings at each encounter, use uniform methods when instructing / assisting patient. • Bed in lowest position when patient is resting, change to hi-lo bed, move bed against wall. • A flop mattress or sensor mat may be placed on the floor beside the bed • Sometimes it may be necessary to nurse patients on a mattress on the floor, assess the suitability of the patient i.e. ability to get up off the floor, not suitable for patients who have had joint replacements • Place patient closer to nurse's station if risk-taking behaviours evident to ensure increased observation, visualise frequently, especially at night. • Medical assessment for depression / behaviour if appropriate. • Patients requiring supervision or assistance with transfers or walking, remind patients to ask for assistance for any activity which involves this. • Reorient to ward, especially to own room / toilet hourly / every shift / each encounter as appropriate. • Use uniform methods when instructing/assisting. • Discuss falls risk with family; encourage them to sit with patient. • Investigate possible cause of confusion e.g. medications, sepsis. • Consider specialling or use of an alert alarm. • Provide regular activity during the day to aid sleep at night and / or reduce agitation during the day (ask families for relevant information). • Investigate patient's previous / preferred ADL routines (e.g. evening shower), and integrate where possible into care plan. • Provide supervision with ADL's, do not leave patient alone in shower or toilet, and provide regular toileting. Consider if patient's personal ADL's should be attended to before others
Continence Problems	• Maintain normal bladder / bowel function • Provide toileting regime (e.g. 2-4 hourly / after meals / before settling at night) and ensure adhered to (document in Falls Care Plan). • Place patients with urgency near toilets, consider use of commode. • Regular checks following laxatives or diuretics and at night if required. • Monitor floor for wet areas and clean ASAP. • Use night lights to ensure good visibility, supervise if needed. • Continence assessment & / or review of continence chart. • Consider use of continence aids or referral to continence nurse. • Adequate hydration during day, not excess late pm.
Medical Conditions	• Liaise with medical staff for review of medical condition, e.g. stability of condition, pain, medications, risk of osteoporosis. • Consider allied health referral, e.g. stroke, Parkinson's Disease, respiratory conditions.

Unsteady Transfers/ Ambulation	• Observe patient/client/resident performing transfer bed to chair and walking away from bedside if appropriate • Ensure patient's feet are on the ground before standing up from chair/bed. • Provide level of assistance indicated, assist / supervise ambulation and transfers - ask for demonstration by physiotherapist if unsure. • Refer to physiotherapy if altered from previous functional level. Provision of walking aids, use of aids / gait / balance assessment as appropriate • Ensure call bell / gait aid within reach if appropriate. • Consider hip protectors
Impaired Vision	• Provide optimal lighting, e.g. night lights, reduce glare. • Ensure glasses are worn and clean, within reach if not worn. • Ensure appropriate use of glasses, e.g. reading vs distance. • Use of impaired vision signage
Impaired Hearing	• Use common gestures / cues and minimise excess / extraneous noise. • Ensure hearing aid is worn, turned on and working. • Use of impaired hearing signage
Sensation Loss in feet	• Assess patients/clients/residents foot health e.g. corns, bunions, nail care, diabetes • Educate patient to monitor skin integrity daily.
Foot Problems	• If ulcers or foot condition impeding mobility, referral to medical officer.
Communication Difficulties	• Assess communication – the patient/client/resident may not understand instructions and may not be able to inform staff of their needs. • Use interpreters / family members and provide common cues, e.g. white board / instructions. • Refer to speech language therapy if altered from previous level.
IV Therapy	• Secure drip lines and provide assistance / instruction for ambulation.
24 Hours post surgery	• Provide supervision with ADLs and ambulation e.g. caution 1st time up.
Polypharmacy (≥4 meds)	• Medication review by doctor/pharmacist: highlighting falls risk, total number of medications prescribed, drug interactions, administration times.
Types of Medications	• Liaise with med staff/pharmacist about timing of administration of medications and limit combinations. • Educate patient– slow rising from sitting/lying position, sit on bed or stand for few minutes before moving off, especially if taking meds which may cause postural hypotension. • Anticipate possible side effects & take appropriate measures, report if they occur. • Sedatives – toilet & prepare for bed prior to giving night sedation, monitor overnight and supervise in morning. • Psychotropics- cause sedation, postural hypotension & impair balance. • Diuretics – anticipate immediate and subsequent toileting.
Footwear	• Liaise with family to provide appropriate shoes. If shoes too tight or loose fitting, ambulate bare foot. If using slippers, must be good fit with back of heel support. Do not ambulate in socks on.
Clothing	• Liaise with family to provide good fitting clothes – not too long or loose.
Nutrition	• Maintain optimal nutritional status • Encourage oral & fluid intake. • Dietitian referral if appropriate

