Falls and falls injury prevention activity audit for residential aged care facilities

National Ageing Research Institute

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This tool is based on a tool that was originally developed by the National Ageing Research Institute and Word Design Interactive for the Victorian Quality Council (2004) “Minimising the Risk of Falls & Fall-related Injuries” Guidelines Pack. It was modified for use in the Star Falls Prevention project that was funded through the Australian Government Department of Health and Ageing’s Enhancing Better Practice in Residential Aged Care Program (2009).
**Aim of the audit tool**

This tool has been designed to assist residential aged care facilities to reflect on their current practice in relation to evidence based falls prevention. The audit can be used to identify areas for improvement and to inform quality improvement activities.

**Completing the audit tool**

The tool would normally be completed by nursing and/or management staff who are aware of various policies and practices within the facility. Some parts of the tool may also require discussions with other staff working in the facility to determine whether practice reflects policies.

The audit tool can be used intermittently to gauge change over time and to ensure gaps in evidence based practice are identified and addressed.

If you are completing the tool electronically, the check boxes can be filled automatically by double clicking on the text box. A screen will appear and the default value of ‘not checked’ will be selected. Click on ‘checked’ and then ‘OK’ to place a cross in the box.

**Outline of the audit tool**

The following falls and injury prevention topics are covered in the audit tool:

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Section 1: Falls risk screening

Falls risk screening refers to a brief (often less than 5 item) check to determine a resident’s risk of falling. It is usually used to identify residents who need to have a more detailed assessment of falls risk carried out.

There is no evidence to indicate that a screen should or should not be conducted in residential care. However, guidelines for falls prevention recommend that for high risk groups, such as the majority of residents in residential care facilities, a full assessment should be conducted, rather than a screening process, as the screening process is likely to classify most residents at high risk and therefore require a detailed falls risk assessment (see section 2 on Falls risk assessment).

1. Does your facility currently use a falls risk screening tool to identify residents who are at high risk of falling and require in-depth risk assessment?
   - Yes
   - No (go to Section 2)
   If yes, can you please attach a copy of the tool?

2. When is the tool completed (please tick all that apply)?
   - on admission
   - daily or more often
   - weekly
   - monthly
   - after a fall or other incident
   - other (please specify) ____________________________

3. Has the falls risk screening process and tool used by your facility been reviewed or updated in the past two years?
   - Yes
   - No
   If yes, please provide details.
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________

4. Has the accuracy of the falls risk screening tool in classifying resident’s level of risk been assessed in the past?
   - Yes
   - No
   If yes, please provide details.
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
5. Has your facility audited completion of the falls risk screening tool in the past two years?

☐ Yes ☐ No

If yes, please provide details, outcomes and any actions as a result of the audit.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

6. Is your falls risk screening tool used in other parts of the organisation?

☐ Yes ☐ No

If yes, please provide details of what parts of your organisation use it.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

7. Please add any other information about your falls risk screening tool or risk screening process you consider relevant.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
Section 2: Falls risk assessment

Falls risk assessment is a systematic comprehensive process to identify an individual resident’s risk factors for falling.

Detailed falls risk assessment has been used as part of multi-factorial falls prevention studies that have been shown to reduce falls in residential care facilities. They are recommended as a core part of falls prevention guidelines in residential care facilities.

1. Does your facility currently use a falls risk assessment tool?
   - ☐ Yes
   - ☐ No
   If yes, can you please attach a copy of the tool?

2. When is the tool completed (please tick all that apply)?
   - ☐ on admission
   - ☐ daily or more often
   - ☐ weekly
   - ☐ monthly
   - ☐ after a fall or other incident
   - ☐ after a change in a resident’s health status
   - ☐ following a change in environment (e.g. post hospital admission)
   - ☐ other (please specify) ________________________________

3. Who is the falls risk assessment tool completed by?
   - ☐ only one discipline completes the entire form (e.g. only ever completed by nursing staff) (please specify which discipline completes the form)

   __________________________________________________________

   - ☐ any discipline completes the entire form (e.g. any person from any discipline can complete the form but they complete the entire form) (please specify which disciplines may complete the form)

   __________________________________________________________

   - ☐ a multi-disciplinary team completes the form (e.g. one section is completed by nursing staff, one section by physiotherapists, one section by a doctor, etc) (please specify which disciplines complete the form)

   __________________________________________________________

   - ☐ other (please specify)

   __________________________________________________________
4. Please select, from the list below, the risk factors asked about on your risk assessment tool:

- ☐ leg muscle weakness and deconditioning
- ☐ poor balance and unsteadiness in walking
- ☐ medicines
- ☐ cognitive impairment
- ☐ postural (orthostatic) hypotension
- ☐ incontinence
- ☐ sensory loss (☐ vision, ☐ somatosensory, ☐ vestibular, ☐ hearing)
- ☐ feet and footwear problems
- ☐ fear of falling
- ☐ inadequate nutrition
- ☐ history of previous falls
- ☐ other (please specify) ____________________________

5. Has the falls risk assessment process and tool used by your facility been reviewed or updated in the past two years?

- ☐ Yes     ☐ No

If yes, please provide details.

