



Standard 10

Preventing Falls and
Harm from Falls

Safety and Quality Improvement Guide



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Australian Commission on Safety and Quality in Health Care

GPO Box 5480

Sydney NSW 2001

Email: mail@safetyandquality.gov.au

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Table of Contents

The National Safety and Quality Health Service Standards	2
Terms and definitions	5
Standard 10: Preventing Falls and Harm from Falls	6
Criterion: Governance and systems for the prevention of falls	8
Criterion: Screening and assessing risks of falls and harm from falling	16
Criterion: Preventing falls and harm from falls	21
Criterion: Communicating with patients and carers	26
References	28
Appendix: Links to resources	29





Standard 10: Preventing Falls and Harm from Falls

The National Safety and Quality Health Service Standards

The *National Safety and Quality Health Service (NSQHS) Standards*¹ were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients.

The primary aims of the *NSQHS Standards* are to protect the public from harm and to improve the quality of care provided by health service organisations. These Standards provide:

- a **quality assurance** mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met
- a **quality improvement** mechanism that allows health service organisations to realise developmental goals.

Safety and Quality Improvement Guides

The Commission has developed Safety and Quality Improvement Guides (the Guides) for each of the 10 *NSQHS Standards*. These Guides are designed to assist health service organisations to align their quality improvement programs using the framework of the *NSQHS Standards*.

The Guides are primarily intended for use by people who are responsible for a part or whole of a health service organisation. The structure of the Guides includes:

- introductory information about what is required to achieve each criterion of the Standard
- tables describing each action required and listing:
 - key tasks
 - implementation strategies
 - examples of the outputs of improvement processes
- additional supporting resources (with links to Australian and international resources and tools, where relevant).

Direct links to these and other useful resources are available on the Commission's web site:

www.safetyandquality.gov.au

The Guides present **suggestions** for meeting the criteria of the Standards, which should not be interpreted as being mandatory. The examples of suggested strategies and outputs of improvement processes are **examples only**. In other words, health service organisations can choose improvement actions that are specific to their local context in order to achieve the criteria. The extent to which improvement is required in your organisation will heavily influence the actions, processes and projects you undertake.

You may choose to demonstrate how you meet the criteria in the Standards using the example outputs of improvement processes, or alternative examples that are more relevant to your own quality improvement processes.

Additional resources

The Commission has developed a range of resources to assist health service organisations to implement the *NSQHS Standards*. These include:

- a list of available resources for each of the *NSQHS Standards*
- an *Accreditation Workbook for Hospitals* and an *Accreditation Workbook for Day Procedure Services*
- *A Guide for Dental Practices* (relevant only to Standards 1–6)
- a series of fact sheets on the *NSQHS Standards*
- frequently asked questions
- a list of approved accrediting agencies
- slide presentations on the *NSQHS Standards*.



Overarching NSQHS Standards

Standard 1: Governance for Safety and Quality in Health Service Organisations, and *Standard 2: Partnering with Consumers* set the overarching requirements for the effective application of the other eight *NSQHS Standards* which address specific clinical areas of patient care.

Standard 1 outlines the broad criteria to achieve the creation of an integrated governance system to maintain and improve the reliability and quality of patient care, and improve patient outcomes.

Standard 2 requires leaders of a health service organisation to implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care. Patients, carers, consumers, clinicians and other members of the workforce should use the systems for partnering with consumers.

Core and developmental actions

The *NSQHS Standards* apply to a wide variety of health service organisations. Due to the variable size, structure and complexity of health service delivery models, a degree of flexibility is required in the application of the standards.

To achieve this flexibility, each action within a Standard is designated as either:

CORE

- considered fundamental to safe practice

OR

DEVELOPMENTAL

- areas where health service organisations can focus activities or investments that improve patient safety and quality.

Information about which actions have been designated as core or developmental is available on the Commission's web site.

Quality improvement approaches in health care

Approaches to improving healthcare quality and safety are well documented and firmly established. Examples of common approaches include Clinical Practice Improvement or Continuous Quality Improvement. The Guides are designed for use in the context of an overall organisational approach to quality improvement, but are not aligned to any particular approach.

Further information on adopting an appropriate quality improvement methodology can be found in the:

[NSW Health Easy Guide to Clinical Practice Improvement](#)²

[CEC Enhancing Project Spread and Sustainability](#)³

[Institute for Healthcare Improvement \(US\)](#)⁴



The National Safety and Quality Health Service Standards (continued)

Roles for safety and quality in health care

A range of participants are involved in ensuring the safe and effective delivery of healthcare services. These include the following:

- **Patients and carers**, in partnership with health service organisations and their healthcare providers, are involved in:
 - making decisions for service planning
 - developing models of care
 - measuring service and evaluating systems of care.

They should participate in making decisions about their own health care. They need to know and exercise their healthcare rights, be engaged in their healthcare, and participate in treatment decisions.

- Patients and carers need to have access to information about options and agreed treatment plans. Health care can be improved when patients and carers share (with their healthcare provider) issues that may have an impact on their ability to comply with treatment plans.
- The role of **clinicians** is essential. Improvements to the system can be achieved when clinicians actively participate in organisational processes, safety systems, and improvement initiatives. Clinicians should be trained in the roles and services for which they are accountable. Clinicians make health systems safer and more effective if they:
 - have a broad understanding of their responsibility for safety and quality in healthcare
 - follow safety and quality procedures
 - supervise and educate other members of the workforce
 - participate in the review of performance procedures individually, or as part of a team.

When clinicians form partnerships with patients and carers, not only can a patient's experience of care be improved, but the design and planning of organisational processes, safety systems, quality initiatives and training can also be more effective.

