



***Foundation Education Resource  
For Health and Social Care Workers***

# Core Learning - Session One

## Introduction to Falls Prevention and Management

**Aim:**



To provide staff with an overview of the  
*National Strategy to Prevent Falls and Fractures*  
in Ireland's Ageing Population and introduce them to falls  
prevention and management

# **Introduction to Falls Prevention and Management**

## **Definition of a fall:**

The WHO has defined a fall “as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level”

## **Prevalence of Falls:**

- More than one third of people 65 yrs and older fall each year and in half such cases the falls are recurrent (Tinetti & Kumar 2011) in people over 80 yrs of age 50% fall each year
- Older women make up 65% of 80 + age group – they are at greatest risk

# Introduction to Falls Prevention and Management

## Prevalence of Falls

- One fifth of those who fall sustain serious injury. Hip fractures are one of the most serious injuries due to falls and result in approximately 2,800 hospital admissions in Ireland each year
- 80% of these hip fracture patients are over 75 years with an average hospital stay of 18 days
- Three quarters of all fall related deaths are over 65 year of age

# Cost of Falls

- Falls related injuries among older people especially among women are associated with substantial economic cost
- In 2010 the estimated cost was €20-€51 million
- If current trend continues estimated costs will be
  - €92 - €1077 million by 2020
  - €1587 - €2043 million by 2030
- Direct costs do not account for long term effects of injuries such as disability dependence on others reduced quality of life
- The economic cost of falls is likely to be much higher than policy makers appreciate (Davis et al 2010)



# Risk Factors



## Intrinsic Risk Factors

- History of falls
- Muscles weakness
- People over the age of 65-50% of people over 80 years fall
- Gender ( female
- Fear of falling )
- Deterioration in Health and mobility
- Impaired Gait and Balance
- Medical conditions (Ex Parkinsons Disease
- Nutritional deficiencies
- Cognitive impairment & depression
- Poor Vision

## Extrinsic Risk Factors

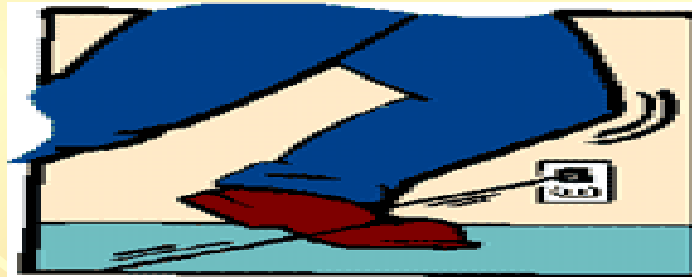
- Footwear and clothing
- Inappropriately used assisted devices ( Hoists , Wheel chairs)
- PolyPharmacy –Multiple Medication
- (Drug Interactions)



# Risk Factors

## Environmental Risk Factors

- Uneven /Slippery floor surfaces
- Inadequate Lighting
- Trailing flexes and cables
- Loose mats /rugs
- Unfamiliar Enviroment
- Inadequate Safety rails ( bedrooms Bathroom /kitchen )( Adapted from Todd 2004)and HSC 2009)



# Consequences of falls

## Physical Consequences

- Death
- Head Injuries
- Dislocation /fractures Cuts/  
Bruises /Soft tissue Injuries
- Pressure Ulcers/ Leg Ulceration
- Dehydration
- Immobility
- Pneumonia/Chest infections
- Incontinence

## Psychological Consequences

- Low self esteem
- Social isolation  
Anxiety/Depression
- Increased Dependency
- Emotional distress  
Embarrassment
- Fear of further falls
- Self-worthlessness
- Loss of confidence
- Carer Stress

# Consequences of Falls

## **Social Consequences**

- Decreased Quality of life
- Loss of Independence
- Changes to Daily Routine
- Financial Cost of Help/Care
- Social Isolation Decreased Mobility

(Adapted from NHS, 2011)

# Fear of Falling



## Fear of Falling

- Fear of falling is one of the major issues relating to the overall health of older people (Jung 2008)
- One in four older Irish people report a fear of falling
- The prevalence increases with age from 17% in those aged 50-64 to 40% in those aged 75yrs and older (TILDA 2011)
- Older people often reluctant to report a fall .It is important that older people tell a health professional if they have a fear of falling or have had a fall

***Falls can happen anywhere but more than half of all falls happen at home.***

***Many of these falls can be prevented by making simple changes in the home (CDC, 2012)***

# Screening and Assessment

**Screening:** The Aim of screening for falls in older people is to identify those who are at risk of falls ( **Appendix 2**)

*Older persons in contact with Health Care Professionals or their care givers should be asked the following at least once a year:*

- Have you fallen during the past years?
- If the older person has fallen, ask about the frequency and characteristics of their falls.
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on Healthy Aging Tips on Bone health
- If the person has had a Single Explained Fall, carry out Gait and Balance Test Get up and Go ( **Appendix 7**)
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment

# Screening and Assessment

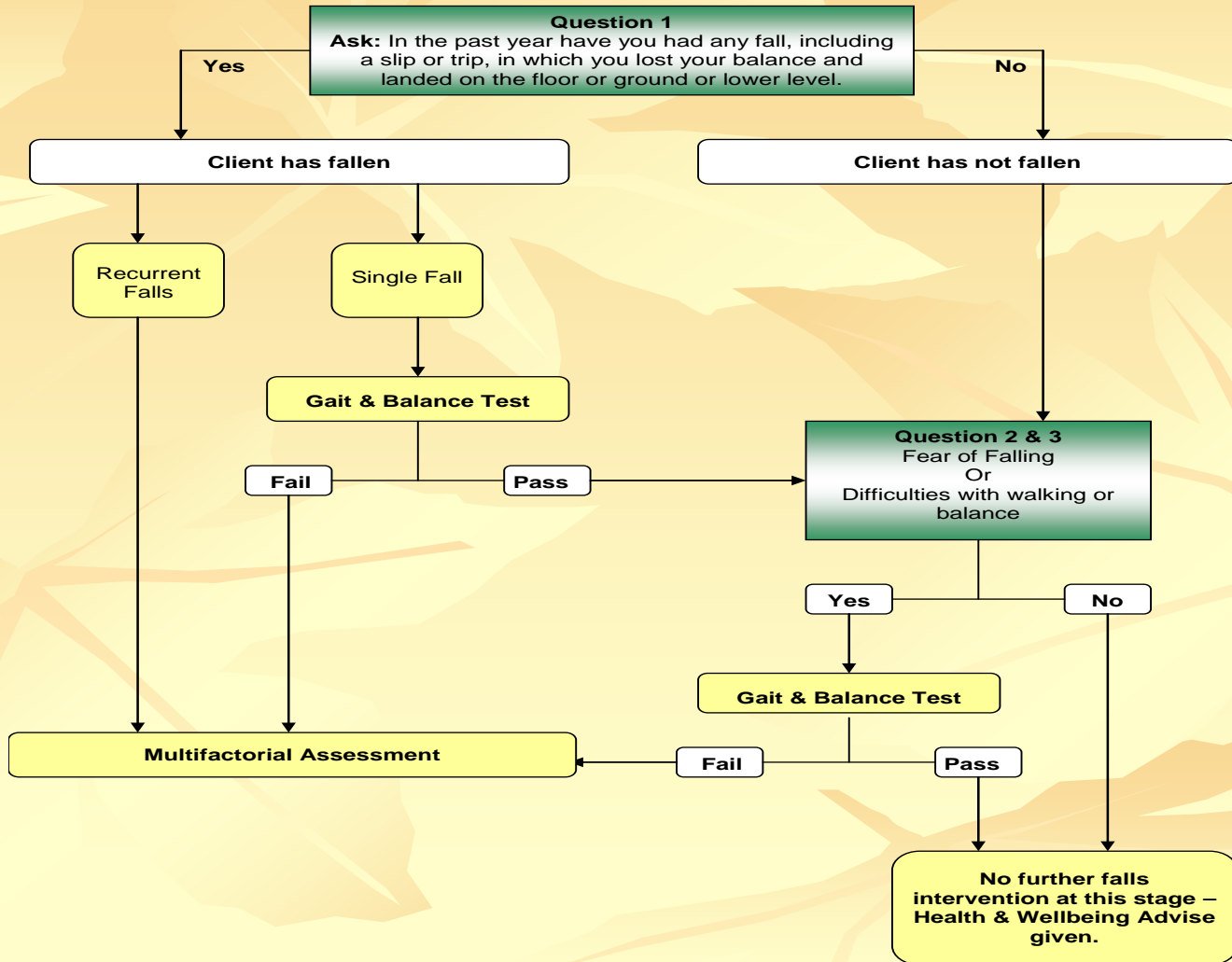
- **Assessment:** The Aim of the multi factorial assessment is to identify the falls risks. A multi factorial fall risk assessment should be performed for older people who: (**Appendix 3**)
- Report recurrent (2 or more) falls in the past year.
- Report difficulties with gait and balance.
- Report fear of falling.
- Seek medical attention because of a fall.

