Appendix A: The Injury Advisory Committee Terms Of Reference

AIMS:

1. To prevent and reduce the incidence of injury in the people of South Western Sydney

2. To improve treatment, rehabilitation and outcome in injury victims in South West Sydney.

PURPOSE:

The Injury Advisory Committee has been established to provide South Western Area Health Service with advice regarding the means by which injury can be prevented and the impact of injury on the people of South West Sydney can be minimised when it occurs and where appropriate, to initiate and co-ordinate action based upon this advice.

TERMS OF REFERENCE:

1. To identify the key issues in injury that need to be addressed in South Western Sydney Area Health Service.
2. To advise and act upon South Western Sydney Area Health Service wide population strategies for injury prevention.
3. To advise on provision of information to patients, carers and other stakeholders regarding service availability.
4. To advise and act upon strategies to develop injury services to meet the needs of South Western Sydney residents.
5. To advise and act upon strategies to achieve increased equity of access for all injured persons in South Western Sydney.
6. To advise and act upon strategies to improve continuity of care and ensure appropriate planning, management and co-ordination of services, including working and consulting with other advisory groups on issues of mutual concern. Create a corporate culture that will foster the provision of a co-ordinated injury service.
7. To identify and promote current evidence based best practice in injury and to provide the highest quality standards and advice and act upon strategies to ensure uptake of this practice.

8. To advise and develop appropriate performance indicators for injury**.**
9. To develop a comprehensive injury profile for South Western Sydney.
10. To advise strategies on research priorities in injury.
11. To identify opportunities and advise on strategies to promote South Western Sydney Area Health Service Injury Services to other Health Service Areas.

MEMBERSHIP:

Membership will be multidisciplinary and drawn from sectors across the South Western Sydney Area Health Service so as to provide an appropriate balance of expertise and sector representation, and will include community representation.

REPORTING AND MECHANISM:

Advice and six monthly reporting of progress with health outcome indicators is given through a member of the Area Executive to the Health Priorities and Outcomes Committee and will be reported annually to QOC. Minutes to have specific action and time frame.

Membership of the Injury Advisory Committee

Dr Barbara Booth	Staff Specialist, GP unit	Fairfield Hospital
Ms Kathy Bowie	NUM Emergency Nursing	Bowral Hospital
Ms Erica Caldwell	Trauma Clinical Nurse Consultant	Liverpool Hospital
Dr David Conforti	Director of Rehabilitation and Geriatrics	Liverpool Hospital
Dr Scott D'Amours	Deputy Director of Trauma	Liverpool Hospital
Ms Elizabeth Halcomb	Trauma Data Manager	Liverpool Hospital
Dr David Hugelmeyer	Director, Emergency Medicine	Macarthur Health Service
Ms Lisa Kremmer	Nursing Unit Manager	Camden Hospital
Ms Danielle Miller	Senior Project Officer, Area Services	Liverpool Hospital
Ms Denise Oakes	Injury Prevention Program Manager	SWSAHS
Dr Charles Pain	Area Director of Medical & Clinical Services	Liverpool Hospital
Ms Kathleen Peters	Project Officer/Trauma	Liverpool Hospital
Mr Doug Sawtell	Duty Inspector	Ambulance Service of NSW
Mr Bruce Scott	District Inspector	Ambulance Service of NSW
Ms Christine Stott	Service Co-Ordinator Physiotherapy	Braeside Hospital
Dr Michael Sugrue	Director, Trauma Services	Liverpool Hospital
Ms Daena Wilson	Service Co-Ordinator Occupational Therapy	Bankstown Hospital
Ms Mandy Williams	Director Health Promotion	Liverpool Hospital
Mr Jeff Woods	Operations Manager	NSW Ambulance Service
Dr Peter Wyllie	Staff Specialist Emergency Department	Liverpool Hospital

Appendix B: Falls Risk Assessment Tool

Emergency Department Falls ACAT Referral Form

Name: _____ **Referring Dr:** _____

Date: _____ / _____ / _____ **Time:** _____

FALL HISTORY

First Fall Yes / No No. of Falls in previous Year _____ No. of Falls last week _____

