Falls Review Tool

A user guide for reviewing adverse patient safety events relating to falls

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# Falls Review Tool: Quick reference

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| Before a fall | | |
|  | [**Are you prepared**](#_Part_One:_Before)**?** | * A multidisciplinary team completes **Organisational Review - Template 1** independent of a specific falls event. * This template establishes the known system factors contributing to a consumers likelihood of falling within your organisation. It is used as a ‘work as imagined’ (how your health service should be able to prevent and respond to falls in principle) reference when reviewing a specific falls event. |
|  | | |
| When a fall occurs | | |
| Play Button Icon #17749 - Free Icons Library | **1.** [**Set up review process**](#_Steps_1-4:_the) | * Verify the adverse patient safety event: Ensure any reporting requirements are completed. * Ensure **open disclosure** and **duty of candour** have been addressed * Apply [**just culture principles**](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/just-culture-training-and-resources) |
|  | **2.** [**Form the review team**](#_Steps_1-4:_the) | * Form the review team * Review[**core falls principles**](#_Core_Falls_Review)that should be central to how the review team frames and undertakes the review |
|  | **3.** [**Gather what happened**](#_Steps_1-4:_the) | * Include information from medical records, interviews etc. * Complete a brief written summary of the falls event |
|  | **4.** [**Develop a timeline**](#_Steps_1-4:_the) | * Succinct and factual * Do not make assumptions * Start date/time will be contextual to the fall |
|  | **5.** [**Complete Patient Factors**](#_Step_5:_complete) | * Complete **Patient Factors - Template 2** * *Ask- could we mitigate patient factors that contributed to the fall?* * Put this aside after completion for now, as we need to focus on system issues in the next step |
|  | **6**[**. Complete Systems Factors**](#_Step_6:_complete) | * Complete **Systems Factors - Template 3** * Use the *prompting questions* to identify systems factors that contributed to the fall. |
| C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\icon-compare-1.jpg | **7.** [**Compare**](#_Step_7:_compare) | * Compare **Organisational Review - Template 1** & **System Factors - Template 3**. * *Ask –Were systems of care in place as they should have been?* * *Where are the differences between the* *work we say we do (‘work as imagined’), and what happened in practice? Are the contributing factors known to us or are they new?* |
| C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\connect-icon-16.jpg | **8.** [**Linking system factors**](#_Step_8:_complete) | * Transfer contributing factors to **Linking System Factors - Template 4** * ***First*** *ask - When did the contributing factors have an effect? Did the factor contribute to the patient’s likelihood to fall (pre fall care), the real time context of the fall (at the time of the fall) or to the patient’s likelihood of dying or suffering significant injuries* *because of the fall (post fall care)? Were processes followed to ensure that the right care was given, and the right people communicated to? Did care occur in a timely manner?* * ***Then*** *ask – What are the possible relationships between the contributing factors at each level?* * Draw a line between any contributing factors that have a relationship. Note: there may be multiple connections with multiple contributing factors at many levels. Embrace the complexity. |
|  | **9.** [**What did we learn?**](#_Step_9:_Create) | * Examine the links between the contributing factors to develop systems-based finding statements that describe those relationships. * Reflect on system improvement ideas from **Patient Factors – Template 2**. * Finding statements should focus on system changes at the appropriate level that could mitigate risks for patients in the future. |
| C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\action-icon-png-22.jpg | **10.** [**How can we change?**](#_Step_10:_Develop) | * Create an action plan to ensure recommendations are actioned to improve falls prevention within your organisation. |

# Background

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

## Definitions

**Adverse patient safety events** are an incident that results in harm to a person receiving care. Harm included disease, suffering, impairment (disability) and death[[1]](#endnote-2). **Adverse events** are an “incident that results, or could have resulted, in harm to a patient or consumer”[[2]](#endnote-3). For the purposes of this document, adverse patient safety events and adverse events are used interchangeably.

A **fall** can be defined as “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects.”[[3]](#endnote-4)

For the purposes of this document, the words **consumer** and **patient** are both used to describe the person who has experienced a fall. Depending on your health context, you could also interchange the terms client or resident. **Consumer** can also be used to refer to family members or carers of people admitted to a health service.