_________________________________________________________________________________

_________________________________________________________________________________

6. Has the accuracy of the falls risk assessment tool in classifying resident’s level of falls risk been assessed in the past?

- ☐ Yes     ☐ No

If yes, please provide details.

_________________________________________________________________________________

_________________________________________________________________________________

7. Has your facility audited completion of the falls risk assessment tool in the past two years?

- ☐ Yes     ☐ No

If yes, please provide details, outcomes and any actions as a result of the audit.

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________
8. Is your falls risk assessment tool used in other parts of the organisation?
   ☐ Yes ☐ No
   If yes, please provide details of what parts of your organisation use it.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

9. Please add any other information about your falls risk assessment tool you consider relevant.
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Section 3: Falls and falls injury prevention interventions

A range of single and combined falls prevention interventions have been shown to reduce falls in residential care facilities. Guidelines recommend combinations of the interventions listed in this section (below).

1. What processes are used to facilitate staff decision making about falls / falls injury prevention interventions when an individual has been identified at increased risk of falling (tick more than one if appropriate)?
   - risk assessment form completed / reviewed
   - resident’s risk discussed at team meeting / handover
   - checklist of risk factors and interventions referred to
   - resident’s falls risk discussed with general practitioner / other health professional (e.g. physiotherapist)
   - other (please specify) ____________________________

2. Are the strategies that are implemented aimed to address each modifiable risk factor that is identified on a resident’s risk assessment tool?
   - Yes
   - No

3. Please select the falls prevention interventions (from the selection below) that are available in your facility:
   a) Group exercise ☐ (if selected please provide more information about the intervention below by completing i, ii, iii, iv, v & vi)
      i) How often are the group exercises run each week? ________________________________
      ii) How long is each of the group exercise sessions (minutes)? __________________________
      iii) What proportion of residents participate in the group exercise programs? ________________________________

      iv) Who leads the group (e.g. physiotherapist, activities leader)? ________________________________

      v) What type of exercises are used (please tick all that apply)?
         - standing ☐ seated ☐ some standing, some sitting
         - flexibility exercises ☐ resistance or weight exercises
         - balance exercises ☐ walking / fitness exercises
         - other (please specify) ____________________________

      vi) Please add any other information about your group exercise programs you consider relevant. ________________________________
b) **Individual exercise** [ ] (if selected please provide more information about the intervention below by completing i, ii, iii, iv, v & vi)

i) What proportion of residents are prescribed an individual exercise program?

_______________________________________________________________________________

ii) Who prescribes the individual exercise program (e.g. physiotherapist, activities leader)?

_______________________________________________________________________________

iii) Who implements the individual exercise program with the resident?

[ ] physiotherapist
[ ] activities leader
[ ] nursing staff
[ ] personal care staff
[ ] other (please specify) ______________

iv) What is the average duration (minutes) and frequency (days/week) that the individual exercise program is run?

_______________________________________________________________________________

v) What type of exercises are used (please tick all that apply)?

[ ] standing [ ] seated [ ] some standing, some sitting

[ ] flexibility exercises [ ] resistance or weight exercises

[ ] balance exercises [ ] walking / fitness exercises

[ ] other (please specify) ______________

vi) Please add any other information about your individual exercise programs you consider relevant.

_______________________________________________________________________________

_______________________________________________________________________________

c) **Walking aids** [ ] (if selected please provide more information about the intervention below by completing i, ii, iii, iv & v)

i) Who prescribes new or changes to walking aids (e.g. physiotherapist)?

_______________________________________________________________________________

ii) What types of walking aids are used in your facility (e.g. single point sticks, wheelie frames)?

_______________________________________________________________________________

iii) Of the residents in your facility who are mobile, what proportion use a walking aid?

_______________________________________________________________________________

iv) Is there a regular maintenance program for the walking aids used in your facility (e.g. review of stoppers on sticks and frames)?