**The multi factorial risk assessment should be carried out and should incorporate the following: ( Appendix 3)**

- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.
- Medications Environmental Issues Feet and Footwear Vision Impairment  
Related Medical History Social Factors
- Dietary intake including hydration

***Any team member can complete the Multi factorial Fall Risk assessment.***

# Screening and Assessment



# Interventions

**The Multi factorial interventions** include management of the risk factors identified in the multi-factorial Assessment (would include:

## Interventions

- A falls risk assessment, followed by intervention to modify the identified risk (deficit), is the most effective strategy to reduce both the risk of falling and incidence of falling in older people.
- Strategies that combine interventions, targeted at more than one risk factor, to reduce falls are:
- Interventions that have been shown to reduce falls are individualised exercise programme that includes a combination of resistance, (strength) training, gait, balance, and co-ordination training.

# Interventions

- Medication review and withdrawal of psychotropic and other culprit medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.
- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and calcium insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (Adapted from National Strategy HSE 2008)

***Tips for healthy Aging ( Appendix 6)***

***I Had a fall Poster ( Appendix 1)***

# **Establishing a working group in your setting**

## **Establishing a falls prevention & bone health working group**

- Be familiar with the National Strategy “To Prevent Falls and Fractures in Irelands Aging Population” (available from HSE).
- Start engaging with the relevant heads of services/departments to get commitment.
- Establish how significant the problem of falls is within your setting and gather baseline data.
- Review how falls prevention is currently being addressed; are falls prevention programmes/services available?

# Establishing a working group in your setting

- Falls working group needs to be established and must be multi-disciplinary or falls could be incorporated into another working group i.e. Health and Safety, Quality and Safety
- Develop Terms of Reference for the working group.
- Decide how often the group meets.

## Tips for the working group

- Develop a policy in line with the National Strategy or adapt a policy from a similar setting where possible.
- If you already have a falls prevention programme in place, ensure it is in line with the National Strategy and best practice.
- Assess the fall prevention needs within your setting.
- Identify what programmes or services are currently available.
- Prioritise area of falls prevention that need to be addressed.

# Establishing a working group in your setting

- Agree on short, medium and long-term actions.
- Seek support from similar settings/departments that have established falls and fracture prevention programmes.
- Be clear about what you want to do and how it will be done.
- Decide on definite actions and timeframe.
- Implement actions.
- Monitor and review process.
- Education and Learning Sessions to be provided for all staff (including – Catering, Housekeeping etc) appropriate to their level of responsibility and role

# Resources

- **Strategy to Prevent Falls and Fracture in Irelands Ageing Population, (2008) – [www.hse.ie](http://www.hse.ie)**
- **(TILDA) Fifty Plus in Ireland 2011 Irish Longitudinal Study on Ageing (2011)**
- **(TILDA) Growing old with Intellectual Disability in Ireland (2011)**
- **NICE Clinical guidance 161 [guidance.nice.org.uk/cg161](http://guidance.nice.org.uk/cg161)**
- **Falls Awareness: Live Life Safely Booklet (Falls Multidisciplinary Committee, St Mary's Hospital Phoenix Park, 2010) [Phone Number 01 625041]**
- **Falls Prevention and Management Policy\_St Mary's Hospital Phoenix Park**  
**[http://hsenet.hse.ie/Hospital\\_Staff\\_Hub/StMary%27sHospitalPhoenixPark/Falls\\_Prevention\\_Policy.pdf](http://hsenet.hse.ie/Hospital_Staff_Hub/StMary%27sHospitalPhoenixPark/Falls_Prevention_Policy.pdf)**
- **Falls Prevention Centre of Excellence: [www.stopfalls.org](http://www.stopfalls.org)**
- **Falls safe project-royal college of physicians :[www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)**
- **Videos on Fall Prevention and How to Get Up After a Fall:**  
**<http://www.rospa.com/homesafety/adviceandinformation/falls/videos/falls-360.wmv>**

# Core Learning - Session Two

## Osteoporosis / Bone Health

**Aim:**



```
graph TD; A[Aim:] --> B[To improve awareness and knowledge of bone health and osteoporosis among health service workers]
```

To improve awareness and knowledge of bone health and osteoporosis among health service workers

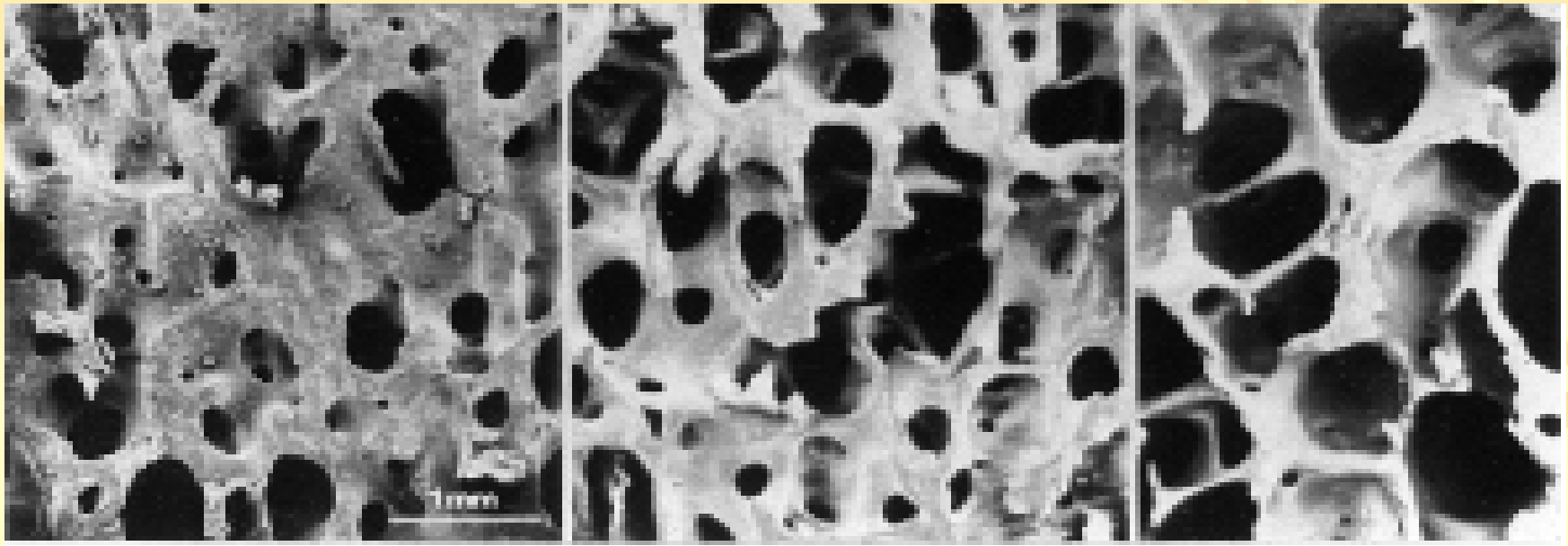
# Keeping Bones strong /preventing Osteoporosis

- To ensure the best bone health possible across all stages of life it is important to have adequate calcium intake, vitamin D levels and appropriate physical activity.
- Bones grow during childhood and adolescence and peak bone mass (strongest bone) is usually reached between age 25 and 30 with men reaching it earlier than women.
- Exercise and a good diet in childhood and adolescence are very important in aiming for the best possible peak bone mass.

# What is Osteoporosis

- The word osteoporosis literally means “porous bones” It occurs when bone loses an excessive amount of their protein and mineral content particularly calcium
- Over time bone mass therefore bone strength is decreased , as a result bones become fragile and break easily

**Osteopenia:** Mild thinning of the bone mass but is not as severe as osteoporosis



# Risk Factors for Osteoporosis (National Osteoporosis Foundation 2013)

## **Risk Factors for Osteoporosis (National Osteoporosis Foundation 2013)**

- There are many factors that can increase the risk of osteoporosis. Some of these are different for men and women. Osteoporosis can occur at any age in both males and females, and persons of all races. One in five men (over 50) and 1 in 2 postmenopausal women (over 50) will develop a fracture during their lifetime (Irish Osteoporosis Society Guidelines 2010).

### **Women**

- A lack of oestrogen caused by:
- Early menopause (before the age of 45).
- Early hysterectomy (before the age of 45), especially if both ovaries are removed.
- Missing periods for six months or more (excluding pregnancy), as a result of over exercising or over dieting.

# Risk Factors for Osteoporosis

## Men

- Low levels of the male hormone testosterone (hypogonadism)
- **Family History:** Family history of osteoporosis is a very strong risk factor, particularly if it includes a history of hip fractures as approximately 80% of a persons bone is genetic.
- **Age:** Bone loss increases in later life so by the age of 75 about half of the population will have osteoporosis. As we get older bones become more fragile and more likely to break.