## Purpose

This tool is designed to assist health services in applying a system thinking approach when it comes to reviewing adverse patient safety events related to falls.

|  |
| --- |
| A note on adverse event falls  Falls that occur outside the health service and are therefore not subject to the health service's influence (but may for example, be the original reason for admission) are not themselves subject to adverse event review.  However, if a patient admitted for a fall that occurred prior to their admission to the health service experiences another fall within the health service, the latter fall may be subject to adverse patient safety event review.  There may also be other reporting that is concurrently required when undertaking an adverse event review, for example, Coroner’s Office reporting. |

## Overview

Falls are not limited to the elderly, but falls are the most frequent, significant adverse event for older hospitalised health care consumers in Victoria[[4]](#endnote-5). There is a significant personal, economic and health care delivery cost associated with inpatient falls. Given our aging population, the increasing cost of health care and demands on the public health system, falls prevention is a major public health issue.

### A fall is not usually an isolated event

A patient who falls once, especially an older person, is more likely to fall again. As a result, those caring for a patient who has a high risk of falling are likely to have had repeated exposure to this type of event which may affect how they react to the fall event.

### Avoid assumptions about staff coping

It is important not to assume that people (i.e., staff members) who have had repeated experience of incidents involving consumers that result in harm or death will not be adversely affected. It is also important not to assume that people will respond in a similar way to each instance of consumer harm or death. A health care worker who has ‘coped well’ with previous instances may have a different response and experience to future instances.

### Falls are complex

Consumers who fall often have complex co-morbidities and the risks associated with falling are multifactorial. Not surprisingly, there is limited evidence to support one single intervention that significantly reduces the risk of falling[[5]](#endnote-6) but a person-centred approach with multiple interventions targeting various risk factors, can reduce a person’s risk of falling whilst in care[[6]](#endnote-7). This already complex situation is further complicated by the positive risk management of promoting the dignity afforded to individuals by being able to choose to engage in activities that improve their quality of life[[7]](#endnote-8).

Given that falls are complex, and the complexities of the health care system in which people fall, it is not surprising that analysing falls can be complicated and difficult to undertake. By acknowledging the complexity of falls prevention, we must also acknowledge that there may not be a definable critical event, at which point a single intervention would have altered the sequences of events, prevented the event from occurring, or altered the outcome.

### Methodology

Falls have traditionally been reviewed using the Root Cause Analysis (RCA) methodology; a limitation of this method is that it requires a critical event to be identified which serves as the start for identifying root causes. This linear approach can be difficult to apply to the analysis of falls incidents[[8]](#endnote-9).

This falls review tool is addressing the economic burden of falls reviews by providing a tool that can be applied by a smaller team, over a potentially shorter period, whilst still addressing the complex nature of contributing factors which influence falls.

This tool incorporates features from several systems-focused adverse event review methodologies including AcciMap, Bowtie and London Protocol.

Given that many contributing factors will be contextualised to an organisation and relevant to many falls, there is an opportunity to consider these factors when using the tool with a multidisciplinary team prior to any adverse event review. A review can then be completed by a smaller team once an event occurs.

# Core Falls Review Principles

There are a few core principles that should be central to a review team’s thinking in how they frame and undertake the review process. Conducting a review is an iterative process. Review teams should continually refer to these principles throughout the process to ensure they stay on track.

## 1. Falling is not inevitable

Whilst falling is more common as we age falls should not be seen as a normal or expected part of ageing[[9]](#endnote-10). A patient’s likelihood of falling is affected by both intrinsic (physical and behavioural) and extrinsic (environmental, socioeconomic) risk factors[[10]](#endnote-11). We can reduce a patient’s risk of falling by implementing falls risk reductions strategies[[11]](#endnote-12)[[12]](#endnote-13)[[13]](#endnote-14).

## 2. Not all falls are preventable

The fact that some (especially high risk) consumers will fall is predictable and it is acknowledged that not all inpatient falls are preventable despite interventions. If our aim is the reduction of inpatient falls, then improving falls preventions strategies should be the focus. It is acknowledged that there is limited evidence related to the effectiveness of many falls’ prevention interventions[[14]](#endnote-15). However, improving falls prevention strategies is central to a strong safety culture that is driven by continuous feedback and learning from adverse events related to falls.