[ ] Yes [ ] No

If yes, please provide details:

_______________________________________________________________________________

_______________________________________________________________________________
v) Please add any other information about the use of walking aids in your facility you consider relevant.

|________________________________________________________________________________________|
|________________________________________________________________________________________|

**d) Hip protectors** [ ] (if selected please provide more information about the intervention below by completing i, ii, iii, iv & v)

i) What proportion of residents in your facility use hip protectors?

|________________________________________________________________________________________|

ii) Who or what determines which residents are provided with hip protectors?

|________________________________________________________________________________________|

iii) What kind of hip protectors are used in your facility (brand, type)?

|________________________________________________________________________________________|

iv) What is the compliance rate with residents wearing their hip protectors (i.e. what proportion of those recommended to use them actually do wear them)?

|________________________________________________________________________________________|

v) Please add any other information about the use of hip protectors in your facility you consider relevant.

|________________________________________________________________________________________|

**e) Medicine review** [ ] (if selected please provide more information about the intervention below by completing i, ii & iii)

i) Who does the medicine review (e.g. GP, pharmacist)?

|________________________________________________________________________________________|

ii) When are medicine reviews done?

- [ ] on a regular basis (e.g. weekly, fortnightly)

- [ ] when it is identified as necessary following a falls risk assessment

- [ ] when there is a change in the resident’s condition

- [ ] other (please specify) ____________________________________________________________

|________________________________________________________________________________________|

iii) Please add any other information about medicine reviews in your facility you consider relevant.

|________________________________________________________________________________________|
f) **Vitamin D and calcium supplementation** □ (if selected please provide more information about the intervention below by completing i, ii, iii & iv)

i) What proportion of residents take vitamin D and/or calcium supplements?

- Vitamin D: ___________%
- Calcium: ___________%
- Vitamin D & Calcium: ___________%

ii) When are residents’ vitamin D and/or calcium levels monitored and reviewed?

- □ on a regular basis (e.g. weekly, fortnightly) _________________________________
- □ when it is identified as necessary following a falls risk assessment
- □ when there is a change in the resident’s condition
- □ other (please specify) _______________________________________________________

---

iii) Are other strategies to improve vitamin D levels in residents used with the facility (e.g. increased sunlight exposure for 20 minutes per day outside of peak sun times)?

- □ Yes
- □ No

If yes, please provide details:

_______________________________________________________________________________
_______________________________________________________________________________

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iv) Please add any other information about vitamin D and/or calcium supplementation in your facility you consider relevant.

_______________________________________________________________________________
_______________________________________________________________________________

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g) **Toileting assistance program** (to address continence issues) □ (if selected please provide more information about the intervention below by completing i, ii & iii)

i) What type of toileting assistance program is used in your facility?

- □ timed voiding program (a fixed schedule of toileting)
- □ habit retraining (identifying a pattern of voiding and individualising the toileting schedule)
- □ prompted voiding program (increasing a person’s ability to discriminate their continence status and to respond appropriately)
- □ other (please specify) _______________________________________________________

ii) Who is responsible for implementing the toileting assistance program with the residents?

_______________________________________________________________________________
_______________________________________________________________________________

---

iii) Please explain how the toileting assistance program works in your facility?

_______________________________________________________________________________
_______________________________________________________________________________

_______________________________________________________________________________
v) Please add any other information about the toileting assistance program in your facility you consider relevant.

__________________________________________________________________________

h) **Adequate condition and use of aids for sensory loss** (e.g. glasses appropriate and used correctly, hearing aids appropriate and used correctly) ☐ (if selected please provide more information about the intervention below by completing i, ii & iii)

i) Who is responsible for ensuring that sensory aids are appropriate for the resident, being used correctly and are in good working order?

__________________________________________________________________________

ii) Is there a regular review process for sensory aids to ensure that they are always in good working order?

☐ Yes  ☐ No

If yes, please provide details:

__________________________________________________________________________

iii) Please add any other information about the maintenance and use of sensory aids in your facility you consider relevant.

__________________________________________________________________________

i) **Feet in good condition and appropriate footwear** ☐ (if selected please provide more information about the intervention below by completing i, ii & iii)

i) Does a podiatrist regularly check resident’s feet and footwear?

☐ Yes  ☐ No

If yes, please indicate frequency of review:

☐ fortnightly  ☐ monthly

☐ bi-monthly  ☐ six monthly

☐ annually  ☐ other (please specify) ____________________________

ii) If it is recommended that a resident requires new footwear, what is the process for this?

__________________________________________________________________________

iii) Please add any other information about ensuring residents have good feet and footwear in your facility you consider relevant.

