Falls Review Tool

This tool has been specifically designed to analyse adverse patient safety events related to falls that occur within Victorian health services.

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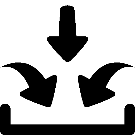
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### Part One: Before a fall – Organisation Review: Template 1

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| --- | --- | --- | --- |
| Contributing systems factors levels | Prompting questions to answer prior to any fall adverse event occurring (Can be done by Falls Committee) | Free text- Evidence (review periodically independently of any fall event)  Strategies in place | Free text- Evidence (review periodically independently of any fall event)  Known gaps or inefficiencies |
| Government, regulators, and external influences | Have external factors that may influence falls prevention been identified and actioned? E.g., funding, standards, staffing ratios? |  |  |
| Organisational and management factors | Are there falls procedures/policy/processes embedded in the organisation (e.g., falls prevention, falls risk screening, deteriorating patient, post fall huddles, advanced care planning, dignity of risk, handover, and transitions)?  Do managers lead/support falls prevention?  Are falls outcomes measured and reported?  Is equipment available or able to be sourced when needed?  Are processes in place for patients to be involved in their own care planning? |  |  |
| Work environmental factors – physical | Have hazards been identified and minimised/eliminated in care areas?  Are there assistive devices installed where needed? (e.g., handrails)  Are there sensor devices in use and if so, are they effective? (What is organisation view?)  Can patients who are high falls risk be placed in a room that is visible to staff?  Are required ambulating devices readily available (crutches, walkers, SPS etc.)?  Do all patients have access to a call bell?  Is lighting adequate in bedroom and toilet areas?  Is there guidance on the use of bed rails for clinical staff? |  |  |
| Work environmental factors – workforce | Are staffing levels/mix adequate for supervision of patients?  Are staff meal breaks adequately covered?  Is there a process for acquiring specialling/close observation?  What happens to staffing at handover? |  |  |
| Task and technology factors | Has the use of Falls Risk assessment tools been reviewed/audited (e.g., in the last 12 months)?  Are the actions from the falls risk assessments implemented?  Is there regular checking/rounding in place?  Is toileting offered to patients on a scheduled basis?  Is there a process for high-risk falls patients to have their medications reviewed that may contribute to falls? |  |  |
| Teamwork | Are multidisciplinary team involved/referrals made for falls prevention strategies?  Is a patient’s risk of falling communicated between clinical staff?  (Consider handover, patient journey boards, over bed boards, multidisciplinary meetings, family meetings, care plans, discharge documentation) |  |  |
| Staff Factors (individual) | Are staff adequately trained in falls prevention? |  |  |
| Family/NOK | Are families/carers contributing to falls prevention strategies?  Are families/carers involved in the care planning process? |  |  |

 **Part Two: When a fall occurs – Written Description**

(Gather information and write your description of the event here)

 **Part Two: When a fall occurs – Timeline**

(Insert or create your timeline here)

### Part Two: When a fall occurs – Patient Factors: Template 2

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **How might we improve the system to better support future patients with similar characteristics and needs?**  **What systems factors might we leverage? Indicate in the left-hand columns which system levels your improvement ideas are linked to.** | | | | | | | |
| PATIENT FACTOR  CATEGORY | EVIDENCE | RECOMMENDATIONS | Government, regulators & external influences | Organisational & management factors | Work environment factors - physical | Work environment factors - workforce | Task & technology factors | Teamwork | Staff factors | |
| History of falls |  |  |  |  |  |  |  |  |  | |
| Medications  (Consider Narcotics, Benzodiazepines, Antidepressants, Antipsychotics, Beta Blockers, ACE Inhibitors, Anticoagulants, Diuretics) |  |  |  |  |  |  |  |  |  | |
| Medical history |  |  |  |  |  |  |  |  |  | |
| Cognition  (Delirium, Dementia, Hypoxia, Short term memory loss, Impulsive behaviour) |  |  |  |  |  |  |  |  |  | |
| Continence and toileting |  |  |  |  |  |  |  |  |  | |
| Communication |  |  |  |  |  |  |  |  |  | |
| Vision |  |  |  |  |  |  |  |  |  | |
| Mobility and Gait Aides  (Ambulation status, aides, footwear) |  |  |  |  |  |  |  |  |  | |
| Other  (You can add additional rows if required) |  |  |  |  |  |  |  |  |  | |