## 3. There is dignity in taking risks

The preferences of the consumer should be considered when reviewing falls prevention strategies[[15]](#endnote-16). The ability to mobilise at will to attend to one’s activities of daily living has a strong relationship with quality of life and wellbeing[[16]](#endnote-17). The risk of falling is directly linked to mobilising to attend to activities of daily living[[17]](#endnote-18). Dignity of Risk is the principle of allowing an individual the dignity afforded by risk-taking, with the subsequent enhancement of personal growth and quality of life[[18]](#endnote-19).

## 4. Multidisciplinary approach

Falls are complex. Our approach should be systems-focused and consider multiple contributing factors. When reviewing falls adverse patient safety events, incorporate a multidisciplinary approach, using your multidisciplinary team including consumers, allied health, medicine, and nursing where available to assist in the review and prevention of falls[[19]](#endnote-20).

## 5. A patient’s risk of falling is personal and dynamic

A patient’s risk for falling is dynamic and may change during their admission[[20]](#endnote-21). Include initial/admission risk assessments and most recent risk assessments, review any alterations in the patient’s risk factors over time and interventions implemented to address these risks.

## 6. Advanced care planning

To provide holistic person-centred care, those identified as a high falls risk should also have an advanced care directive in place. Older, frail consumers who are assessed at being a high risk for falling are also at high risk of significant injury or death from a fall[[21]](#endnote-22). Consideration for advanced care planning should be standard for this cohort[[22]](#endnote-23) and be included in any falls management strategy.

## 7. Focus on systems

A human factors systems approach is central to this method of falls incident analysis because we acknowledge that falls are complex and occur in a complex health care system. A systems approach assumes that individuals are fallible, and errors are to be expected, it concentrates on the conditions under which individuals work and tries to build defences in the system to prevent errors or mitigate their effects[[23]](#endnote-24). A systems approach acknowledges that a range of system factors contribute to human behaviour and performance. Consequently, this system focused falls review tool helps to identify systems-contributing factors of falls, as well as systems-focused recommendations to mitigate their recurrence.

## 8. Just culture

Falls reviews should apply the principles of a just culture. A just culture is the foundation upon which a strong organisational safety culture is built. In a just culture when an adverse event such as a fall occurs, accountability is shared between individual staff and the organisational systems they are working within. Staff are expected to come to work with good intentions and report safety risks, and the organisation is responsible for providing safe systems for employees and patients, and to respond to reported risks and adverse event reports by strengthening these systems[[24]](#endnote-25).

The Safer Care Victoria Just Culture Guide provides a summary of just culture principles, and how to apply these when undertaking a review. Three main actions are involved to apply a Just Culture mindset: make sure that everyone involved in the adverse event is OK, manage cognitive biases and consider systems factors contributing to the adverse event.

## 9. Duty of candour

From 30 November 2022 when a patient suffers a serious adverse patient safety event (SAPSE), relevant health service entities will be required to provide them with a Statutory Duty of Candour (SDC). The SDC builds on existing requirements under the Australian Open Disclosure Framework.

When a patient suffers a SAPSE, the health service entity will be legislated to comply with any requirements within the *Victorian Duty of Candour Guidelines*. The apology provided under the SDC will be protected and not be relevant in civil or disciplinary proceedings. If relevant requirements within the *Health Services Act 1988* are followed, a health service entity may conduct a protected adverse event review called a ‘SAPSE review’.

The Guidelines and additional resources can be accessed from [Statutory Duty of Candour and protections for SAPSE reviews | Safer Care Victoria](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour).

# Using the Falls Review Tool

## Part One: Before a fall

### Task: Preparation and review

To establish the known systems factors that contribute to clinical decisions and actions that influence consumers’ likelihood of falling within your organisation document them using the Organisation review: Template 1. This template is to be completed independently from a specific falls event.