# Risk Factors for Osteoporosis

- **Race:** Osteoporosis affects men and women of all races. But Caucasians and Asian women are more at risk. Dark skinned people tend to have larger bones, however they have decreased ability to absorb vitamin from the sun.
- **Low Body Weight:** If you have low BMI (body mass index) you are at greater risk of developing osteoporosis.
- **Previous Fractures:** If you have already broken bones easily, including in the spine after minor trauma.
- **Some medical conditions increase your risk;**
- **Rheumatoid Arthritis:** The disease itself and steroid treatment can increase the risk.
- **Eating Disorders:** People who have a history of eating disorders may have missed out on vital nutrients to their bones at a vital stage of development.
- **Gastrointestinal Disorders:** Disorders such as Coeliac disease, Crohns Disease Ulcerative Colitis or primary Biliary Cirrhosis.

# Risk Factors for Osteoporosis

- **Endocrine Disorders:** Disorders such as Hypogonadism, cortical or thyroid and parathyroid hormone problems, diabetes turners syndrome in females and Klienfelters in males.
- **Medications:** Some medicines can increase the risk of osteoporosis e.g. corticosteroids (7.5 mgs daily for more than 3 months), some anti convulsants post organ transplant therapy diuretics.
- **Chemotherapy or Radiation:** Any adult or child who has received or who will be receiving treatment should have a DEXA scan.

## Life Style factors

- Lack of regular weight bearing exercises
- Low daily intake of calcium and or Vitamin D
- Excessive physiological stress
- Smoking
- Excessive alcohol consumption
- Excessive exercise particularly with inadequate caloric intake
- Getting too much protein increase calcium loss
- Excessive sodium and caffeine

# Risk Factors for Osteoporosis

These factors associated with osteoporosis can be categorised as:

- non-modifiable risks like age, family history of osteoporosis
- modifiable factors which are mainly lifestyle and dietary choices which a person can try to control.

## **Modifiable Factors**

- Exercise Nutrition and balanced diet Low dietary calcium Vitamin D
- Deficiency Low body mass index Smoking Alcohol Caffeine

## **Non Modifiable Factors**

- Age Race Gender
- Family history (parent with hip fracture) Previous fracture Ethnicity (more common in Caucasians and Asians) Early menopause / hysterectomy
- Long term glucocorticoid (steroid) therapy

# Risk Factors for Osteoporosis

- Often the first time a person realises they have osteoporosis is when they fracture a bone.
- If an older person has had a previous fracture as a result of very little trauma (fragility fracture), then they need to have their osteoporosis managed and it is especially important that they are assessed by their doctor.
- Getting the appropriate management at this point may prevent a future fracture. It is especially important that they are assessed by their doctor regarding their bone health and their need to be on medications, supplements or taking specific exercise.

# Prevention of Osteoporosis

- Given the modifiable risk factors, there is a great deal that can be done at all different stages in life to guard against osteoporosis and to reduce the risk of fracture.
- Appropriate diet and exercise are critical in aiming to maximise bone mass. Diet is also important to support muscle strengthening exercise programmes and to slow down the effects of ageing on muscle
- Strong muscles are important for everyday function and reducing the risk of falls. Strong muscles are important in maintaining strong bones.

# Prevention of Osteoporosis

## Diet

Everyone needs a balanced diet to promote strong bones. A good diet includes sufficient calories, protein, fat and carbohydrates, as well as minerals and vitamins

- Calcium and Vitamin D are the most important of these for bone health.
- **Calcium** is essential throughout life for bone health and the prevention of osteoporosis.. Calcium comes from the food that we eat, when we consume less calcium than our body requires, it is taken from our bones (National Osteoporosis Foundation - US, 2013).
- Dairy products (milk, cheese and yoghurt) are the richest source of calcium. Consuming 3 servings a day will help meet your calcium needs. Low fat dairy products have similar calcium content to full fat products so calcium intake need not be compromised if people have to alter dietary intake for health reasons.

# Prevention of Osteoporosis

- The recommended daily allowance\* of calcium is:

Women	Allowance
Aged 19 to menopause	1000 mg/day
Post menopause	1300 mg/day
Men	Allowance
Aged 19–65 years	1000mg/day
65+ years	1300mg/day

- <http://www.iofbonehealth.org/calcium-calculator>

# Prevention of Osteoporosis

- **Vitamin D** plays a vital role in bone health – without it calcium, which is required for strong and healthy bones cannot be absorbed.
- Sunlight exposure is probably the most important source of Vitamin D and people should aim to expose skin to natural sunlight to achieve requirements. Diet can provide vitamin D and this may be particularly important for people not frequently exposed to sunlight. The richest sources of dietary vitamin D include:
  - Oily fish
  - fish liver oil
  - Liver
  - Eggs
  - Milks
  - Spreads

# Prevention of Osteoporosis

**The recommended daily\* vitamin D intake is:**

## **Women and Men**

- 51 to 65 years                      400 IU/day
- 65+ years                          600 IU/day

## **Calcium and Vitamin D Supplementation**

- Supplementation with calcium and vitamin D may be necessary for people who do not get outdoors much or who have restricted exposure to sunlight or who have a restricted diet. Older frail people may have insufficient exposure to sunlight and a low dietary intake thus decreasing vitamin D levels in the blood.
- **Calcium and Vitamin D supplements are only necessary:**
- If a person is not getting adequate amounts of Calcium via diet or Vitamin D via diet and exposure to sunlight
- If a person is unable to absorb sufficient calcium and Vitamin D

# Prevention of Osteoporosis

- **Protein**

- Protein is important for muscle and bone health. European guidance for the diagnosis and management of osteoporosis in postmenopausal women recommends a daily intake of at least 1g/kg body weight of protein for all women aged over 50 years (Rizzoli et al, 2014). So if a person weighs 65kg that means eating a minimum of 65g of protein.

- **Sources of protein**

- Lean red meat, Chicken, Hummus, Kidney beans, Lentils, Salmon
- There are two other factors to consider in a person's diet; alcohol and caffeine

- **Alcohol**

- Excessive alcohol intake can increase loss of calcium from bone. The Department of Health and Children recommend not more than 14 units per week for women and 21 units for men. No more than 3-4 units should be taken in any one day. People should try to have a few alcohol free days every week.

# Prevention of Osteoporosis

## Caffeine

- Caffeine can increase the amount of calcium lost from a person's body. Daily intake of coffee (not more than 3 cups) and high caffeine drinks (e.g. cola) should be limited.

## Smoking

- Give up smoking!

## Exercise for Bone Health

Exercise is important in promoting bone health. The overall goal is to prevent a fracture and this can be achieved by:

- Building bone or slowing down bone loss
- Preventing falls

# Prevention of Osteoporosis

## Key points for bone building:

- To build bone, or slow down the rate of bone loss, exercises which load bones are necessary.
- Bones can be loaded by impact exercise such as jogging, skipping, and jumping for the hips and spine or taking load through the arms.
- Resistance training using weights, resistance machines or elastic band/tubing will also improve bone health.
- The best way of improving bone health through exercise is by performing a structured mixed loading programme consisting of resistance training and impact such as jumping, jogging, step training and walking (Howe, 2011).

***Tips for Bone Health (Appendix 5)***

# Who needs to be screened for osteoporosis by DXA?

- A DXA scan is recommended, generally, for people who are at high risk of osteoporosis (see risk factors above, then a DXA is not necessary).

## What is DXA?

- A bone density scan called a DXA scan is used to measure the density of bones. The letters DXA stand for: **D**ual-energy **X**-ray **A**bsorptiometry. This test is currently the most accurate and reliable means of assessing the strength of one's bones and risk of fracture. It is a simple painless procedure that uses very low doses of radiation.

# Treatment options for Osteopaenia /Osteoporosis



# Treatment with Osteoporosis Medication (National Osteoporosis Foundation)

- There are many things to think about when choosing the right osteoporosis medicine. You and your healthcare provider may want to look at:
- **Your gender.** Calcitonin (Fortical® and Miacalcin®), estrogen and hormone therapies, and estrogen agonists/antagonists (Evista®) are only approved for women. Some bisphosphonates ®) are approved for both men and women.
- **Your age.** Some medicines may be more appropriate for younger post-menopausal women while others are more appropriate for older women.
- In general, osteoporosis medicines are not recommended for pre-menopausal women. Certain osteoporosis medicines are approved for the prevention and treatment of osteoporosis in pre-menopausal women, as a result of the long-term use of steroid medicines.

# Treatment with Osteoporosis Medication (National Osteoporosis Foundation)

## **How severe your osteoporosis is.**

- Osteoporosis medicines work in different ways. A person with more severe bone loss or a broken bone may take a different medicine than a person with less bone loss. (Forteo®).

## **Personal preference.**

- Do you prefer a pill, liquid or IV medicine or one that is given as a nasal spray or an injection? Does it work better for you to take your medicine every day, once a week, once a month, several times a year or even once a year?