__________________________________________________________________________
j) **Surveillance** □ (if selected please provide more information about the intervention below by completing i, ii, iii, iv & v)
   
i) What forms of surveillance are used in your facility?
   - □ locate at risk residents closer to nurses station
   - □ bed / chair alarms
   - □ sitters
   - □ flagging those at high risk with indicator (e.g. coloured sticker above bed)
   - □ other (please specify) _____________________________________________________________
   
ii) If you use a bed / chair alarm, what type and model do you use?
   _________________________________________________________________________________
   _________________________________________________________________________________

iii) If you use a sitter, who undertakes this role and how long do they do it for?
   _________________________________________________________________________________
   _________________________________________________________________________________

iv) If you use an indicator to flag residents at high risk, what do you use and where is it located (e.g. above resident’s bed, on resident’s case notes)?
   _________________________________________________________________________________
   _________________________________________________________________________________
   _________________________________________________________________________________

v) Please add any other information about surveillance options used in your facility you consider relevant.
   _________________________________________________________________________________
   _________________________________________________________________________________
   _________________________________________________________________________________

k) **Hi-lo or lo-lo beds** □ (if selected please provide more information about the intervention below by completing i, ii, iii & iv)
   
i) What proportion of residents in your facility use hi-lo or lo-lo beds?
   _________________________________________________________________________________
   _________________________________________________________________________________

ii) Who or what determines which residents are provided with hi-lo or lo-lo beds?
   _________________________________________________________________________________

iii) What kind of hi-lo or lo-lo beds are used in your facility (brand, type)?
   _________________________________________________________________________________

iv) Please add any other information about the use of hi-lo or lo-lo beds in your facility you consider relevant.
   _________________________________________________________________________________
   _________________________________________________________________________________
Referral to other health professionals (e.g. physiotherapist, occupational therapist, podiatrist, doctor, psychologist, dietitian) ☐ (if selected please provide more information about the intervention below by completing i, ii & iii)

i) What health professionals are available to refer to (please tick all that apply)?
- ☐ physiotherapist
- ☐ occupational therapist
- ☐ psychologist
- ☐ podiatrist
- ☐ dietitian
- ☐ geriatrician
- ☐ general practitioner
- ☐ psycho-geriatrician
- ☐ pharmacist
- ☐ other (please specify) ____________________________________________

ii) What process is followed when referring residents to health professionals?

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

iii) Please add any other information about the referral process in your facility you consider relevant.

_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

m) Other health professionals ☐ (please specify and provide details on the intervention below by completing i)

i) How many hours per month does your facility have routinely available for each of the following disciplines (please indicate hours next to each discipline you have in your facility)?

- Dietitian ___________________________ hours per month
- General practitioner ____________________ hours per month
- Geriatrician __________________________ hours per month
- Occupational therapist ____________________ hours per month
- Pharmacist ____________________________ hours per month
- Physiotherapist ________________________ hours per month
- Podiatrist ____________________________ hours per month
- Psycho-geriatrician _____________________ hours per month
- Psychologist __________________________ hours per month
- Other (please specify) ____________________________
n) Other [ ] (please specify and provide details on the intervention)

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

4. What processes are used to communicate to other staff about falls / falls injury prevention interventions that are being / have been implemented (tick all that apply)?

☐ team meeting / handover
☐ client notes / file
☐ care plan
☐ falls prevention risk assessment sheet
☐ other (please specify) __________________________________________________________

5. Has the process used to implement falls / falls injury prevention interventions been reviewed in the past?

☐ Yes ☐ No

If yes, please provide details.
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

6. Do the processes used to implement falls/falls injury prevention interventions appear to be working well in your facility?

☐ Yes ☐ No

Please provide details of why or why not.
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
Section 4: Falls incident monitoring processes

Guidelines recommend that a standard definition of a fall should be used by an organisation to determine whether an incident is to be regarded as a fall. All falls should be systematically documented in the organisation’s incident reporting system.