### Part One: Before a fall - Organisation review

This method streamlines the process of adverse event review by allowing some of the contributing factors to be pre-populated, for example: sources of information and known hazards, potential risks, and gaps, as well as existing prevention strategies contextualised to service and cohort. You should support your views with evidence where you can, for example links to audit results.

Note: This work is completed independently from any fall event that requires a review. It will assist you to use the Falls Review Tool more efficiently in the future by providing current state and gap analysis on your falls processes. You can still use Templates 2 (Patient factors), 3 (System factors) and 4 (Linking system factors) to complete a review without having completed this step, however, you will find it easier to do if you have the information from Template 1 (Organisation review) at hand when completing a review.

#### Steps

1. Consider who should constitute the multidisciplinary team within your organisation to complete this template.
2. Establish the multidisciplinary team to consider the factors within your organisation that contribute to clinical decisions and actions that influence patient’s likelihood of falling. Your organisations Falls Committee could be the multidisciplinary team that already exists to undertake this process.
3. A consumer should be part of the team.
4. Once each factor/question has been reviewed enter the evidence into the Organisation Review: Template 1. Note that you do not have to follow the system factors levels in order- you may find it easier to begin with organisational and management factors, for example.
5. Establish a strategy to ensure that the Organisation Review: The multidisciplinary team regularly reviews Template 1 to ensure its accuracy e.g. add to meeting schedule at Falls Committee. Part One should be updated with findings from individual and multiple fall reviews as part of the continuous quality improvement process.

In the event of a review being required, the team can use this information to understand the resources, gaps and risks that may have influenced the fall.

#### Use existing resources

If your organisation has a multidisciplinary falls review committee then utilise this group to pre-populate the tool rather than having to convene a team specifically for this purpose.

#### Size matters

Context is important and depending on the size of your organisation you may want to complete a separate Organisation review: Template 1 for different high-risk falls areas within your service.

#### Not everything is included

The differing contributing factor levels will be dynamic. The template should be seen as a tool to focus your review of an adverse event rather than a definitive document that identifies all aspects of falls prevention. The questions in the table are not exhaustive- you can add anything else that is relevant in each of the levels. The questions should be seen as a prompt to get you thinking.

#### References

Templates 1 and 3 used in this methodology are based on the New Zealand Health and Safety Commissions Human Factors Guide to analysing fall events[[25]](#endnote-26) and has been designed using the London Protocol‘s contributing factors framework[[26]](#endnote-27).

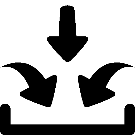
### Template 1: Before a fall – Organisation review

|  |  |  |  |
| --- | --- | --- | --- |
| 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? | *EXAMPLE: Staff are aware of falls prevention policies and procedures that are available the intranet*. |  |
| 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? |  | *EXAMPLE: There are limited rooms with visibility from* *common areas.* |
| 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? | *EXAMPLE: Meal breaks are structured to enable coverage of staff in each area whilst breaks are in progress* |  |
| 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? |  | *EXAMPLE: There is currently no process to flag patients who are high falls risk to pharmacy* |
| 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? | *EXAMPLE: Comprehensive Care Policy states that family and carers should contribute to care planning, including falls prevention* | *EXAMPLE: No measure/audit to indicate how often families are participating in care planning* |

## Part Two: When a fall occurs

If an adverse event fall occurs, follow the steps that you normally take when starting the review.

### Steps 1-4: The setup

1. Play Button Icon #17749 - Free Icons Library Set up the review process- apply just culture principles. Verify the adverse patient safety event ensuring any reporting requirements are completed.
2.  Form the review team- less team members may be used if you have a multidisciplinary falls committee (including a consumer) that reviews your Organisational review: Template 1. An example review team may be – clinical governance lead, nurse unit manager and external reviewer. It is important at this stage to identify an appropriate executive sponsor to support the recommendations and action plan.
3.  Gather what happened- this might include, but is not limited to, information from the medical record, interviews, audit results, risk screening, environmental audits. Complete a written summary of the event.
4.  Develop a timeline ensuring that it:
   1. is succinct and factual
   2. does not assume steps have been taken because they ‘should be’ - only include what happened
   3. includes days and times where possible
   4. shows if patient risk assessment(s) were completed, when, and by whom.