# Secondary Prevention Following Fragility Fracture

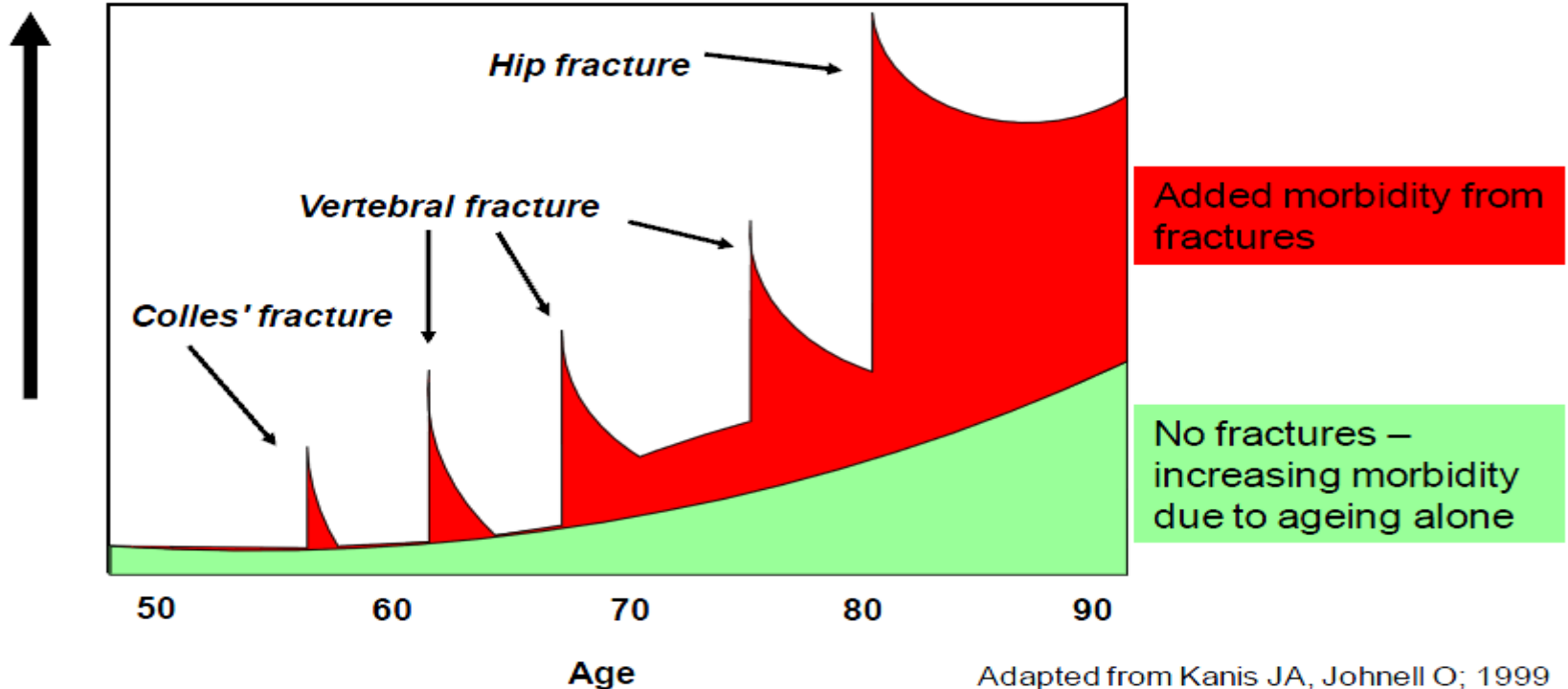
## Secondary Prevention-Following Fragility Fracture

- There is now a growing body of evidence on the effectiveness of secondary prevention using anti-resorptive drugs to improve bone quality.
- One of the most important initiatives for minimising the burden of osteoporosis related fractures is to identify people who have sustained a minimal trauma fracture early and initiate appropriate treatments (Department of Health, Western Australia: Osteoporosis Model of Care. Perth: Health Networks Branch, Department of Health, Western Australia; 2011.page 16).

# Fragility Fracture Career

## The fragility fracture 'career' - a chronic disease

Morbidity  
Dependence



# Fracture Liaison Service

## Development of a Fracture Liaison Service

- Fracture Liaison Services, commonly known as FLS, are co-ordinator based secondary fracture prevention services implemented by health care systems for the treatment of osteoporotic patients.

## The FLS is designed to:

- Close the care gap for fracture patients who are currently never offered screening and/or treatment for osteoporosis.
- Enhance communication between health care providers by providing a care pathway for the treatment of fragility fracture patients.

# Resources

- Irish Osteoporosis Society - [www.irishosteoporosis.ie](http://www.irishosteoporosis.ie)
- National Osteoporosis Foundation – [www.nof.org](http://www.nof.org)
- Osteoporosis (UK) [www.nos.org.uk](http://www.nos.org.uk)
- Strategy to Prevent Falls and Fracture in Irelands Ageing Population, 2008 – [www.hse.ie](http://www.hse.ie)
- Osteoporosis Poster – [www.bonehealth.co](http://www.bonehealth.co)
- Eat Well for Bone Health Booklet (Paula Mee, 2014) – [www.paulamee.com](http://www.paulamee.com)
- Access <http://www.iofbonehealth.org/calcium-calculator> for a calcium calculator

# Core Learning - Session Three

## Primary Care Setting

**Aim:**



**To provide Health Care professionals in the Primary Care Settings with the information and knowledge on the screening, assessment and intervention process for falls prevention and bone health**

# Primary Care Setting

- The Primary Care Draft Working Guidelines (2012) inform Health Professionals on how to screen and assess for falls at risk people ( $\geq 65$  years) and refer for appropriate interventions at primary care level.
- Primary Care Services mean all of the health or social care services in your community.
- Nine Community Healthcare Organisations are being established and they each will have 10 Primary Care networks. The Primary Care Network supports several Primary Care teams
- Primary Care Team consists of health professionals who work closely together to meet the needs of the people living in the community; they provide a single point of contact to the health system. (HSE, 2013)

# Primary Care Team

The Primary Care team consists of:

- General Practitioner & Practice Nurse
- Community Nursing Service – Public Health Nurse & Community Registered Nurse
- Occupational Therapist
- Physiotherapist
- Home Help/Support Staff
- The Primary Care Team also links in with other community-based disciplines to ensure all health and social needs are provided for

(HSE, 2013)

# Target Population for Guidelines

- Ideally are older people ( $\geq 65$  years)
- living in the community who are availing of services provided at primary care level.
- Priority may need to be given to the highest risk groups such as older people who attend Emergency Departments or out of hours GP services with a history of falls, frail elderly, or older people attending day centres
- Structured falls prevention programmes in primary care settings have been shown to achieve a reduction, of between 15% and 30%, in falls and potentially, could see a reduction nationally of up to 10,200 admissions per annum, which equates to a saving of €17.7m - Primary Care (Teams HSE Board Report 2011).

# Primary Care Working Guidelines

Screen older people for risk of falling

Encourage a multidisciplinary assessment and management approach of older adults who are at risk of falling

Provide an individually tailored action plan for clients identified as a falls risk.

Involve the client in formulating an action plan and inform the client of the outcome of referral processes

Link in local referral pathways within the various services

# Screening and Assessment

**Screening:** The Aim of screening for falls in older people is to identify those who are at risk of falls (**Appendix 2**)

*Older persons in contact with Health Care Professionals or their care givers should be asked the following at least once a year:*

- Have you fallen during the past years?
- If the older person has fallen, ask about the frequency and characteristics of their falls.
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on Healthy Aging Tips on Bone health
- If the person has had a Single Explained Fall, carry out Gait and Balance Test Get up and Go( **Appendix 7**)
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment

