

Actionable Patient Safety Solutions (APSS) #14A: **Falls and fall prevention in adults**

How to use this guide

This guide gives actions and resources for creating and sustaining practices to help prevent patient falls. In it, you'll find:

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APSS #14: Falls and fall prevention

Executive summary checklist

Patient falls are a major cause of in-patient injury and even death. Healthcare administration must develop, revise, and support the plan through the following actionable steps (AHRQ, 2013; Boushon et al., 2008):

Use data to find areas for improvement

- Conduct a Gap Analysis to compare current best practices versus actual organizational practices.
- Evaluate if the organization has implemented the best practices
- Include the patient and family voice in this process by involving your organization's patient and family advisory body (such as a Patient and Family Advisory Council (PFAC)) or by including current or former patients or patient advocates
- Identify opportunities for improvement and set aims (Goodwin et al., 2014; Mion et al., 2012; Mccurley and Pittman, 2014; Waters et al., 2015)
- Collect fall and injury data to improve the performance of your fall prevention and protection from injury program:
 - Consider tracking and collecting inpatient fall data and outcomes post-discharge to monitor the frequency and cost of morbidity and mortality
 - Sustain focus on fall prevention with system-wide visibility on metrics at multiple touch-points within the organization (ex: use a "days since last" fall or fall with injury)
 - Share this data with patients and families
- Consider bundling evidence-based recommendations to achieve greater outcomes
- Consider new technologies to advance performance and reduce injuries
- Provide role specific training for all staff to ensure knowledge of each person's responsibility in falls prevention and fall injury prevention, appropriate use of screening tools and assessment frequency, and effective use of falls prevention and falls injury prevention strategies
- Provide training for the patient and their family on preventing falls before, during, and after a patient's hospital stay (see examples at CampaignZERO.org, especially the Fall Prevention Checklist for patients' families)

Engage staff

- Develop a multidisciplinary team to create, implement, and sustain fall prevention and protection from injury initiatives. This team should include, but is not limited to:
 - Executive sponsor, environmental manager, risk manager, physical therapist, occupational therapist, medical doctor, pharmacist, unit manager, frontline nursing staff, and/or certified nursing assistant
 - Current or former patients or patient advocates to represent the patient voice
 - Patients at high risk for falling and their family member care partners
 - Patient-centered principles to guide as many hospital representatives from all shifts and the entire team, best summarized as "Nothing about me without me"
- Develop fall prevention champions throughout all departments who further drive organizational knowledge and action in the healthcare setting:

- Provide clear and concise communication on the champion's role and responsibilities
- From the champion's perspective, develop feedback mechanisms to learn what is working and what can be improved upon in the fall prevention and protection from injury plan
- Use patient stories - in written and video form - to identify gaps and inspire change in your staff
 - For example, Bill Aydt's story: <https://youtu.be/npAC2DJClgA>
- Incorporate change management principles to promote maximum success and sustainment of the fall prevention and protection from injury initiatives

What we know about falls and fall prevention

Factors that increase fall risk

Fall prevention and protection from injury is an organizational issue and needs to be addressed by all employees who might encounter a person who is at risk for a fall. Consider ensuring that rotations of students, volunteers, and new employees understand the importance of your actions related to fall prevention and protection from injury. Establish processes to educate newly admitted patients and their families/advocates on admission and throughout their hospital stay as their condition changes. Education should include the risk-factors and how to avoid falls. Clearly define their role and expectations of their actions.

Guiding principles related to fall prevention and protection from injury are (RNAO, n.d.):

- Many falls are predictable and preventable
- Some falls cannot be prevented (i.e. unanticipated physiological events); in these cases, the focus should be on proactively preventing fall injuries and decreasing the frequency of falls
- Fall prevention is a shared responsibility within health care and throughout the institution
- Person and family-centered care is foundational to the care of patients at risk for a fall and fall injuries
- The risks and benefits should be considered in partnership with patients and their advocates when implementing interventions to fall prevention and protection from injury
- Evaluate for appropriateness of altering the content of their referenced points

The performance gap in preventing falls

Preventing falls and minimizing injuries is difficult and complex. Often, organizations have competing priorities which lead to placing management of fall prevention and protection from injury under just 1 discipline, such as nursing. Fall prevention and protection from injury must be organization-wide, with all employees understanding their role and the impact that they can have in creating a culture of safety (AHRQ, 2016).