For those familiar with Root Cause Analysis (RCA) method, simply produce a standard timeline but do not try to identify the ‘critical events’ or ‘root causes.’

Once your timeline is complete, you can commence the analysis of your information using the templates below (Patient factors: Template 2, System factors: Template 3 and Linking system factors: Template 4).

#### 

### Step 5: Complete patient factors

Often patient factors will contribute to a fall, however, remember to focus on improving the system factors influencing falls when you develop recommendations.

Patient factors that often contribute to falls may include:

* a history of falls
* medication such as sedatives and painkillers
* impaired cognition that may affect communication or change behaviour.

Where the above factors or other patient factors have contributed to the fall it is important to still focus on recommendations that achieve systems improvements.

Use the Patient Factors: Template 2 below to elicit patient factors that contributed to the event and reframe them as potential systems improvements.

List the patient factors relevant to this case under “Evidence” using the categories in the first column as prompts.

In the “System Improvement Ideas” column, brainstorm system improvement ideas that could ensure future patients with similar characteristics and needs are better supported.

For each patient factor identified, categorise and mark the corresponding contributing systems factors levels (i.e., task & technology) in the check boxes in the right end of the table. This will help you later when you are developing your recommendations.

Keep in mind the purpose here is to reframe your thinking and brainstorm creative solutions.

If you get a few impractical and far-fetched ideas, this is fine – they will be refined and tested for feasibility at the recommendations stage.

Return to this information when formulating your finding statements and recommendations.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | 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 | *EXAMPLE: Patient had previously fallen in hospital* | Any fall could involve a multidisciplinary “post fall huddle” to ensure falls prevention strategies are in place and effective |  |  |  |  |  |  |  |
| Medications  (Consider Narcotics, Benzodiazepines, Antidepressants, Antipsychotics, Beta Blockers, ACE Inhibitors, Anticoagulants, Diuretics) | *EXAMPLE: Patient was on medications that increased the likelihood of falling* | A medication reconciliation could be completed by a pharmacist within 24 hours of admission |  |  |  |  |  |  |  |
| Medical history |  |  |  |  |  |  |  |  |  |
| Cognition  (Delirium, Dementia, Hypoxia, Short term memory loss, Impulsive behaviour) |  |  |  |  |  |  |  |  |  |
| Continence and toileting | *EXAMPLE: Patient had urge incontinence that increased the likelihood of falling* | Explore a business case for an in-reach  Continence Nurse to assist patients and staff with continence management plans |  |  |  |  |  |  |  |
| Communication |  |  |  |  |  |  |  |  |  |
| Vision | *EXAMPLE: Patient had no deficits in vision* | N/A |  |  |  |  |  |  |  |
| Mobility and Gait Aides  (Ambulation status, aides, footwear) |  |  |  |  |  |  |  |  |  |
| Other  (You can add additional rows if required) |  |  |  |  |  |  |  |  |  |

Using the timeline and other data that you have, analyse the information, and identify contributing factors.

Could we mitigate Patient Factors that contributed to the fall?

### Template 2: When a fall occurs – Patient factors

#### Step 6: complete System Factors

Using the information from your timeline and other sources, answer the questions below and document in the right-hand column. These will form the basis for the contributing factors. Were processes followed as they should have been? If not- why not? Are policies and procedures fit for purpose? **Identify any contributing factors** that influenced the fall event and use the free text column to document them. Also document the care that successfully made the consumer less likely to fall or supported the consumer to make informed choices about their risk taking in relation to their likelihood of serious injury or death.

 What System Factors contributed to the fall?