# Screening and Assessment

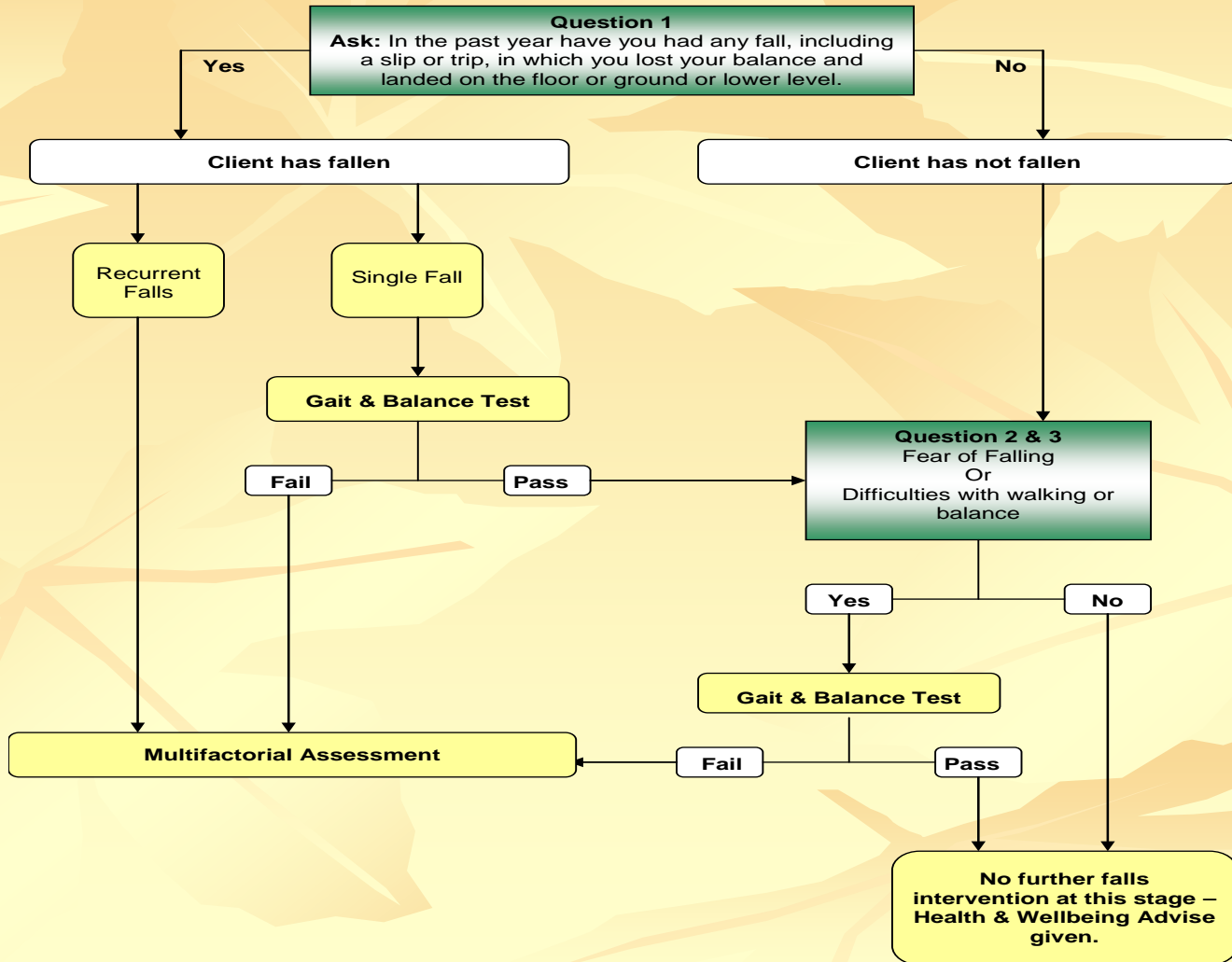
- **Assessment: The Aim** of the multi factorial assessment is to identify the falls risks. A multi factorial fall risk assessment should be performed for older people who: (**Appendix 3**)
- Report recurrent (2 or more) falls in the past year.
- Report difficulties with gait and balance.
- Report fear of falling.
- Seek medical attention because of a fall.

**The multi factorial risk assessment should be carried out and should incorporate the following: (Appendix 3)**

- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.
- Medications Environmental Issues Feet and Footwear Vision Impairment  
Related Medical History Social Factors
- Dietary intake including hydration

***Any team member can complete the Multi factorial Fall Risk assessment.***

# Screening and Assessment



# Interventions

- Medication review and withdrawal of psychotropic and other culprit medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.
- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and calcium insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (Adapted from National Strategy HSE 2008)

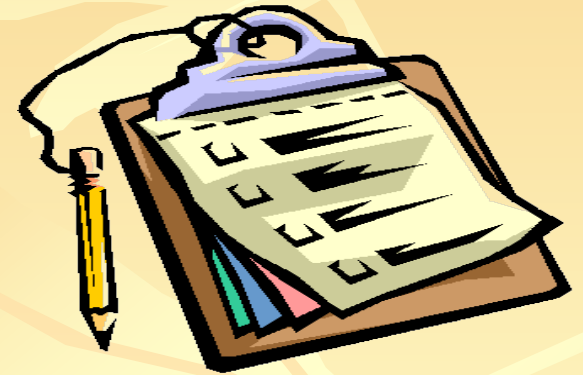
# **Reporting Falls**

**In keeping with the  
HSE Safety Incident Management Policy 2014  
and/or your local policy (for non HSE services),  
all falls witnessed/unwitnessed need to be reported to the National Incident  
Management System (NIMS), using a risk Management Occurrence Form  
(all clinical incidents including falls must  
be reported and reviewed)**

# Reporting Falls

In the situation of a fall /reported fall, a Clinic incident/Near Miss form should be completed. The following details should be included in the form:

- Location of fall
- Time of Day
- Activity at time of fall
- Immediate Management
- Trauma both physical and psychological
- Environmental Factors i.e. no hand rails, trailing leads, etc
- Service user factors i.e. no footwear, stocking feet, etc
- If the fall resulted in harm
- A no harm fall where no harm occurred
- Service user had a falls risk management completed on admission / transfer and or/within the last 3 months in line with older people Services Falls Metrics (Adapted from HSE, 2013)



# Tips for Home Help Service

## **Members of the Home Help Service should:**

- Observe for and notify manager of possible risk factors for falls
- Report witnessed, un-witnessed and near-falls to clinicians and managers
- Report home safety hazards such as poor lighting, throw rugs and trailing flexes
- Encourage patient and caregiver to use walkers or canes, if patient has a device
- Ensure proper use of adaptive equipment in bathrooms
- Check that the older person's glasses are clean
- Check if hearing aids are ok
- Remind the older person to exercise as regularly as possible
- Observe the older person has safe footwear



# Primary Care Setting - Resources

- **HSE, 2012. A Guide to Falls Screening and Multi-factorial Falls Risk Assessment *in* Primary Care. National Care of the Elderly and Primary Care Clinical Programmes.**
- **Eat Well for Bone Health Booklet (Paula Mee, 2014) – [www.paulamee.com](http://www.paulamee.com) (Pg: 189-190)**
- **Falls Awareness: Live Life Safely Booklet (Falls Multidisciplinary Committee, St Mary's Hospital Phoenix Park, 2010) [Phone Number 01 6250414]**
- **Osteoporosis Poster – [www.bonehealth.co](http://www.bonehealth.co)**

# Resources

- HSE, 2012. A Guide to Falls Screening and Multi-factorial Falls Risk Assessment *in* Primary Care. National Care of the Elderly and Primary Care Clinical Programmes.
- Eat Well for Bone Health Booklet (Paula Mee, 2014) – [www.paulamee.com](http://www.paulamee.com) (Pg: 189-190)
- Falls Awareness: Live Life Safely Booklet (Falls Multidisciplinary Committee, St Mary's Hospital Phoenix Park, 2010) [Phone Number 01 6250414]
- Osteoporosis Poster – [www.bonehealth.co](http://www.bonehealth.co)

# Core Learning - Session Four

## Falls in the Acute Setting

**Aim:**



To provide staff in the Acute Setting with the information and knowledge on the screening assessment and management process for falls and bone health