Able to get self off floor: Yes / No Time on floor (mins)_____ Definite slip/trip Yes / No

Other Associated Symptoms: Yes / No _____

1. Social Circumstances and Cognition

Lives Alone Yes / No Required Services Unavailable Yes / No Cognitive Impairment Yes / No

No Carer Yes / No Dangerous Home Environment Yes / No Alcohol Contributing Yes / No

2. Pre-Fall Impaired Function

Mobility Impaired Yes / No Transfers Impairment Yes / No Difficulty with Stairs Yes / No

3. Change in Function Post Fall

Mobility Impairment Yes / No Transfers Impairment Yes / No Cognitive Change Yes / No

Details _____

EXAMINATION

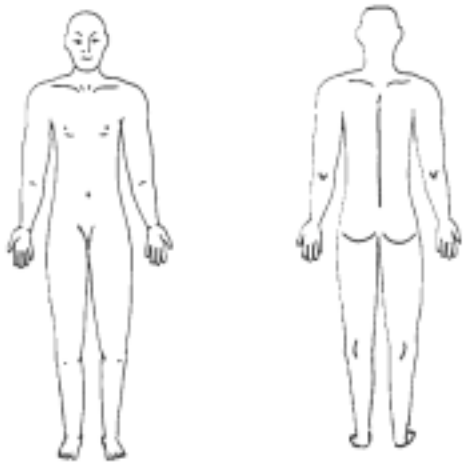
Temp: _____ Pulse: _____ BP: Lying: _____ / _____ BP Standing: _____ / _____

Possible Medical Causes

Medication Toxicity ❒
Syncope ❒
Other Cardiac ❒
Stroke ❒
Epilepsy ❒
Other Neurological ❒
Diabetes ❒
Sepsis ❒
Delirium ❒

Other Causes – (please state) _____

Indicate Site of Injury Including Pressure Areas



Consider senior ED or Medical / Geriatric review if medical cause or significant change in cognitive stet or function

Comments: _____

_____

Urgency for ACAT Assessment

Next Day Within 48 Hours Within 1 Week Within 2 Weeks

Appendix C: Acknowledgements

These guidelines draw heavily on an extensive literature search conducted by a project team from the National Ageing Research Institute and their report compiled for the Commonwealth Department of Health and Aged Care, Injury Prevention Section in April 2000[4]. The Clinical Practice Guidelines on elderly people in inpatient setting has also utilised a systematic review[3] of research related to patient falls in hospitals undertaken by the Joanna Briggs Institute for Evidence Based Nursing as well as an education package[2] developed by a multi-disciplinary working party at Liverpool Health Service.

Submissions were received from the following people

David Basic- Staff Specialist Geriatrician Liverpool Health Service
Barbara Depczynski –Staff Specialist Endocrinology Liverpool Health Service
Peter Wyllie - Staff Specialist Emergency Department, Liverpool Health Service
Daena Wilson – Occupational therapy, Bankstown Health Service
Jenny Jacka – Physiotherapy, Bankstown Health Service
Kerry Plumer – Occupational therapy, Bankstown Health Service
Gail Forlonge – Division of General Practice, Wingecarribee
Kung Lim – Nursing Director, Division of Surgery, Liverpool Health Service
Dr Roderick McKay – Director Aged Care Psychiatry, Braeside Hospital
Claire Hewat – Director, Wingecarribee Community & Allied Health Service
Dianna Kenrick – Director Community & Allied Health, Fairfield Health Service
Stacy Wake – Director, Residential Care Services, Frank Whiddon Masonic Homes/Easton Park
Toni Doherty – Aged Care Service Manager
Margaret Sim – Director of Nursing, Harbison Hostel, Mossvale
Simon Grant – Medical Superintendent, Bowral Hospital
Sandra Bishop – Service Manager, Occupational Therapy Liverpool Health Service
Sue Ieraci – SWS Area Advisor in Emergency Medicine, Staff Specialist Emergency Medicine, Bankstown
Margaret Thorpe – Director of Aged Care and Rehabilitation, MacArthur
Andrew Bernard – General Manager, Bankstown Health Service
Raad Richards - General Manager, Liverpool Health Service
Lyn Curtis - General Manager, Fairfield Health Service