### Template 3: When a fall occurs – System factors

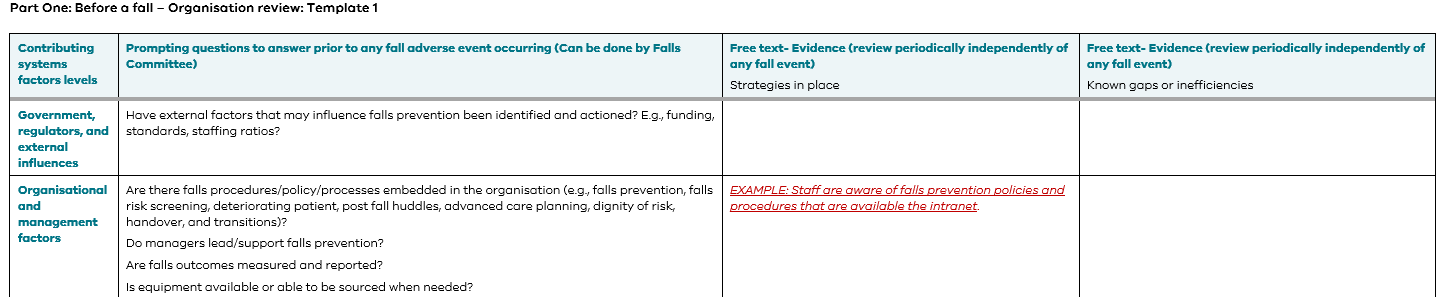
|  |  |  |
| --- | --- | --- |
| Contributing systems factors levels | Questions to prompt thinking- not all questions need answering, keep your thinking to the context of the fall being reviewed. Some system levels may not have contributing factors for the fall being reviewed. | Free text (use this 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? | *EXAMPLE: The orientation manual had not been updated for 2 years and did not include new processes for risk screening* |
| 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? | *EXAMPLE: There were two new staff members working in the same section* |
| 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? | *EXAMPLE: The patient did not have an updated risk screen at the time of the fall.* |

|  |  |  |
| --- | --- | --- |
| 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? | *EXAMPLE: New staff were unaware of the need to update the risk screening when a patient’s condition changes because it was not included in the orientation package* | |
| 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 |  |  | |

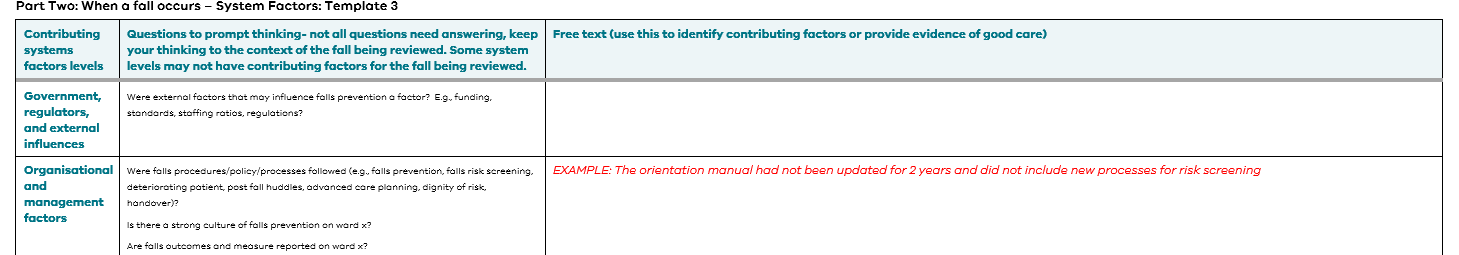
### C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\icon-compare-1.jpg Step 7: Compare what did happen with what should have happened

Now compare the information of what happened in this instance to what should have happened (using Part One Organisation review: Template 1 that has previously been completed). You do not need to document this as part of the tool. This step is a prompt to think. See the questions below you can ask when comparing what occurred to what should have happened.

 Did care occur as it should have? Where are the differences in the work that we say we do (policies and procedures) to what happens in practice? Are the contributing factors known to us or are they new?



Compare work as imagined in Template 1 (above) to work as done in Template 3 (below).



Use the above exercise to frame your thinking for the next step- linking system factors.

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### C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\connect-icon-16.jpg Step 8: Complete linking system factors

Now look at system factors you have identified in Template 3. Copy these factors and enter them into the final template Linking System Factors: Template 4. Place the factors into the template based on when they may have had an effect (prior to fall, at the time of the fall or after the fall), and in the corresponding system layer (see examples below).