# Why Do Patients Fall in a Hospital Setting?

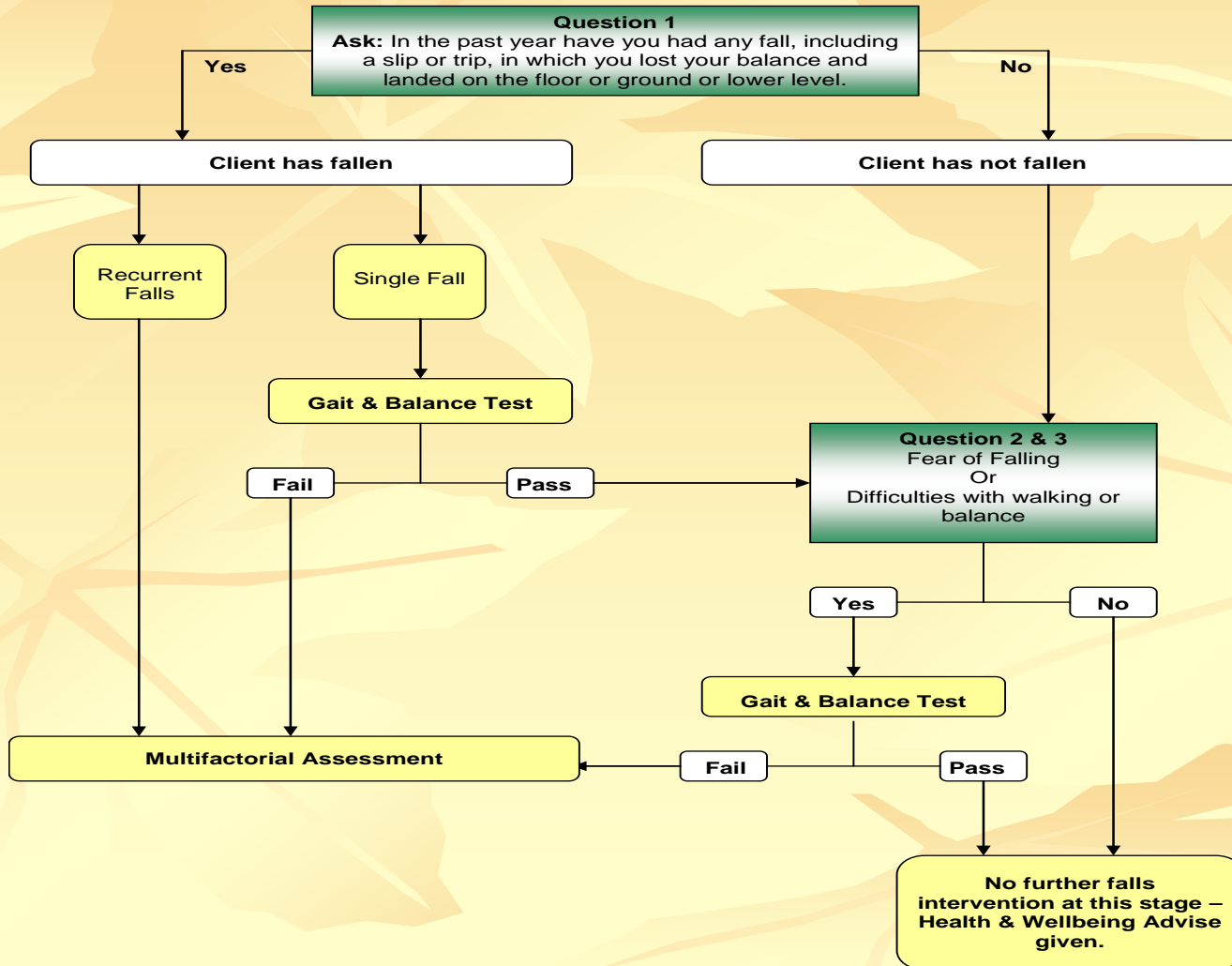
- Hospital patients are at greater risk of falling than people in the community (NICE, 2004).
- Some reasons might include that they may have recently undergone surgery that affects their memory or mobility, and they may have cardio-vascular problems or need medication, which may increase the risk of falling.
- Dementia also increases the risk as these patients are less likely to recognise environmental hazards, less likely to recover their balance and are often unaware of their limitations.
- All patients in hospital, whether suffering from dementia or not, have to adapt to a different environment and to changes in their strength and mobility (NHS, 2010).

# Acute Hospital

## **All acute hospitals should have:**

- A falls policy. Sample policy (**Appendix 9**)
- A multidisciplinary Falls Group.
- A process for screening assessment and interventions for service users at risk.
- A process for reporting falls and fall related injuries.
- A structure for educating staff on falls and fracture prevention.

# Screening and Assessment



# Falls Screening and Assessment

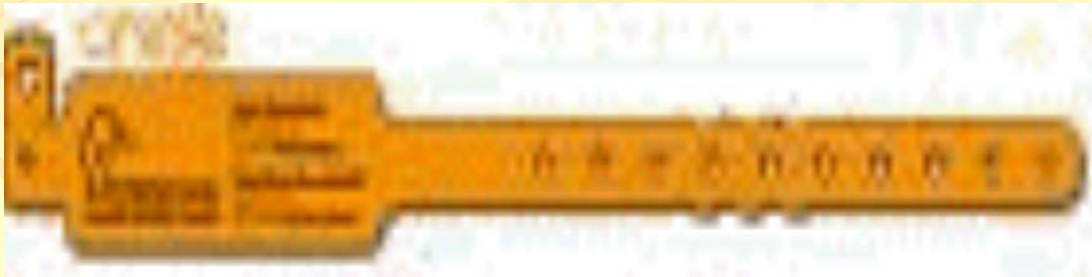
All patients 65 or older who are admitted to hospital should be considered for a multi- factorial assessment, for their risk of falling during their hospital stay.

## Screening (Appendix 2)

- **The Aim** of screening for falls in older people is to identify those who are at risk of falls
- Older persons in contact with Health care professional or their care givers should be asked the following at least once a year
- Have you fallen during the past years
- If the older person has fallen, ask about the frequency and characteristics of their falls
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on healthy Aging and Tips on Bone health

# Falls Screening and Assessment

- If the patient answers **yes** to any of the screening questions apply orange band or other alert. Carry out a falls risk assessment and initiate a Falls Care Plan.
- If the patient has a single explained fall i.e. tripped over object, clothing etc, test for Gait and balance (**Appendix 7**)
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment and apply orange alert band



# Falls Screening and Assessment

- **Assessment (Appendix 3)**
- **The Aim** of the multi factorial assessment is to identify the falls risks. A fall risk assessment Multi factorial falls risk Assessment should be performed for older people living who (**Appendix 3**)
- Report recurrent (2 or more) falls in the past year
- Report difficulties with gait and balance
- Report fear of falling
- Seek medical attention because of a fall
- The multi factorial risk assessment should incorporate the following:
- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.

# Falls Screening and Assessment

- Medications
- Environmental Issues
- Feet and Footwear
- Vision Impairment
- Related Medical History
- Social Factors
- Dietary intake including hydration
- Any team member can complete the Multi factorial Fall Risk assessment.

***Be Aware that screening methods may under or over estimate an Individual's risk of falling therefore clinical judgement is also required***

# Interventions

The **multi-factorial interventions** would include:

- A falls risk assessment followed by intervention, to modify the identified risk (deficit), is the most effective strategy to reduce both the risk of falling and incidence of falling in older people.
- Strategies that combine interventions and target more than one risk that have been shown to reduce falls are:
- individualised exercise programme that includes a combination of resistance. (strength) training, gait, balance, and co-ordination training.
- Medication review and withdrawal of psychotropic and other medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.

# Interventions

- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (A Guide to Falls Screening and Multi factorial Falls Risk Assessment in Primary Care 2012)

# Safety Pause

- The aim of the safety pause is to enhance communication, prioritise patient safety and experience and embed quality improvement in daily practice
- It can be used in any ward, department, clinic, unit or service e.g., prior to medical rounds, at the beginning or end of the handover and is wider than the nurse handover
- It should be multidisciplinary and take no longer than 5 minutes. It is a method of alerting staff to patient safety issues for the shift/day and actions needed. The HSE safety pause Information Sheet.

[www.hse.ie/go/clinicalgovernance](http://www.hse.ie/go/clinicalgovernance)

# **Additional Safety Precautions for High Fall Risk Patients**

- Move the patient closer to the nurse's station where possible.
- Have the bed down low, with the brakes locked.
- Keep floor surfaces dry and uncluttered.
- Have the patients belongings and drinking water within their reach.
- Ensure footwear is non-slip and well-fitting.
- Ensure clothes/nightwear are not trailing, causing a tripping hazard.
- Monitor regularly throughout the day/night.

# Intentional Rounding Or Comfort Checks

**Aim** to provide a regular routine of individualised checks at times agreed within the acute setting. This enables staff to interact with patients every hour or every 2 hours depending on needs. (**Appendix 10**)

- The idea around this is for staff members to check in on patients in order to address any needs they may have, which are linked with Pain, their Position, their Personal Needs and Placement. “Four P’s
- The patients at risk or who have had a fall should be rounded on.
- This may only be required at certain times of the day when there is less staff/patient activity.
- Each ward can identify which parts of the day when there is less staff supervision of the patients and intentionally round at those times.
- All staff have a role to play in this the “Four P’s”
- **Positioning:** Making sure the patient is comfortable and assessing the risk of falls or pressure ulcers.
- **Personal Needs:** Scheduling patient trips to the bathroom to avoid unsafe conditions.
- **Pain:** Asking patients to describe their pain level on a scale of zero to 10.
- **Placement:** Making sure the items a patient needs are within easy reach, such as water, tissues, television remote control and the telephone.

# Falls Risk Alert Symbols and Signs

If on admission a patient is identified as being at risk of falling “an appropriate risk alert symbol”, (e.g. orange wrist ban or other) should be put in place and a falls risk assessment carried out and a falls care plan initiated. These symbols/alerts are visual reminders to staff that the patient is at risk of falling.

- Orange is generally considered the national colour for falls risk. They are used in the form of stickers, bracelets or signage placed above the patient's bed, on the patient's door, or on the patient's chart.