- The role of the **non-clinical workforce** is important to the delivery of quality health care. This group may include administrative, clerical, cleaning, catering and other critical clinical support staff or volunteers. By actively participating in organisational processes – including the development and implementation of safety systems, improvement initiatives and related training – this group can help to identify and address the limitations of safety systems. A key role for the non-clinical workforce is to notify clinicians when they have concerns about a patient's condition.
- The role of **managers in health service organisations** is to implement and maintain systems, resources, education and training to ensure that clinicians deliver safe, effective and reliable health care. They should support the establishment of partnerships with patients and carers when designing, implementing and maintaining systems. Managing performance and facilitating compliance across the organisation is a key role. This includes oversight of individual areas with responsibility for the governance of safety and quality systems. Managers should be leaders who can model behaviours that optimise safe and high quality care. Safer systems can be achieved when managers in health service organisations consider safety and quality implications in their decision making processes.
- The role of **health service senior executives and owners** is to plan and review integrated governance systems that promote patient safety and quality, and to clearly articulate organisational and individual safety and quality roles and responsibilities throughout the organisation. Explicit support for the principles of consumer centred care is key to ensuring the establishment of effective partnerships between consumer, managers, and clinicians. As organisational leaders, health service executives and owners should model the behaviours that are necessary to implement safe and high quality healthcare systems.



Terms and definitions

Falls risk assessment: Falls risk assessment is usually a more detailed and systematic process than a falls risk screen and is used to identify a person's risk factor for falling. This facilitates development of a care plan to address the identified risk factors.

Falls risk screen: Falls risk screening is the minimum process for identifying people at greatest risk of falling, and those who require assessment. Screening can be a quick, but less accurate, process than assessment.

Flexible standardisation: Flexible standardisation recognises the importance of standardisation of processes to improve patient safety. However, the standardisation of any process, and related data sets and participants, must be designed and integrated to fit the context of health service organisations, including varying patient and staffing profiles. These will vary widely as health service organisations will have differing functions, size and organisation with respect to service delivery mode, location and staffing. Tools, processes and protocols should be based on best available evidence and the requirements of jurisdictions, external policy and legislation.

Governance: The set of relationships and responsibilities established by a health service organisation between its executive, workforce, and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way an organisation is directed, administered, or controlled. Governance arrangements provide the structure through which the objectives (clinical, social, fiscal, legal, human resources) of the organisation are set, and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help in aligning the roles, interests, and actions of different participants in the organisation in order to achieve the organisation's objectives. The Commission's definition of governance includes both corporate and clinical governance and where possible promotes the integration of governance functions.

Outputs: The results of your safety and quality improvement actions and processes. Examples of outputs are provided in this guide. They are examples only and should not be read as being checklists of evidence required to demonstrate achievement of the criterion. Outputs will be specific to the actions, processes and projects undertaken in your context which will be influenced by your existing level of attainment against the criterion and extent to which improvement has been required.



Standard 10: Preventing Falls and Harm from Falls

Clinical leaders and senior managers of a health service organisation implement systems to prevent patient falls and minimise harm from falls. Clinicians and other members of the workforce use the falls prevention and harm minimisation systems.

The intention of this Standard is to:

Reduce the incidence of patient falls and minimise harm from falls.

Context:

It is expected that this Standard will be applied in conjunction with *Standard 1: Governance for Safety and Quality in Health Service Organisations* and *Standard 2: Partnering with Consumers*.

Introduction

Falls-related injury is one of the leading causes of morbidity and mortality in older Australians with more than 80% of injury-related hospital admissions in people aged 65 years and over due to falls and falls-related injuries.⁵ Fall rates are greater for older people.⁵

Fall rates of 4–12 per 1000 bed days during health care have been described in patients 65 years and older.⁶ Incident rates vary between wards and departments in hospitals. In the subacute or rehabilitation hospital setting, more than 40% of patients with specific clinical problems, such as stroke, experience one or more falls during their admission.⁷ Injuries result from approximately 30% of such falls in hospital.⁸

Implementing systems to prevent falls and harm from falls

The intention of this Standard is to reduce the incidence of patient falls and to minimise harm from falls for patients in care. Standard 10 requires health service organisations to establish and maintain systems for prevention of falls including screening and/or assessing patients for falls risk and having multifactorial falls prevention strategies in place.

The intention of the Standard is to ensure that a patient's falls risk is recognised promptly, and appropriate action is taken. While this Standard applies to all patients in health service organisations,

it is primarily focused on those at risk of falls. While falls can occur at all ages, the frequency and severity of falls-related injuries increases significantly with age.⁷ Therefore the main resource document for health services meeting this Standard is *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009*.⁹ The guidelines are designed with older people in mind but may apply to younger people at increased risk of falling, such as those with a history of falls, neurological conditions, cognitive problems, depression, visual impairment or other medical conditions leading to an alteration in functional ability.

Health service organisations range from large tertiary referral centres to small district, multi-purpose and community hospital services. While Standard 10 applies to all health service organisations, it is recognised that some health service organisations, such as day procedure services (including fertility clinics, endoscopy centres and cardiac catheterisation laboratories), need to ensure that patients do not fall but do not require the significant system of falls prevention envisaged in this Standard. In addition, day procedure services would not be required to undertake comprehensive falls screening or assessment of patients. This is because the follow up action, which is identified through screening and assessment, is not possible. Some strategies which have falls prevention benefits will apply, such as post-anaesthetic care and post-procedure mobilisation, rather than comprehensive falls prevention systems.



Similarly, the majority of falls in paediatric patients are associated with normal stages of childhood development and age-related behaviour. Therefore this Standard should be applied flexibly in paediatric settings. Paediatric health service organisations should not be required to establish the significant system of falls prevention required for older patients at risk of falling and experiencing harm from falls described in this document or to screen and assess all patients.

This Standard does not apply to post-fall physical and psychological harm management, but it does describe incident reporting and management.

Criteria to achieve the Preventing Falls and Harm from Falls Standard:

Governance and systems for preventing falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls.

Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls.

Preventing falls and harm from falling

Prevention strategies are in place for patients at risk of falling.

Communicating with patients and carers

Patients, families and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.

For purposes of accreditation, please check the Commission's web site regarding actions within these criteria that have been designated as core or developmental.