### Part Two: When a fall occurs – System Factors: Template 3

| Contributing systems factors levels | Questions to prompt thinking- not all questions need answering, keep your thinking to the context of the fall being reviewed. Some system levels may not have contributing factors for the fall being reviewed. | Free text (use this to identify contributing factors or provide evidence of good care) |
| --- | --- | --- |
| Government, regulators, and external influences | Were external factors that may influence falls prevention a factor? E.g., funding, standards, staffing ratios, regulations? |  |
| Organisational and management factors | Were falls procedures/policy/processes followed (e.g., falls prevention, falls risk screening, deteriorating patient, post fall huddles, advanced care planning, dignity of risk, handover)?  Is there a strong culture of falls prevention on ward x?  Are falls outcomes and measure reported on ward x?  Was equipment available that was required for patient care?  Was the patient involved in their own care planning? |  |
| Work environmental factors – physical | Was the area where the fall occurred free from hazards? E.g., linen skips, cords, waste bins etc.  Were the appropriate assistive devices available to the patient at the time of the fall?  If a sensor device was used, was it effective?  If the patient was a high falls risk – were they placed in a room that was visible?  Were the required ambulating devices available? (e.g., Gait aid within reach?)  Did the patient have access to a call bell?  Was the lighting adequate at the time of the fall?  Were bed rails used appropriately? |  |
| Work environmental factors – workforce | Were staffing levels/mix adequate for supervision of patients? E.g. mealtimes and handover times  Did the patient have the right type of assistance or supervision at the time of the fall?  Were meal breaks adequately covered if fall happened during this time?  If the fall happened during a staff meal break did adequate handover occur?  If the patient required close observation was this in place? |  |
| Task and technology factors | Was an accurate falls risk assessment completed?  Were the actions from the falls risk assessments implemented?  Was hourly rounding in place at the time of the fall?  Was the patient’s toileting managed appropriately?  Was the patient’s medication reviewed to decrease the risk of falling? |  |

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| Contributing systems factors levels | Questions to prompt thinking- not all questions need answering, keep your thinking to the context of the fall being reviewed. Some system levels may not have contributing factors for the fall being reviewed. | Free text (use this to identify contributing factors or provide evidence of good care) |
| Teamwork | Was the multidisciplinary team involved in this patient’s plan for falls prevention?  Were the recommended strategies from the plan in place?  Was the risk of falling communicated to clinical staff?  (Consider handover, patient journey boards, over bed boards,  multidisciplinary meetings, family meetings, care plans, discharge documentation) |  |
| Staff Factors (individual) | Did staff involved in care at the time of the fall have training in falls prevention? |  | |
| Family/Next of Kin | Did we enable the family able to contribute to falls prevention strategies?  Did we enable family involvement in the care planning process?  Was open disclosure followed? |  | |
| Other Factors |  |  | |

### C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\connect-icon-16.jpg Part Two: When a fall occurs – Linking System Factors: Template 4

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| --- | --- | --- | --- |
| Systems Layers | Systems factors contributing prior to fall | Systems factors contributing to the fall at the time | System factors contributing after the fall |
| Government, regulators, and external influences |  |  |  |
| Organisational and management factors |  |  |  |
| Work environmental factors – physical |  |  |  |
| Work environmental factors – workforce |  |  |  |
| Task and technology factors |  |  |  |
| Teamwork |  |  |  |
| Staff Factors |  |  |  |
| Other Factors |  |  |  |
| Family/NOK |  |  |  |