Appendix D: Clinical Indicators

It is recommended that hospitals gather data and monitor trends in the rate of falls so that they can improve performance. To arrive at a fall rate, hospitals should calculate the number of falls per 1000 patient days per three months (the number of patients multiplied by the number of days they were in hospital during the quarter, divided by 1000). The number of falls for the period should be divided by the number obtained per thousand patient days. This would give the rate of falls per thousand patient days each three months. For example if there were 1192 patient days for the quarter, dividing that number by 1000 gives 1.192. If there were ten falls for that quarter, ten is divided by 1.192. This would result in a rate of 8.4 falls per thousand patient days.

Numerator Number of falls for the period

_____

Denominator Number of patient days for the period / 1000

Of further statistical significance is the number of patients who fall more than once in the same hospital episode of care. To arrive at a rate of falls per patient, the total number of falls for the period is divided by the total number of patients who fell. For example, total number of falls per three months equals 350. Total number of patients who fell during the three months equals 200. Falls rate per patient equals 350 divided by 200, giving a rate of 1.5 falls per patient. Any patient who falls more than twice in the one episode of care, should be investigated more closely.

Numerator Total Number of falls for the period

_____

Denominator Total Number of patient who fell

Hospitals should also monitor falls outcomes. Serious injury (death, fracture, cerebral bleed or joint dislocation) that is directly related to the consequences of a fall, should be treated as a sentinel event.

Appendix E: Classes of Drugs Associated with Falls

Classes of drugs associated with falls include:

- Anxiolytics or sedatives (alprazolam, bromazepam, clonazepam, diazepam, lorazepam, oxazepam, flunitrazepam, nitrazepam, temazepam)
- Antipsychotics (chlorpromazine, fluphenazine, trifluoperazine, thioridazine, haloperidol, clozapine)
- Opioids (morphine, codeine, oxycodone, pethidine, methadone)
- Antidepressants (amitriptyline, nortriptyline, clomipramine, desipramine, doxepin, dothiepin, imipramine, mianserin, phenelzine, tranylcypromine, moclobemide, fluvoxamine, fluoxetine, paroxetine, citalopram)
- Antiparkinsonians (levodopa, bromocriptine, selegiline, benzhexol, benztropine, biperiden, orphenadrine, procyclidine)
- Hypoglycaemics (insulin, glibenclamide, gliclazide, glipizide, tolbutamide, metformin)
- Antihypertensives (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, remipril, trandolapril, candesartan, irbesartan, losartan, telmisartan, amlodipine, dilatizem, nifedipine, felodipine, verapamil, atenolol, pindolol, propanolol, metoprolol, labetolol, prazosin, clonidine,)
- Diuretics (frusemide, ethacrynine, buemtanide, bendrofluazide, chlorothiazide, hydrochlorothiazide, methyclothiazide)
- Laxatives/stool softeners within previous 24 hours

Appendix F: Criteria for a Diagnosis of Delirium

Diagnostic Statistical Manual (DSM - 1V, 1994) provides the following diagnostic criteria for the diagnosis of delirium: (from Schuurmans: J.Clinical Nursing, volume 10(6). November 2001 721-729)

A	Disturbance of consciousness with reduced ability to focus, sustain or shift attention
B	Changed cognition (e.g. memory, disorientation, language disturbance)or the development of a perceptual disturbance that is not better accounted for by preexisting or evolving dementia
C	Disturbance develops in a short period of time (hours to days) and tends to fluctuate over the course of the day
D	There is evidence from history, physical examination or laboratory findings that the disturbance is:
1	Physiological consequence of general condition
2	Caused by intoxication (infections, dehydration or other metabolic disturbances)
3.	Caused by medication
4.	Caused by more than one aetiology