Standard 10

Criterion: Governance and systems for the prevention of falls

Health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls

Ensuring patient safety in relation to falls requires sound governance structures and falls prevention systems. Health service organisations will need to ensure that:

- falls risk is screened and documented
- falls risk is assessed, if required, and documented
- appropriate multifactorial strategies are available and used
- falls are reported and investigated to ensure that falls, and the harm endured from them, is minimised.

In addition, health service organisations will need to inform patients and carers about falls risks and available strategies, and engage them in the development of appropriate falls prevention plans.

A range of professionals share the responsibility for establishing and maintaining falls prevention governance and systems. These include health service executives and owners, health service managers, clinicians, educators and people with responsibility for policy and quality improvement. It is recommended that the falls prevention system should be developed considering local circumstances. Consideration needs to be given to the individual roles and resources of each health service organisation, and each clinical area within a health service organisation, during the implementation process. Facilities may need additional resources such as equipment, personnel, education and training to ensure patients are appropriately screened, risk assessed and suitable risk minimisation strategies implemented.

Whether systems are developed on a national, state-wide or local basis, health service organisations may need to establish local project teams to oversee, plan and coordinate implementation and evaluation of falls prevention systems. Project teams should include representation from across the range of health professionals responsible for falls prevention. In addition, involving patients, families and carers as partners in these processes brings benefits in terms of improved services and higher satisfaction.¹⁰

Robust clinical governance frameworks and processes for evaluation, audit and feedback are also important for the establishment and improvement of falls prevention systems. Each health service organisation in Australia is responsible for ensuring that their systems for preventing falls and harm from falls are operational and effective. Including falls prevention systems in clinical governance frameworks allows a coordinated and systematic approach to evaluation, education, policy development and system improvements.

Evaluation helps to:^{11–13}

- identify and drive system improvements
- prioritise the allocation of resources
- identify educational needs
- develop future policy.

Evaluation of new systems is important to establish efficacy and determine the changes needed to optimise performance.¹⁴ Ongoing monitoring of falls prevention systems is also necessary to track changes over time, to ensure that systems continue to operate effectively and to identify areas for improvement. Data obtained from evaluating falls prevention systems should be communicated to the clinical workforce. This may help to inform health professionals of areas that need improvement, and motivate them to change practice and participate in improvement activities.^{15–17} These feedback processes also contribute to a culture of transparency and accountability.

An important part of evaluating systems for falls prevention is engaging frontline clinicians to obtain information on any barriers to utilising the system. Similarly, evaluating patient, family and carer perspectives and experiences provides valuable information on the personal aspects of care, identifies areas requiring improvement, and may provide solutions to system problems.^{13,18}

Health service executives are responsible for ensuring that falls prevention systems are developed, implemented and operating as planned within a health service organisation. A health service organisation's clinical governance framework provides the mechanism for this to occur.

Health service executives need to identify relevant committees, meetings or individuals and form clinical governance frameworks that encourage falls prevention systems to be developed, monitored and continuously improved. The frameworks may include one or more relevant committees (such as a quality and safety committee, or a falls prevention committee) that oversee some or all of the components of the falls prevention system. In some cases, the committees may include one or more individuals with responsibilities in these areas as well as consumers.

A useful strategy for ensuring advisory clinical governance frameworks are in place is to map key requirements for the governance of falls prevention systems against existing relevant committee roles or individuals with clinical governance responsibilities. If no suitable advisory clinical governance framework can be identified, facilities may need to establish new structures or redefine roles and responsibilities within existing governance frameworks. This mapping will ensure that all components of falls prevention systems are included in the clinical governance framework.

While Standard 10 applies to all health service organisations, it is recognised that some acute services, such as day procedure services (including fertility clinics, endoscopy centres and cardiac catheterisation laboratories), need to ensure that patients do not fall but do not require the significant system of falls prevention envisaged in this Standard. Similarly, paediatric services will need to recognise specific condition and treatment falls risks but not require the significant system of falls prevention required primarily for older patients at risk of falling and suffering harm from falls.



Actions required	Implementation strategies
<p>10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls</p> <p>10.1.1 Policies, procedures and or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools</p>	<p>Key task:</p> <ul style="list-style-type: none">• Develop, implement or review policies, protocols or procedures to ensure they are consistent with best practice guidelines <p>Suggested strategies:</p> <p>You must ensure that health service organisation-wide guidance is consistent with national guidelines, endorsed by the executive and communicated to the relevant clinical and non-clinical workforce.</p> <p>A health service organisation document (such as a falls prevention policy) can be a local, hospital group or jurisdictional policy. You should ensure that it describes minimum requirements for screening and/or assessing patients for falls risk (and which may or may not include a tool), subsequent action such as care planning, reporting of falls prevention activity and positions responsible for enactment.</p> <p>Day procedure services will have procedures which are appropriate for their patient populations and which address the falls risks inherent in the services provided.</p> <p>Policies should address areas such as:</p> <ul style="list-style-type: none">• falls prevention requirements• falls screening and assessment• management of falls risks including:<ul style="list-style-type: none">- balance and mobility- cognitive impairment- continence- feet and footwear- syncope- dizziness and vertigo- medication- vision- environmental considerations- individual surveillance and observation- restraint- requirement for minimising injury from falls- protective equipment- adequacy of calcium and vitamin D• management of falls. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• policies, procedures and protocols which are consistent with <i>National Preventing Falls and Harm from Falls Best Practice Guidelines 2009</i> and describe delegated roles, responsibilities and accountabilities of the workforce for falls management. <p>Resources:</p> <p>Evidence-based national best practice falls prevention for people over 65 (and for others at risk of falling) is described in <i>Preventing falls and harm from falls in older people 2009</i>.</p>