1. Does your facility use a standard definition for a fall?
   - [ ] Yes
   - [ ] No
   If yes, please provide the definition:

2. How are resident fall incidents documented in your facility?
   - [ ] General Incident Report form (paper based)
   - [ ] Falls Incident Report form (paper based)
   - [ ] Computerised Incident Reporting System (please specify what system you use)
   - [ ] Client notes / file
   - [ ] Other (please specify)

   If a paper based form is used please attach a copy

3a. If your facility has a paper based incident reporting system, what happens to the completed incident forms (please tick all that apply)?
   - [ ] Paper based copies are sent to administration
   - [ ] Data is collated and reported back to nurse unit manager
   - [ ] Data is collated and reported back to staff intermittently
   - [ ] Data is collated, reported back to nurse unit manager and then to staff routinely
   - [ ] Other (please specify)

3b. If your facility has a computer based incident reporting system, what happens to the completed incident forms (please tick all that apply)?
   - [ ] Data is collated and reported back to nurse unit manager
   - [ ] Data is collated and reported back to staff intermittently
   - [ ] Data is collated, reported back to nurse unit manager and then to staff routinely
   - [ ] Other (please specify)
### Section 5: Environmental audits

Research has indicated that between 10% and 50% of falls in residential care facilities involve an environmental hazard, and over half of them occur around the resident’s bedside. Several randomised controlled trials using multi-factorial interventions in the residential care setting have incorporated an environmental checklist or assessment and modifications to the environment and resulted in a significant reduction in falls.

1. Is the environment of your facility audited for falls / falls injury hazards?
   - [ ] Yes
   - [ ] No

   If yes:
   a) How often are these environmental audits conducted?

   b) Is a standard falls environmental audit tool used?
      - [ ] Yes
      - [ ] No

      If yes, can you please attach a copy of the tool?

   c) What happens to completed environmental audit tools?

   d) Is there any system for monitoring environmental audit findings and actions taken to address findings over time?
      - [ ] Yes
      - [ ] No

      If yes, please specify
Section 6: Organisational support for falls / falls injury prevention activity

Guidelines recommend that falls / falls injury prevention activities should exist within an organisational framework of activities, processes and policies and procedures for the monitoring and improvement of safety and quality of care.

Research conducted in a hospital setting found organisational issues to be a main contributory factor in 66% of falls.

1. Does your facility or organisation have any of the following (please tick all that apply)?
   a) one person who is responsible for falls prevention  
      □ Yes  □ No
   b) a falls prevention committee  
      □ Yes  □ No
   c) an incident / risk management committee  
      □ Yes  □ No
   d) any other committee that has responsibility for falls prevention activities  
      □ Yes  □ No
      Please specify _______________________________________
   e) a falls prevention policy / procedure?  
      □ Yes  □ No (if yes, please attach a copy)

2. Are there any other ways your organisation has been supporting falls / falls injury prevention activities in your facility (e.g. ensuring adequate staff at peak fall times, appropriate equipment)?
   □ Yes  □ No
   If yes, please provide details.
   _______________________________________
   _______________________________________
   _______________________________________

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### Section 7: Falls and falls injury prevention staff training

1. In the past 12 months has there been any staff training on falls / falls injury prevention conducted in your facility?
   - [ ] Yes
   - [ ] No

   If yes, please provide details.
   a) Type of training (e.g. lecture) _____________________________________________

   b) Duration of training ___________ (hours)

   c) Frequency of training (e.g. monthly) _________________________________

   d) Staff groups targeted with training (e.g. nurses, allied health)
      ______________________________________________________________________
      ______________________________________________________________________

   e) Resources used (e.g. specific program available)
      ______________________________________________________________________
      ______________________________________________________________________

   f) Proportion of staff who undertook this training __________________________

### Section 8: Falls and falls injury prevention information for residents

1. Do you have any falls / falls injury prevention information available for distribution to residents and their relatives / carers?
   - [ ] Yes
   - [ ] No

   If yes, please provide details and attach a copy:
   - [ ] Brochure ___________________________________________________________
   - [ ] Poster _____________________________________________________________
   - [ ] Education session __________________________________________________
   - [ ] Other (please specify) ______________________________________________

2. How is this information made available to residents and their relatives / carers?
   - [ ] Resident/family notice boards
   - [ ] Resident/family meetings
   - [ ] Resident/family newsletters
   - [ ] Other (please specify) ______________________________________________
Section 9: Monitoring falls / falls injury prevention activities

1. Are there currently any of the following processes in place in your facility to monitor falls / falls injury prevention activities and outcomes?
   - [ ] Audits of completion of falls risk screening or assessment tools
   - [ ] Feedback / evaluation of falls prevention staff training
   - [ ] Monthly review of falls incident report data
   - [ ] Key performance indicators relating to falls / falls injury prevention (e.g. proportion of residents with falls risk assessment completed within 2 days of admission)
   - [ ] Other (please specify) __________________________

Section 10: Other falls / falls injury prevention activities

1. Has your facility taken any other measures to prevent falls / falls injuries?
   - [ ] Yes       [ ] No
   - If yes, please provide details.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________