The Confusion Assessment Model (CAM) (from Wallace, J 2001)

1. Acute onset and fluctuating course: is there evidence of an acute change in mental status from patient's baseline? If present, did this behaviour fluctuate during the course of the day?
2. Inattention: Did the patient have difficulty focusing attention, e.g. easily distractable, difficulty tracking conversation?
3. Disorganized thinking: was thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching of topics
4. Altered level of consciousness: rate patient as to whether alert (normal) hyperalert(easily startled), lethargic (drowsy, easy to arouse) stupor (difficult to arouse), coma (unarousable)

CAM algorithm: Diagnosis of delirium requires both 1 and 2 in table, PLUS either 3 or 4 in table.

Appendix G: Patient Fall Prevention on the Aged Care Unit

Expected Outcome

Individualised fall prevention interventions will be implemented for each patient on the Aged Care Unit following multidisciplinary functional and physical assessment on admission to the unit. This will reduce their risk of falling during their admission to the Aged Care Unit [1,2].

Policy Statement

All patients on the Aged Care Unit will have a Falls Risk Management [3] score and multidisciplinary functional and physical assessment attended on admission to the Unit. From the findings multidisciplinary interventions will be implemented to prevent inpatient falls.

Procedure

- As part of comprehensive geriatric assessment, all patients admitted to the Aged Care Unit under the care of a geriatrician will have a multidisciplinary assessment attended to.

- During the assessment fall risk factors, illnesses and impairments are identified by:-

  (i) Past history of falls, fractures or fear of falling [1,2,4].

  (ii) General medical assessment including delirium, vision impairment, cardiac disease, postural hypotension, neurological disorders, incontinence, polypharmacy, metabolic disturbance, deconditioning, osteoporosis, musculoskeletal and podiatric problems 1,2,4.

  (iii) Balance and gait assessment 1,2,4.

  (iv) Cognitive assessment [1,2,4].

  (v) Functional assessment [1,2,4].

  (vi)Risk behavioural assessment [1,2,4].

- All patients on admission to the Aged Care Unit are to have a Falls Risk Management [3] completed and the score documented in the Patient Nursing History (CR38) and in the “Special observations” section of their Patient Care Plan (CR118).

- Falls Risk Management score will be attended to daily or as the patients condition changes. The current Falls Risk Management score is to be recorded in the “Special observations” section on the Patient Care Plan (CR118).

- The Falls Risk Management score to be reported at every handover, on every patient by nursing staff.

- Interventions are to be implemented following multidisciplinary assessment. An individual patient fall prevention plan is to be formulated based on the patient’s needs.

- All interventions that are to be used is to be documented in the patient's continuation notes once every twenty-four hours and when there is a change in interventions [1,2,4.]

- Interventions are to be reviewed second daily, or as the patients condition changes [1,2,4].

There are a number of interventions that may be implemented in falls prevention dependant on the patients needs. These include interventions in the following areas:

Education targeted to patients, relatives and staff [1,2,4].
Improve mobility under supervision [1,2,4]
Improve orientation and minimise confusion [1,2,4]
Reduce bedrest [1,2].
Improve transfers in particular bed mobility [1,2,4].
Minimise environmental risk [1,2,4].
Review the effect of medication, reduce psychotropic usage [1,2,4].
Provide appropriate aids [1,2].
Maintain and assist continence [1,2,4].
Reduce dehydration and malnutrition [1,2].
Improve sensory deficits (vision and hearing) [1,2,4].
Treat underlying medical conditions [1,2].
Injury minimisation (hip protectors).

- All interventions in use are documented in the patient's continuation notes once every twenty-four hours and when there is a change in interventions.

- Interventions are to be reviewed second daily, or as the patients condition changes.

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Policy Authors: Clinical Nurse Educator Aged Care Unit, Director of Geriatrics and Rehabilitation & Nurse Unit Manager Aged Care Unit
Policy Reviewers: Division of Medicine Policy & Procedure Committee

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