Actions required	Implementation strategies
10.1 Developing, implementing and reviewing policies, procedures and/or protocols, including the associated tools, that are based on the current national guidelines for preventing falls and harm from falls (continued)	
<p>10.1.2 The use of policies, procedures and/or protocols is regularly monitored</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Identify an individual or group responsible for monitoring the use of policies, protocols and procedures for preventing falls and harm from falls • Develop evaluation processes for the use of falls prevention and management policies, procedures and protocols across the organisation <p>Suggested strategies:</p> <p>You must ensure that policies, procedures and protocols are readily available to the workforce, and members of the workforce need to be trained in their use.</p> <p>You should monitor data from the policies, procedures and protocols to ensure they are comprehensive and provide all the information needed to support clinical practice, and make changes consistent with evidence which are necessary to maximise their effectiveness.</p> <p>Monitoring of falls prevention policies, procedures and protocols will assist you to monitor compliance. Gap analysis informs overall falls prevention system improvements.</p> <p>You should audit (either clinical or observational) the patient clinical record to confirm policies, procedures and protocols are in use. This will also provide information on situations where the policy is not applicable, screening is documented and assessment tools are completed.</p> <p>You can determine the frequency of the audit by considering the risk profile of the patient population, the number and trend in falls incidents. The greater the risk, the more closely and more frequently monitoring is required.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols that are available to the workforce • analysis of incident reports • results from audits and evaluations of patient clinical records and observational audit of compliance against policies, procedures and protocols • education and orientation resources and records of attendance at training by the workforce on the use of falls management policies, procedures and protocols.



Actions required	Implementation strategies
<p>10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents</p>	
<p>10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Implement or review the incident management system to capture information about falls incidents, adverse events and near misses • Develop reports on falls for the monitoring group to inform patient safety and quality of care improvement activities <p>Suggested strategies:</p> <p>You should have in place a standardised, organisation-wide system of reporting which details the data to be collected and mandatory reporting on falls. The incident reporting system should have the capacity to report falls and facilitate assessment of the relevant contributing factors.</p> <p>You should ensure that routine monitoring of reporting occurs. The workforce is encouraged to report falls incidents. Reported incidents should be monitored and reported to the relevant governing committee. Investigations are undertaken for incidents of appropriate severity. Trended data for lower severity incidents are also analysed.</p> <p>You should ensure that the results of investigations are used to inform practice change as required (i.e. information is communicated back to the workforce).</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • incident reporting forms and processes are included in policies, procedures and protocols • reports of falls incidents across the organisation, including trends in falls incidents and causes, adverse events and near misses • orientation and education resources, training attendance records and/or results of competency-based training by the workforce on falls reduction and reporting systems • agendas, meeting minutes and/or relevant committee minutes or outcomes • measures of falls incidents over time and in comparison to peer health services if available.
<p>10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Identify or adapt a data set from administrative and clinical data collections to determine the frequency and severity of falls in the organisation <p>Suggested strategies:</p> <p>You should ensure that administrative and clinical data on falls are collected and analysed and contribute to monitoring of use of policies, procedures and protocols and to practice improvement activities.</p> <p>You should monitor regular trend reporting on falls to support the development of improvement strategies that reduce the incidence and severity of falls.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • reporting template for clinical data sets. Documented process and reporting template to extract data on falls from clinical and administrative data systems • audit reports on patient clinical records of frequency and severity of falls • regular reports on trends in falls incidence, prevalence of falls.

Actions required	Implementation strategies
10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents (continued)	
<p>10.2.3 Information on falls is reported to the highest level of governance in the health service organisation</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Develop a reporting format and frequency along with performance measures for falls incidents for the governing body • Nominate a sponsor from the senior governance group to take responsibility for presenting on the performance of fall prevention and management to the governing body <p>Suggested strategies:</p> <p>For organisation-wide improvements to be successful, information needs to be provided to all levels and areas that have responsibility for taking action to reduce the incidence and severity of falls. For the governing body, decisions about staffing, purchasing, training and resource allocation are all within their responsibility.</p> <p>You should ensure that administrative and clinical data on falls are reported routinely to the senior governing body. Providing information on trends in falls and the effect on the health service will inform the decisions and actions of the senior governing body.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • documentation from committees and meetings of executive committees relating to falls and harm from falls • annual reports containing falls incidents information • trend reports detailing changes and actions taken • clinical performance information reported to the governing group.
<p>10.2.4 Action is taken to reduce the frequency and severity of falls in the health service organisation</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Develop education and orientation resources and programs for the workforce managing points at risk of falling • Use data from the monitoring system to develop or review improvement strategies and action these at individual unit, service area and/or organisation wide <p>Suggested strategies:</p> <p>You should ensure quality improvement actions to mitigate the risk of falls and severity of falls injury are identified and acted upon as resources permit.</p> <p>You should provide evidence for the links between policy, incident reporting, monitoring and quality improvement. Evidence can include the feedback loop identified in Action 10.1.2.</p> <p>You should use monitoring system data on the frequency and severity of falls collected as part of Action 10.2.2 and information from Action 10.1.2 to identify areas of risk and improvement strategies that can be put in place to address gaps and inconsistencies. Data collection that could be considered include:</p> <ul style="list-style-type: none"> • medication reviews for patients at risk of falls • register of environmental and equipment falls hazards • audit of patient clinical records for evidence of ongoing management of individual environmental risk factors.