Appendix B

Managing Patients Following a Fall

Process	Standards/Tasks	Who
Patient Falls		
Provide first aid measures and reassurance	• Check for ongoing danger • Check whether the patient is responsive (e.g. responds to verbal or physical stimulus) • Seek appropriate level of help • Reassure and comfort the patient, leave on surface until assessed, make comfortable	Member of the Multidisciplinary Team
Take baseline recordings and check for injuries	• Conduct a preliminary assessment that includes taking baseline recordings and blood sugar levels • If the patient has hit their head, or if fall was unwitnessed, record neurological observations (e.g. using the Glasgow Coma Scale), frequency/duration of ongoing observations to be determined by medical officer • Check for signs of shock • If the patient has had any period of unconsciousness follow the Accident Compensation Corporations (ACC) Guidelines for Head Injuries • Assess whether it is safe to move the patient from their position, and identify any special considerations in moving them • Do not move the patient if suspected spinal cord injury / hip or pelvic injury / pain on movement • Staff members should use a lifting device if required. Follow the Safer Patient Handling Protocol (CSPMS2).	
Monitor the Patient	• Take and document appropriate observations, including observations to help to identify medical causes of fall (e.g. temperature to identify a new febrile illness) as well as observations to detect injury, especially hip fracture and head injuries • Observe patients who have fallen and who are taking anticoagulants or antiplatelets carefully, because they have an increased risk of bleeding / bruising and intracranial hemorrhage. Check ACC Guidelines for Head Injuries • Patients with a history of alcohol abuse may be more prone to bleeding • Arrange for ongoing monitoring of the patient, because some injuries may not be apparent at the time of a fall. • Document frequency of observations and reasons in clinical record	
Report the fall	• Medical officers are to be notified of all falls that result in an injury to the patient/client/resident immediately. Non-injury falls are to notified within 24 hours of a fall • Document details of fall in the patient's clinical record • Complete notification as per Incident Reporting and Management Policy QR 8, regardless of where the fall occurred or whether the patient was injured • At the earliest opportunity notify the patients next of kin to inform them that the patient has fallen, consequence of the fall and steps taken following the fall to reduce future risk (discuss with patient prior to contact) • Note all details of the fall in the report, including the patient's description of the fall, the location and time of the fall, what the patient was doing immediately prior to the fall, mechanisms of fall (e.g. slip, trip, overbalance, dizziness) and whether they lost consciousness	
Next Page		

Managing Patients Following a Fall

Process	Standards/Tasks	Who
Previous Page		
Identification and Treatment of Injury	• Identify and treat any injury sustained from the fall, this includes providing comfort, reassurance and pain relief as necessary • Make safe any obvious environmental hazard that contributed to fall. • Identify targeted, individualised falls action plan for patient	Member of the Multidisciplinary Team
Discuss the fall and future risk management	• Communicate to all relevant staff, members of the MDT that the patient has fallen i.e. record in clinical record • Discuss falls prevention education with patient/family/whanau • Once a patient has fallen, they automatically become at high risk of falling again. Update Falls Action Plan to reflect interventions put in place to prevent reoccurrence • Discuss the assessment and management recommendations with the MDT • Ensure patient has a falls identifier wrist bracelet on (unless patient refuses), update Patient at a Glance Board and place falls mobility flipchart above bedside (where available), update the clinical record • Review medications, mobility aids • Investigate the cause of the fall • Encourage the patient to resume their normal activity (if not contraindicated) to reduce the fear of falling • Consider the use of injury-prevention interventions (e.g. hip protectors) • Consider investigations for osteoporosis in the presence of low trauma fractures	
Analysing the Fall	• As per Incident Reporting and Management Policy, QR8 Incident investigation to include: • What risk factors were present? • What was the activity at the time of the fall, is there increased risk relating to time of day or activity? • Has the patient had a falls risk assessment completed? • Consider trends i.e. has this patient fallen before? • If patient identified as med/high falls risk, what interventions were in place? • What was the mechanism of the fall (slip, trip, overbalance, dizziness)? • Does the patient depend on assistance to mobilise? • Any recent changes in medication that might be associated with fall? • Did the environmental conditions contribute to the fall (i.e. floor, lighting) • Did patient have access to aids (i.e. glasses, hearing aid, bell, mobility aids) • Patients perception of the fall • Status following fall (baseline observations, injuries)? • Interventions put in place following the fall and medical treatment • Was it a confirmed or suspected fall, were there any witnesses to fall?	3rd Tier Manager or delegate
Next Page		

Managing Patients Following a Fall

Process	Standards/Tasks	Who
Previous Page		
Discharge Planning	• Patients considered to be at high risk of falling should be referred to an occupational therapist and physiotherapist for needs and training specific to their home environment and equipment (i.e. home visit) • Referral to community physiotherapist if required (i.e. strengthening exercise programme) • Refer to social worker if patient requires a medical alert system • Ensure falls risk, injuries sustained as result of fall, interventions/actions taken and ongoing plan is included in discharge summary to primary care provider and written on transfer letter if patient is being transferred to another facility	Member of the Multidisciplinary Team
End		

4. Are falls automatically referred to ACC? (we have asked ACC for their figures)
The Falls Prevention/Management Procedure states – 'An Accident Compensation Corporation (ACC) form is to be completed for all patients who present with an injury following a fall'.

5. How many patient falls have had an ACC 45 form filled out and filed with ACC?
This data is not collected by SCDHB in this format.

If you have any further questions please contact me.

Regards

Nicola Prue
Communications Manager
On behalf of
Nigel Trainor
Chief Executive