## **Safety Cross: (Appendix 4)**

- This is a monthly visual alert which is kept at the nurses station which indicates on a daily bases if any falls have occurred

## **An orange wristband**

- An orange wristband indicates a patient who is at increased risk of falling. ***It is used in the acute hospital setting only.*** The older person should have the band placed around their wrist while they remain at risk. If reassessment identifies that they are no longer at risk the orange risk band should be removed

# Post Fall Care

## **Post Fall Care (Appendix 12)**

- If a fall occurs while a patient is in the acute setting the nurse on duty will:
- Call for help and administer first aid if necessary.
- Not attempt to move the patient until sufficient help is available.
- Not manually lift the client from the floor unless in an emergency (Ex: fire, explosion).
- In the event of cardiac arrest, resuscitate the patient on the floor.
- If the patient is uninjured and has recovered sufficiently, assist them to get themselves up by rolling onto all fours or into a kneeling position and pulling themselves in a sitting position with the aid of a chair/stool.
- If the patient is unable to get up themselves from the floor, must use a mechanical aid (Ex: Hoist). If the client is in a confined space, a sliding device can be used to move them to a more comfortable area.
- Call the doctor on-call to assess the patient.
- Contact Patient family as soon as possible

# Post Fall care

- Will complete Clinical Incident/Near Miss form accurately and submit to the Clinical Nurse Manager.
- Submit Incident Report form/Near Miss forms to the line manager for review and sign off and entry on to the STARS system.
- Encourage staff to perform a post fall assessment of the incident eg huddle
- Use a visual cue to identify that a fall has occurred in the setting. i.e.: The Safety Cross (**Appendix 4**)
- Re-assess Patients falls risk after the fall
- Encourage information re patients at risk of falls or who has fallen during that shift, to be handed over at report times between staff

# Post-Fall “Huddle” Tool and/or asking the 5 Why’s

- This is part of the falls care bundle; it is a method used to analysis the reason why the patient fell.
- This tool should be used to guide the immediate post-fall “huddle” and should take only 5 minutes of your time. Gather all available staff, including nurses, NA, and managers.
- As part of the post fall huddle you could use the 5 whys approach.
- Was Assessment undertaken on admission? Risk status- low, moderate, high?
- Why do YOU think the patient fell (based on your nursing assessment of the following):
- Who fell? When did they fall? Where did they fall? What were they doing when they fell?

# Actions Plan Post Fall Huddle

- Update fall risk assessment
- Decide on interventions and time frame
- Decide on review date

# Discharge

## Discharge Home

- The time spent by patients in the acute hospital setting is usually short. It is very important that as part of their discharge plan from the hospital that the falls history, the appropriate treatment and setting for follow-up is included in the letter to the GP, PHN and other relevant health professionals.

## Emergency Department

- For older people who experience a fall and attend the Emergency Department it is a very important point of contact. 13%-52% of older people experience subsequent falls (Close, Ellis et al. 1999; Bloch, Jegou et al. 2009) 49% are re-hospitalised (Bloch, Jegou et al. 2009)
- If Falls Risk Screening identifies that the older person is at risk of falling, a falls risk assessment should be completed by hospital staff if patient is admitted or in the community if the older person is discharged home and the appropriate referral for assessment and appropriate intervention initiated

# Resources

- **Example of Policy Acute Hospital – Appendix 9**
- **Example of intentional rounding Chart – Appendix 10**
- **Multi-Factorial Assessment and Intervention– Appendix 8**
- **Gait and Balance Test Get up and Appendix 7**
- **Safety Pause Information Sheet [www.hse.ie/go/clinicalgoverance](http://www.hse.ie/go/clinicalgoverance)**
- **The Fall Safe Care Bundle [www.bgs.org.uk/campaigns/fallsafe](http://www.bgs.org.uk/campaigns/fallsafe) Pg 116**
- **Safety Alert Form- Appendix 11**
- **Osteoporosis Poster – [www.bonehealth.co](http://www.bonehealth.co)**
- **Safety Cross – Appendix 4**
- **Fall Safe Care bundle [www.bgs.org.uk/campaigns/fallsafe](http://www.bgs.org.uk/campaigns/fallsafe)**

# Core Learning - Session Five

## Residential Care Setting

**Aim:**



To provide staff in the Residential Setting with  
the information and knowledge on the screening assessment and  
management process  
for falls and bone health

# Residential Setting

- Older People in residential setting are generally frailer than older people living in the community. They are usually older, have more chronic conditions, and have more difficulty walking. They also tend to have thought or memory problems, to have difficulty with activities of daily living, and need help getting around or taking care of themselves.
- Approximately 6% of people aged 65 years and older in Ireland are receiving residential care (CSO, 2012). Of those requiring long-term care, approximately 70% are aged 80 years and older (Department of Health, 2010).

# Residential Setting

- Older people in residential settings residents are at highest risk of falls, fractures and osteoporosis. Their rate of hip fracture is 3-11 times greater than age-matched community dwelling older people (HSE, 2008).
- An estimated 50% of older people in residential settings fall each year, this fall rate is more than double the rate for older people living in the community (CDC, 2008).

# All Resident Settings Should Have

- A falls prevention and management policy. (Sample Policy Residential setting) [http://hsenet.hse.ie/Hospital Staff Hub/StMary%27sHospitalPhoenixPark/Falls Prevntion Policy.pdf](http://hsenet.hse.ie/Hospital%20Staff%20Hub/StMary%27sHospitalPhoenixPark/Falls%20Prevention%20Policy.pdf)
- A process for screening assessment and interventions for patients at risk.
- A process for reporting falls and fall related injuries.
- A structure for educating staff on falls and fracture prevention. All staff have a role in preventing falls

# Screening and Assessment

**Screening:** The Aim of screening for falls in older people is to identify those who are at risk of falls( **Appendix2**)

*Older persons in contact with Health Care Professionals or their care givers should be asked the following at least once a year:*

- Have you fallen during the past years?
- If the older person has fallen, ask about the frequency and characteristics of their falls.
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on Healthy Aging Tips on Bone health
- If the person has had a Single Explained Fall, carry out Gait and Balance Test Get up and Go
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment

# Screening and Assessment

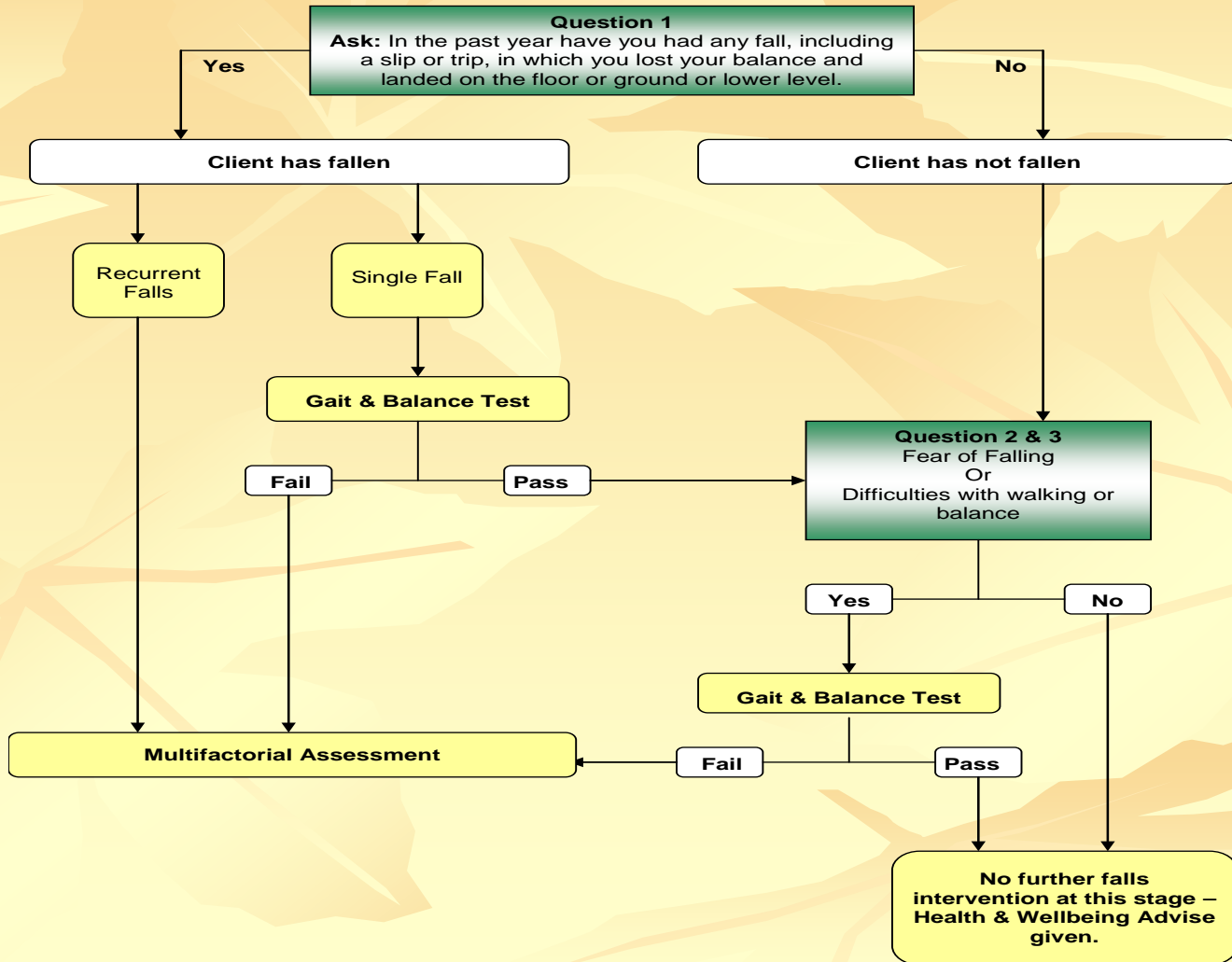
- **Assessment: The Aim** of the multi factorial assessment is to identify the falls risks. A multi factorial fall risk assessment should be performed for older people who(**Appendix3**)
- Report recurrent (2 or more) falls in the past year.
- Report difficulties with gait and balance.
- Report fear of falling.
- Seek medical attention because of a fall.