Actions required	Implementation strategies
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<p>10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents (continued)</p>	
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<p>(continued)</p> <p>10.2.4 Action is taken to reduce the frequency and severity of falls in the health service organisation</p>	<p>Actions would generally include:</p> <ul style="list-style-type: none"> • communicating evaluation and audit information to the clinical workforce on changes resulting from improvement strategies • amending policy, procedures and/or protocols • orientation, education, training, communication and information resources that address patient safety and quality care improvements for falls. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • information provided to the workforce on falls risks and prevention strategies • orientation and education resources, training attendance records and/or results of competency-based training by the workforce on falls reduction and reporting systems • information material such as brochures and fact sheets provided to patients and their carers on preventing falls and harm from falls • documentation from improvement activities that have been adapted and adopted locally to reduce the frequency and severity of falls.
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<p>10.3 Undertaking quality improvement activities to address safety risks and ensure the effectiveness of the falls prevention system</p>	
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<p>10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Establish a risk register that identifies falls risks related to individuals and environment • Use the data on falls risks to develop or review improvement strategies <p>Suggested strategies:</p> <p>You should have strategies in place to prevent falls and minimise patient harm. Once implemented, a quality improvement process requires that there is continual review of the effect of these strategies.</p> <p>You should ensure that a continuous improvement methodology is used by wards (units, project teams or services) to undertake project work for specific issues that will contribute to the overall falls prevention system and address areas in need of improvement identified from the monitoring activities.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • safety and quality indicators and data reports • risk register or log that includes actions to address identified risks • agendas, meeting minutes or reports of committees and meetings that detail improvement actions taken • quality improvement plans include actions to address issues identified • examples of improvement activities that have been implemented and evaluated • communication material such as brochures, fact sheets and posters developed for the workforce and patients on improvement activities and outcomes.
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Actions required	Implementation strategies
10.4 Implementing falls prevention plans and effective management of falls	
<p>10.4.1 Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Identify and facilitate access to the equipment and devices required for the patient population being served • Develop a log to register and record maintenance of equipment and devices used in falls prevention and management <p>Suggested strategies:</p> <p>You should adjust the environment for the patient risk profile and equipment should be available for the patient to mitigate the risk of falling. Ensuring a call bell is within reach of patients at risk, as well as personal items including mobility equipment, is important. Special equipment can include commodes, body protective equipment and appropriate footwear.</p> <p>You should facilitate patient access to equipment and devices and take actions including:</p> <ul style="list-style-type: none"> • evaluating previous equipment and device requirements and effectiveness • determining the type and number of support devices your organisation may require and options for accessing the equipment • scheduling routine maintenance and coordinate ad hoc repair to maximise the availability of equipment • reviewing falls incident reports to evaluate the role access to equipment played in the incident. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • inventories of equipment and audit of clinical use • maintenance register log of equipment and devices • systems in place for review and future procurement of equipment and devices • evidence of patient environment review (such as ward safety assessment including general hazard removal) • evidence of reviewing and adjusting the patient environment to match patient needs occurring at each clinical review e.g. equipment to optimise the safety of transfers and mobility, such as bed at right height, call bell and walking aid within reach.



Standard 10

Criterion: Screening and assessing risks of falls and harm from falling

Patients on presentation, during admission, and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls

Screening and assessing identifies patients at risk of falling or suffering serious harm from falling, and identifies activities to mitigate the risk. The terms 'falls risk screening' and 'falls risk assessment' are sometimes used interchangeably, but there are some clear differences and they are considered separate but related processes.

Falls risk screening is a brief process of estimating a person's risk of falling, classifying people as being at either low risk or increased risk. Falls risk screening usually involves reviewing only a few items. Although it is not designed as a comprehensive assessment, positive screening on certain screen items can also provide information about intervention strategies.

A systematic review and meta-analysis of falls risk screening tools showed that using clinical judgement to classify a patient as 'high risk for falls' is at least as good as using a screening tool in acute care.¹⁹⁻²⁰ As such, a screening tool is not necessarily an optimal basis for identifying patients with an elevated risk of falling or suffering serious harm from falling. Therefore an evidence-based approach can substitute exercise of clinical judgement for use of a falls risk screening tool.

Similarly, assessment can be undertaken systematically, and measurably, through policy that requires assessment through means other than a tool, such as a multidisciplinary process that is undertaken following a falls risk screen.

The critical issue is that the result of screening or assessing is recorded and acted upon.

Usually, falls risk assessment is a more detailed process than screening and is used to identify underlying risk factors and inform the development of a care plan to reduce risk. Falls risk assessment tools vary in the number of risk factors they include, and how each risk factor is assessed.

One systematic review identified the following risk factors as predictive of future falls among hospital patients²¹:

- gait instability
- lower-limb weakness
- urinary incontinence or frequency, or need for assisted toileting
- previous falls
- agitation, confusion or impaired judgement
- prescription of 'culprit' drugs (particularly centrally acting sedative hypnotics).

This list is not comprehensive and should be tailored to suit local circumstances or patient profiles and with reference to *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009*. For example, patients prescribed multiple medicines or psychoactive medications (including centrally acting sedatives) should have their medications reviewed as part of a multifactorial approach to falls reduction and harm minimisation.

As with screening, the critical issue is documenting the assessment and outcomes and ensuring appropriate interventions are completed.

Standard 10 applies to all acute health service organisations. However while it is recognised that some acute services, such as day surgery services and fertility clinics, need to ensure that patients do not fall, they do not need to have in place the significant system of falls prevention envisaged in this Standard and specifically in this criterion. In addition, they would not be required to undertake comprehensive falls screening or assessment of patients. This is because the intervention activities identified by screening and assessment are not possible in same day services.

Similarly, paediatric services will need to recognise specific condition and treatment falls risks but not require the significant system of falls prevention required primarily for older patients at risk of falling and suffering harm from falls and specifically that described in this criterion.

Actions required	Implementation strategies
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls	
<p>10.5.1 A best practice screening tool is used by the clinical workforce to identify the risk of falls</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Agree on a tool or process for falls screening • Educate the workforce of the need for training and method of screening for risk of falls <p>Suggested strategies:</p> <p>You are required to develop or adapt processes for reviewing and identifying the risk of falls in conjunction with the clinical workforce.</p> <p>Screening can involve the exercise of clinical judgement. Judgement requires an understanding of falls risk factors which indicate the need for falls risk factor assessment. Screening can use a tool which is based on known falls risk factors and will also indicate the need for a falls risk factor assessment (unless the screening is comprehensive). Screening may be as simple as checking whether the patient has a history of recent falling.</p> <p>You must ensure that the results of falls risk screening are recorded appropriately in the patient clinical record and action taken.</p> <p>You must communicate the process and tools for falls risk screening to the responsible workforce and ensure they have the skills to do so.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols on screening for falls risk accessible to the clinical workforce • pre-admission screening tool or method • orientation and education resources, training attendance records and/or results of competency-based training by the workforce on falls reduction and reporting systems • schedule of training for the relevant clinical workforce • audit of patient clinical records for compliance with screening requirements on admission and when clinically indicated.
<p>10.5.2 Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Review patient clinical records for documentation that screening for falls risk has occurred <p>Suggested strategies:</p> <p>You are required to audit completion of local screening requirements and the actions arising.</p> <p>You are required to monitor use of screening policies, procedures and protocols to measure compliance. You should ensure that gap analysis informs falls prevention system improvements.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • audit of patient clinical records for compliance with screening requirement • observational audit of screening process or tool use.