 When did the contributing factors have an effect? Did the factor contribute to the patient’s likelihood to fall (pre fall care), the real time context of the fall (at the time of the fall) or to the consumers likelihood of dying or suffering significant injuries because of the fall (post fall care)? Were processes followed to ensure that the right care was given, and the right people communicated to? Did care occur in a timely manner?

Now examine this output of Template 4 at each stage of the fall (pre fall, at the time of the fall and post fall) to identify the combination of events and decisions that could have prevented the fall, made the fall more likely, and or affected the consumers likelihood of serious injury or death because of the fall. See the examples in red below.

 What are the possible relationships between the contributing factors at each level?

### Template 4: When a fall occurs – Linking system factors

|  |  |  |  |
| --- | --- | --- | --- |
| 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 | *EXAMPLE: The orientation manual had not been updated for 2 years and did not include new processes for risk screening* |  |  |
| Work environmental factors – physical |  |  |  |
| Work environmental factors – workforce |  | EXAMPLE: *There were two new staff members working in the same section at the time of the fall* |  |
| Task and technology factors |  | *EXAMPLE: The patient did not have an updated risk screen at the time of the fall.* |  |
| Teamwork |  |  |  |
| Staff Factors | *EXAMPLE: New staff were unaware of the need to update the risk screening when a patient’s condition changes.* |  |  |
| Other Factors |  |  |  |
| Family/NOK |  |  |  |

Using the example above you can now start to see the relationships between factors. This will help you formulate your finding statements.

## Part Three: What did we learn and how can we change?

### Step 9: Create finding statements and recommendations

Once you have identified the contributing factors and their relationships the next step is documenting the finding statements that describes those relationships. From that the team can develop recommendations that are focused on the system changes at the appropriate level that could mitigate any falls risks for patients in the future. Remember that the recommendations should follow the SMART principles. Now also review your system improvement ideas that you may have created in step 5- Patient Factors: Template 2. If using these ideas make sure that they align with your findings statements.

|  |  |  |
| --- | --- | --- |
| Theme | Finding Statement | Systems-related recommendations |
| Workforce environmental factors | *EXAMPLE: The patient did not have a current falls risk screen at the time of the fall. The risk screen should be updated in any change of patient condition e.g. deterioration, post operatively. New staff were recently orientated to the ward but were unaware of this requirement as per hospital policy.*  *EXAMPLE: The patient did not have an updated risk screen when their condition changed. New staff were unaware of the need to update the risk screening because it was not included in the orientation package. The orientation package had not been reviewed for 2 years and required updating.* | *EXAMPLE: Implement a falls leadership group within the ward, using an EOI (expressions of interest) process for senior nurses to be responsible for promoting falls prevention, including responsibility for audits, falls prevention awareness and education on falls policy and procedure for new staff including orientation information.* |

### C:\Users\60273422\AppData\Local\Microsoft\Windows\INetCache\Content.Word\action-icon-png-22.jpg Step 10: Develop a recommendation action plan

Create an action plan to ensure recommendations are enacted to improve falls prevention within the organisation. You may wish to use your own action plan template, as long as it uses SMART principles.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Recommendation number | Recommendation | Strength of recommendation | Actions to achieve recommendation | Due date for completion | Outcome measure | Executive sponsor | Position responsible/ accountable |
| 1 | *EXAMPLE: Implement a falls leadership group within the ward, using an EOI process for senior nurses and allied health to be responsible for promoting falls prevention, including responsibility for audits, falls prevention awareness and education on falls policy and procedure for new staff.* | *Strong* | *- Create role description and EOI*  *- Recruit leaders*  *- Leaders to undertake responsibility for auditing program*  *- Leaders to take responsibility for new staff falls education*  *- Leaders to update staff at each ward meeting*  *- Leaders to meet 3 monthly to formulate and lead falls prevention strategies for the ward* | *4 Weeks*  *8 Weeks*  *12 Weeks*  *16 Weeks*  *Established by 6 months* | *Completed EOI*  *Recruitment complete*  *Completed falls audits*  *Number of in-services completed by nurse leaders*  *Number of ward meetings with Falls discussed*  *Creation of Falls Leadership meetings with TOR (Terms of reference)* | *Director of nursing* | *NUM Ward X/ Allied Health Manager* |

# Endnotes

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