**The multi factorial risk assessment should be carried out and should incorporate the following (Appendix 3)**

- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.
- Medications Environmental Issues Feet and Footwear Vision Impairment Related Medical History Social Factors
- Dietary intake including hydration

***Any team member can complete the Multi factorial Fall Risk assessment.***

# Screening and Assessment



# Interventions

- Medication review and withdrawal of psychotropic and other culprit medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.
- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and calcium insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (Adapted from National Strategy HSE 2008)

*Interventions ( Appendix 8)*

# Forever Autumn Alerts / Programme

On admission all residents who have any degree of mobility are assessed for their falls risk and an appropriate coloured leaf (green, amber or red) is displayed to indicate their risk as follows:



The green leaf signifies the resident has a low risk of having a fall. Minimum Falls Prevention Standards will be put in place. A leaf **will not** be on display but will be placed next to the residents name on the white board in the Clinical Nurse Manager's Office



The amber leaf signifies a medium risk of the resident having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a yellow 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf **will be** placed next to the residents name on the white board in the Clinical Nurse Manager's Office



The red leaf signifies the resident has a high risk of having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a red 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf **will be** placed next to the residents name on the white board in the Clinical Nurse Manager's Office

# Post Fall Care

**If a fall occurs while a resident is in residential care, the nurse on duty will inform the Nurse in Charge on the shift**

- Check the environment is safe for all
- Take necessary action; scan body for injuries, assess for pain, tenderness, swelling, laceration, irregularities, and deformities and assess if it is suitable to move the person
- Pathway for residents who have had a slip, trip or fall observed / unobserved should be followed (**Appendix 12**)
- Do not attempt to move the resident until sufficient help is available
- Do not manually lift the resident from the floor unless in an emergency situation, e.g., fire, explosion. In the event of cardiac arrest, residents can be resuscitated on the floor (if this is the starting position)

## **Post Fall Care (contd.)**

- If the resident is uninjured and has recovered sufficiently, S/He may be able to get up themselves by rolling onto all fours or into a kneeling position and pulling themselves in a sitting position with the aid of a chair or stool
- If the resident is unable to get up themselves from the floor, then a mechanical aid must be used, e.g., hoist. If the resident is in a confined space a sliding device can be used to move them to a more comfortable area
- Contact the Doctor as soon as possible. Record the name of the Doctor and time, advice received from Doctor in nursing progress notes. Assessment prior to contacting Doctor (**Appendix 14**)

**Once the resident is stabilised following any slip, trip or fall, reflect and analyse to prevent a further occurrence, using the Falls Huddle method**

# Post Fall Huddle Tool

**Why do YOU think the resident fell (based on your nursing assessment of the following):**

**Who fell? When did they fall? Where did they fall? What were they doing when they fell?**

**Was Assessment undertaken on admission? Is risk status - low, moderate, high?**

- Environmental Assessment
- Bedrails up?
- Bed/Chair alarm on?
- Bed in low position?
- Call light within reach?
- Fall history, fall circumstances, and fall risk factors assessment
- Health history and functional status
- Medications and alcohol consumption review
- Vital signs & Pain assessment
- Vision Screening
- Gait, Balance, or Musculoskeletal/Foot
- Continence Assessment

# Post Fall Huddle Tool

- Neurological Assessment
- Cardiovascular Assessment
- Depression Screening
- Walking Aids, Assistive Technologies, & Protective Devices Assessment
- Why does your patient think s/he fell ?

# Post Fall Huddle Tool

## OR - Additional comments

- • What specifically can you change to prevent the resident from falling again?
- • File Fall Incident Report and include any “huddle” insight.
- BE SURE to document patient fall and complete incident form including the following details:
  - • Signs or Symptoms
  - • Previous Fall
  - • Location of fall
  - • Time of Day
  - • Activity at time of fall
  - • Trauma both physical and psychological
  - • Environmental Factors i.e. no handrails, trailing leads etc
  - • Residents factors i.e. no footwear, stocking feet etc
  - • Harm / No Harm

# A Resident you Observe Falling

- This is a hazardous situation. The key objective of the handler is to guide the resident onto the floor.
  - If the resident is at a distance from you, do not reach out and try and grab the resident.
  - If the resident is beside you when they begin to fall then release your grip on the resident. Stand slightly behind the client and to the side with your feet in a wide base and allow the client to slide to the floor.
  - Remember to bend your knees while lowering the resident. If possible support the residents head. *Do not attempt to support the full weight of the resident (The Guide to Handling of People 2011).*
  - Should a resident require transfer to the acute hospital or another Health Care facility, the resident Safety Alert form should accompany them.
  - A Clinical Incident Form should be completed.

# **Safety Precautions for High Risk patients**

- Ensure Resident has a call bell to hand
- Check that the Resident knows how and when to operate the call bell
- Explain to the Resident the importance of looking for assistance when needed
- Discuss the Residents walking ability with them
- Ensure that the Residents walking aid (if used) is within reach
- Assess that the Residents environment is free from any potential hazards
- Do not leave Residents with cognitive impairment unattended on commodes, toilets, in baths or showers
- Ensure personal belongings are within easy reach for the Resident

(Adapted from NHS Scotland, 2011)

# Residential Setting - Resources

## Resources

- Falls Prevention and Management Policy St Mary's Hospital Phoenix Park  
[http://hsenet.hse.ie/Hospital\\_Staff\\_Hub/StMary%27sHospitalPhoenixPark/Falls\\_Prevention\\_Policy.pdf](http://hsenet.hse.ie/Hospital_Staff_Hub/StMary%27sHospitalPhoenixPark/Falls_Prevention_Policy.pdf)
- Multi Factorial Assessment and Intervention – Appendix 8
- Gait and Balance Test (Get Up and Go) – Appendix 7
- Osteoporosis Poster – [www.bonehealth.co](http://www.bonehealth.co)
- Fall Safe Care bundle [www.bgs.org.uk/campaigns/fallsafe](http://www.bgs.org.uk/campaigns/fallsafe)
- Safety Alert Form – Appendix 11
- Intentional Rounding Chart – Appendix 10
- Pathway for Care of service user Post Fall – Appendix 12
- Assessment Prior to Contacting Doctor – Appendix 14
- Northern Ireland Nursing Home Regional Collaborative, Falls Prevention Toolkit – [www.publichealth.hscni.net](http://www.publichealth.hscni.net)
- Bone health in the Park Forever Autumn (2011/12 ) [www.bonehealth.co](http://www.bonehealth.co)

# Core Learning Session Seven Delivering Information Session

**Aim:**



**To provide staff with guidance on delivering an  
information session**

# Sample of Event Planning Template

Date of Session:	28 <sup>th</sup> August 2014
Time of Session:	2pm - 2.15pm
Location:	Dining Room
Who is to Attend:	Name Name Name
Main Message to be delivered:	Risk Factors for falls and Consequences
Outline of Session:	Risk factors for falls Consequences of falls Questions & Answers

# Planning A Learning Session

- The falls prevention foundation programme is evidence informed, multidisciplinary and organised to meet the needs of a broad range of health and social care workers.
- The **taught programme (see URL –downloadable in full)** addresses the core competencies required by staff working with older people at risk of falls and fractures .
- The programme can be delivered as a half day classroom taught programme.
- It may be delivered locally in different ways (e.g. ward based or session by session over a period of weeks) to health and social care workers caring for patient affected by falls and bone health issues.

# List of Appendices with Sample Tools

- [Appendix 1: I had a fall poster](#)
- [Appendix 2: Level 1 Screen](#)
- [Appendix 3: Level 2: Multi-factorial Falls Risk Assessment](#)
- [Appendix 4: Falls Safety Cross](#)
- [Appendix 5: Quick Tips for Healthy Bones](#)
- [Appendix 6: Tips for Healthy Ageing](#)
- [Appendix 7: Get Up and Go Test](#)
- [Appendix 8: Multi factorial Assessment and Intervention](#)
- [Appendix 9: Sample Policy Acute setting](#)
- [Appendix 10: Intentional Rounding Chart](#)
- [Appendix 11: Safety Alert Form](#)
- [Appendix 12: Pathway for care of older person Post Fall](#)
- [Appendix 13: Post Falls assessment management pathway](#)
- [Appendix 14: Nursing Assessment prior to ringing the G.P](#)