Actions required	Implementation strategies
10.5 Using a best practice-based tool to screen patients on presentation, during admission and when clinically indicated for the risk of falls (continued)	
10.5.3 Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	<p>Key tasks:</p> <ul style="list-style-type: none">• Data from the review of clinical records is used to determine the proportion of at-risk patients screened• Use audit and other data to identify gaps or deviations in compliance with screening requirements <p>Suggested strategies:</p> <p>You should use data on the screening of falls collected as part of Action 10.5.2 and information from Action 10.1.2 to identify issues in screening practices and improvement strategies that can be put in place to address gaps and inconsistencies.</p> <p>You should include actions such as:</p> <ul style="list-style-type: none">• communicating with the clinical workforce about the requirements for screening and documentation of screening• communicating evaluation and audit outcomes to the clinical workforce by their area or individually, if appropriate, including safety and quality indicators benchmarked with other like units• implementing improvement strategies and evaluating effectiveness. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• evidence-based falls screening tools that are readily available to the clinical workforce at the point of patient presentation and during admission• risk register or log that includes actions to address identified risks• audit or other evaluation of clinical records to determine whether those identified as being at risk of falls were assessed for falls risk factors following the falls risk screen• relevant committee meeting agendas and minutes that detail improvement actions taken• patient safety and quality of care improvement plan including actions to address issues identified• examples of improvement activities that have been implemented and evaluated to increase the proportion of at-risk patients who are screened for falls upon presentation.

Actions required	Implementation strategies
<p>10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes</p>	
<p>10.6.1 A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling</p>	<p>Key tasks:</p> <ul style="list-style-type: none"> • Agree on the tool or process for assessing patients at risk of falling • Educate the relevant workforce on the use of the assessment tool or process <p>Suggested strategies:</p> <p>You should be aware that assessment can involve the exercise of clinical judgement and/ or the use of an assessment tool.</p> <p>You should ensure that the results of falls risk assessments are recorded and used to formulate the patient care plan.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • policies, procedures and protocols that describe how patient falls risks are to be assessed and that are evidence-based and consistent with national guidelines • orientation and education resources, training attendance records and/or results of competency-based training by the workforce on falls reduction and reporting systems • falls assessment outcomes are recorded when identified as required.
<p>10.6.2 The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Review the patient clinical record for documentation on use of the assessment tool or process <p>Suggested strategies:</p> <p>You should clinically audit completion of local falls assessment requirements and that actions identified are undertaken.</p> <p>You should monitor assessment policies, procedures and protocols to measure compliance and effectiveness. Gap analysis should inform falls prevention system improvements.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • reports provided to relevant committees detailing the number of patients screened and subsequently receiving a falls risk factor assessment • audit of patient clinical records that show patients identified at risk of falling who have a subsequent falls risk factor assessment • reports on the number of patients assessed and the incidence of falls • observational audit of assessment tool or process use • audit of patient clinical records that show patients who have had a change in health status, a fall, significant change in medication or environment, and prior to discharge, are re-assessed for falls risk factors.



Actions required	Implementation strategies
10.6 Conducting a comprehensive risk assessment for patients identified at risk of falling in initial screening processes (continued)	
10.6.3 Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	<p>Key task:</p> <ul style="list-style-type: none">• Data from the review of patient clinical records is used to determine the proportion of at-risk patients assessed <p>Suggested strategies:</p> <p>You should provide workforce training and awareness-raising activities to embed falls prevention system actions, including risk identification and mitigation, in usual practice.</p> <p>You should report use of assessment policies, procedures and protocols to managers responsible for falls prevention.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• falls assessment tools are available to the clinical workforce at the point of patient presentation and during admission• relevant committee meeting agendas and minutes that detail improvement actions taken• risk register or log that includes actions to address identified risks• quality improvement plan includes actions to address issues identified• examples of improvement activities that have been implemented and evaluated to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment• communication material such as brochures, fact sheets and posters developed for the workforce and/or patients and carers.



Standard 10

Criterion: Preventing falls and harm from falls

Prevention strategies are in place for patients at risk of falling

Standardised, evidence-based falls prevention interventions should be in place for patients assessed at risk of falling.

Successful falls prevention interventions in hospitals use a combination of falls prevention interventions that should be delivered together as part of a multifactorial program, and preferably by members of a multidisciplinary team. Because falls are multifactorial and complex in nature, interventions should be implemented in combination rather than in isolation.²² Using any one intervention on its own is unlikely to reduce the number of falls.

The following falls prevention interventions have been used in successful in-hospital trials and should be included in routine practice:

- Ensure that patients have their usual spectacles and visual aid to hand.
- Review medication, particularly high-risk medications such as sedatives, antidepressants, antipsychotics and centrally acting pain relief.
- Measure postural blood pressure.
- Organise routine screening urinalysis to identify urinary tract infections.
- Organise routine physiotherapy review for patients with mobility difficulties.
- Establish a care plan for bowel and bladder function.
- Make the environment safe.
- Orientate the patient and tell them how they can obtain help when needed.
- Instruct and check that patients understand how to use assistive devices before they are prescribed.
- Minimise the use of restraints and bedside rails.
- Consider vitamin D supplementation as a routine management strategy for mobile older patients.
- Place high-risk patients within view of, and close to, the nursing station.
- Consider hip protectors and alarm devices for high-risk patients.

This list is not comprehensive and reference should be made to the national falls prevention guidelines and to ensure that interventions match local resources and patient profiles.

All implementations should be documented to ensure that health professionals involved in the patient's care are aware of planned and current falls prevention interventions and the basis for them. Other means of communicating between team members should include verbal handover and consideration of the use of a visible flagging system.

Standard 10 applies to all acute health service organisations. However while it is recognised that some acute services, such as day surgery services (including fertility clinics, endoscopy centres and cardiac catheterisation laboratories), need to ensure that patients do not fall but do not require the significant system of falls prevention envisaged in this Standard and specifically in this criterion. This is particularly so in relation to Item 10.8 *Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process*. Some strategies which have falls prevention benefits will apply, such as post-anaesthetic care and post-procedure mobilisation, rather than standardised falls prevention interventions.

Similarly, paediatric services will need to recognise specific condition and treatment falls risks but not require the significant system of falls prevention required primarily for older patients at risk of falling and suffering harm from falls and specifically that described in this criterion.



Actions required	Implementation strategies
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment	
10.7.1 Use of best practice multifactorial falls prevention and harm minimisation plan is documented in the patient clinical record	<p>Key task:</p> <ul style="list-style-type: none">• Identify all areas of risk for falls in the organisation and develop a risk management approach to implementing improvement strategies <p>Suggested strategies:</p> <p>You should ensure that all interventions are documented consistent with local policy and address the risk factors identified.</p> <p>Falls prevention and harm minimisation plans that are based on best practice can improve patient outcomes. You should have in place effective falls prevention and harm minimisation plans that rely on comprehensive screen and assessment (where appropriate), the identification of all potential risks, and the development of tailored prevention plans for patients at risk of falling.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• register or log of falls risk• provision of orientation or training to the workforce on best practice falls interventions• policies, procedures and protocols that describe best practice multifactorial falls prevention plans, provide tools and detail resources available• audit of patient clinical records and case notes for the use of multifactorial falls prevention plans• audit of patient clinical records with a multifactorial falls prevention plan against care provided• review of incidents, adverse events and near misses to determine when interventions were not applied or failed.

Actions required	Implementation strategies
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment (continued)	
<p>10.7.2 The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Information from administrative and clinical data sets, incidents and risk logs are used to monitor trends in falls prevention plans <p>Suggested strategies:</p> <p>You should monitor falls prevention interventions including for effectiveness and appropriateness.</p> <p>You should assess the effectiveness of the prevention and harm minimisation plans as part of ongoing monitoring of outcomes for patients at risk of falls.</p> <p>The frequency with which reviews are to be undertaken will depend on factors such as the:</p> <ul style="list-style-type: none"> • number of at-risk patients • frequency of falls occurring during care • severity of fall injuries during care. <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • root cause analyses of falls resulting in serious harm • regular monitoring and review of patient functional status and incidents, adverse events and near misses pre and post implementation of the plan • reports from administration and clinical data that analyse trends in falls and near misses • audit of patient clinical records with a multifactorial falls prevention plan against care provided • relevant documentation from committees and meetings that describe the effectiveness of falls and harm minimisation plans • observation that the multifactorial action plan is communicated to all members of the workforce concerned with the care of the patient.



Actions required	Implementation strategies
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment (continued)	
10.7.3 Action is taken to reduce falls and minimise harm from at-risk patients	<p>Key task:</p> <ul style="list-style-type: none">• Improvement strategies are developed to increase the effectiveness of falls prevention plans <p>Suggested strategies:</p> <p>You should communicate falls risk at clinical handover and discuss and implement strategies to minimise risk.</p> <p>You should communicate patient falls at clinical handover.</p> <p>You should report on falls prevention interventions to managers responsible for falls prevention and harm minimisation and include administrative and clinical data along with feedback from the clinical workforce, patients and carers. You should audit patient clinical records to identify completion rates and areas poorly completed to inform improvement strategies.</p> <p>You should inform the clinical workforce of changes in policies, procedures, protocols or processes and then evaluate the effect of the changes. This is essential in implementing effective changes.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none">• audit of clinical handover includes identification of falls risk communication• audits of patient clinical records at risk of falls reveal evidence of appropriate interventions• examples of improvement activities that have been implemented and evaluated to reduce falls and minimise harm for at-risk patients• communication material such as brochures, fact sheets and posters developed for workforce, patients and carers.

Actions required	Implementation strategies
<p>10.8 Patients at risk of falling are referred to appropriate services, where available, as part of the discharge process</p>	
<p>10.8.1 Discharge planning includes referral to appropriate services, where available</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Discharging planning protocol prompts consideration of referral to appropriate services <p>Suggested strategies:</p> <p>You should establish a log of services that are available to accept referred patients post discharge.</p> <p>You should establish the criteria for referral and include these in policies, protocols and procedures. Detailing a prevention plan and patient history in discharge information can facilitate continuity of care between health services providing care.</p> <p>You should include falls risks and falls history in discharge reports, including to the patient’s general practitioner, and referrals.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • audit and evaluation of patient clinical records shows that falls risk is identified in the discharge plan and includes referrals to: <ul style="list-style-type: none"> - community health services - Home Medicines Review - specialist medical practitioners such as geriatrician, ophthalmologist - continence consultant or nurse - allied health professionals such as physiotherapist, occupational therapist, podiatrist, dietician, optometrist general practitioners, exercise physiologist, health practitioner, health promotion officer.



Standard 10

Criterion: Communicating with patients and carers

Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan

Consumer participation in health care is central to high-quality and accountable health services. It also encourages shared responsibility in health care. Consumers can facilitate change in healthcare practices.

Clinicians should consider the following actions to encourage patients to participate in falls prevention:

- Educate and discuss falls risks and falls prevention strategies with the workforce, patients and carers.
 - Record falls prevention education of the workforce, patients and carers.
 - Make sure the falls prevention message is presented within the context of people staying independent for longer.
 - Be aware that the term 'falls prevention' could be unfamiliar and the concept difficult to understand for many patients in older aged groups.
 - Provide relevant and usable information to allow patients and their carers to take part in discussions and decisions about preventing falls.
 - Find out what changes a patient is willing to make to prevent falls, so that appropriate and acceptable recommendations can be made.
 - Offer information in languages other than English, when appropriate; however do not assume literacy in the patient's native language.
- Explore the potential barriers that prevent patients from taking action to prevent falls (such as low self-efficacy and fear of falling) and support patients to overcome these barriers.
 - Develop falls prevention programs that are flexible enough to accommodate the patient's needs, circumstances and interests.
 - Place falls prevention posters in the ward in common areas used by patients and family members.
 - Ask family members and carers to assist in falls prevention strategies.
 - Ensure that strategies to promote the continued involvement of patients are included in discharge planning (also called post-hospital care planning) and recommendations.
 - Trial and evaluate a range of interventions with the patient as appropriate.

Actions required	Implementation strategies
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10.9 Informing patients and carers about the risk of falls, and falls prevention strategies

<p>10.9.1 Patient information on falls and prevention strategies is provided to patients and their carers in a format that is understood and meaningful</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Seek feedback on information provided to patient and carers and make amendments to improve the usefulness of the information <p>Suggested strategies:</p> <p>Patients and carers can assist health service providers in the prevention of falls. You should involve them in the development of falls prevention and harm minimisation strategies as this may reduce the frequency and severity of falls. Providing patients and carers with information will assist them in understanding and participating in the development of effective and appropriate strategies. This can involve discussion and participation with the patient and carer (if appropriate) about the care plan and the findings of the assessment.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • patient clinical record and care plan audit undertaken to ensure patient and carer input into falls prevention plans • case conference notes and reports are reviewed.
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10.10 Developing falls prevention plans in partnership with patients and carers

<p>10.10.1 Falls prevention plans are developed in partnership with patients and carers</p>	<p>Key task:</p> <ul style="list-style-type: none"> • Engage patients and carers whenever a prevention plan is developed or amended <p>Suggested strategies:</p> <p>You should document that the patient is aware of assessment findings and has participated in care planning.</p> <p>You should discuss the care plan with the patient and carer (if appropriate) and which is recorded in the patient clinical record.</p> <p>You should survey patients on patient engagement and levels of satisfaction with the process.</p> <p>Outputs of improvement processes may include:</p> <ul style="list-style-type: none"> • patient clinical record and care plan audit undertaken to ensure patient and carer input into falls prevention plans • case conference notes and reports are reviewed.
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Appendix: Links to resources

Australian and New Zealand falls prevention and research organisations

Aged Care in Victoria: Falls Prevention
www.health.vic.gov.au/agedcare/maintaining/falls_dev/index.htm

Australian and New Zealand Falls Prevention Society
www.anzfallsprevention.org/

Australian Centre for Evidence Based Aged Care
www.latrobe.edu.au/acebac

Australian Resource Centre for Health Innovations: Falls Prevention
www.archi.net.au/resources/safety/falls

Centre for Physical Activity in Ageing (SA)
www.cpaas.sa.gov.au

Clinical Excellence Commission (NSW Falls Prevention Program)
www.cec.health.nsw.gov.au/programs/falls-prevention

Council on the Aging (COTA)
www.cotansw.com.au/

Home Modification Information Clearing Warehouse
www.homemods.info/

Independent Living Centre NSW
www.ilcnsw.asn.au/

Injury Control Council of Western Australia
www.iccwa.org.au/falls-prevention/

Injury Prevention in Australia – Department of Health and Ageing
www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-injury-index.htm

The Joanna Briggs Institute
www.joannabriggs.edu.au/

National Ageing Research Institute
www.mednwh.unimelb.edu.au/

National Injury Surveillance Unit
www.nisu.flinders.edu.au/

NSW Ministry of Health – Health Promotion Injury Prevention Branch
www.health.nsw.gov.au/publichealth/healthpromotion/

NSW Injury Risk Management Research Centre
www.irmrc.unsw.edu.au/

Neuroscience Research Australia
www.neura.edu.au/

Osteoporosis Australia
www.osteoporosis.org.au/

PEDro: Physiotherapy Evidence Database
www.pedro.org.au/

Prince of Wales Medical Research Institute, Falls and Balance Research Group
www.neura.edu.au/fbrg

Queensland Injury Surveillance Unit
www.qisu.org.au/ModCoreFrontEnd/index.asp?pageid=109

Community falls prevention program sustainability guidelines and workbook
www.mihsr.monash.org/miri/research/research-areas/home-sport-and-leisure-safety/fpru/nhmrc_guidelines_and_workbook.pdf

Queensland Stay on Your Feet® Falls Prevention Guidelines
www.health.qld.gov.au/stayonyourfeet/default.asp

QuickScreen Information and order form, Falls and Balance Research Group
www.neura.edu.au/research/facilities/falls-and-balance-research-group/quickscreen

Research Review Australia
www.researchreview.com.au/

SA Health
www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/safety+and+quality/falls+and+fall+s+injury+prevention+and+management

South Australian Falls Prevention and Management
www.fallssa.com.au/

Stay on Your Feet® WA
www.health.wa.gov.au/stayonyourfeet/home/

Vision Australia
www.visionaustralia.org.au/

Appendix: Links to resources (continued)

International falls prevention and research organisations

Active for Life

www.activeforlife.com.au/

CDC Injury Center – Preventing Falls Among Older People

www.cdc.gov/injury/index.html

Falls Community (Scotland)

www.fallscommunity.scot.nhs.uk/home.aspx

Injury Control Research Information Network

www.injurycontrol.com/icrin/

Injury Prevention Online (journals)

injuryprevention.bmj.com/

Injury Prevention Web

www.injuryprevention.org/

Prevention of Falls Network Europe:

ProFaNE Home Page

www.profane.eu.org/

SafetyLit – Injury Prevention Abstracts Online

www.safetylit.org/

Simon Fraser University Injury Prevention and Mobility Lab (Canada)

www.sfu.ca/ipml/

Falls Prevention Center of Excellence

www.stopfalls.org/



Australian Commission on Safety and Quality in Health Care

Level 7, 1 Oxford Street, Darlinghurst NSW 2010
GPO Box 5480, Sydney NSW 2001

Phone: (02) 9126 3600 (international +61 2 9126 3600)

Fax: (02) 9126 3613 (international + 61 2 9126 3613)

Email: mail@safetyandquality.gov.au

www.safetyandquality.gov.au