The Joint Commission's Sentinel Alert Event, Issue 55, released September 28, 2015, gives a review and synthesis of current research:

"A considerable body of literature exists on falls prevention and reduction. Successful strategies include the use of a standardized assessment tool to identify fall and injury risk factors, assessing an individual patient's risks that may not have been captured through the tool, and implementing interventions tailored to an individual patient's identified risks. In addition, systematic reporting and analysis of falls incidents are important components of a falls prevention program. Historically, hospitals have tried to reduce

falls - and to some extent have succeeded - but significant, sustained reduction has proven elusive (Alert, 2015)."

Many successes in fall reduction are temporarily due to a "placebo" effect. Simply raising staff awareness will only work to reduce falls for a short period of time.

Use appropriate tools

Most organizations have instituted assessment tools as part of a fall prevention and protection from injury strategy. Organizations should be cautious about using tools that are internally designed without vetting through validation and interrater reliability processes. There needs to be clarification about the role that tools have within the practice setting:

- **Tools used to triage for a fall** are used to predict likelihood of an expected physiological fall and monitor fall risk (Degelau et al., 2012). The tools provide the probability of an anticipated physiological fall but does not inform caregivers what to do about it (Morse, Morse, and Tylko, 1989). A list of tools to consider are listed in Appendix B.
- **Assessment tools** provide an assessment of the patient, such as gait, medication, mental status, and other contributing factors. These tools are used to reduce the probability of an anticipated physiological fall by identifying risk factors with associated interventions. It is important that there is clarity about the tools being used and functionality to assure organizational performance (Degelau et al., 2012)

Analysis of falls with injury in the Sentinel Event database of The Joint Commission revealed the most common contributing factors are (Joint Commission 2015):

- Inadequate assessment
- Communication failures
- Lack of resources, including staffing
- Lack of adherence to protocols and safety practices
- Inadequate staff orientation, knowledge, supervision, or skill mix
- Deficiencies in the physical environment
- Lack of leadership

As part of The Joint Commission Center for Transforming Healthcare's Preventing Falls with Injury Project, 7 U.S. hospitals entered into a pilot study using Robust Process Improvement[®] which incorporates tools from Lean Six Sigma to identify the root cause of falls and develop strategies to reduce them. The top contributing factors to a fall were (HRET, 2016):

- Fall risk assessment issues
- Handoff communication (HOC) issues
- Toileting issues
- Call light issues
- Education and organizational culture issues
- Medication issues

A lack of patient-centered practice, congruence, and organizational focus have caused - and continue to cause - preventable patient injury or death while increasing the costs of care. Closing the performance gap with an organizational focus will require leaders and their health systems to commit to specific actions by all disciplines throughout the organization in partnership with patients at risk, as well as their family-member care partners who support their

safety before, during and after a hospital stay.

A model to help you implement your safety plan

A framework to consider is the “Knowledge-to-Action” model which provides the process steps required for putting knowledge inquiry and application into practice (“Strauss, Tetroe & Graham, 2013).) Moving an organization forward to a precision performance requires an innovative approach with focused intent (**Appendix A**).

Leadership plan

Reducing fall injuries and deaths associated with falls is the ultimate outcome sought by leaders and their respective organizations. While all leaders strive to transform culture and advance patient safety, reducing patient falls requires cutting the invisible rubber bands or biases of traditional actions and focus on the elevation of leadership and health systems’ performance.

Create a culture of safety

Leaders and their governing boards must:

- Find a balance among production efficiency, patient-centered responsibilities, reliability, and patient safety
- Understand trust violations among all stakeholders in care, including patients and families, and sustain a culture of trust among all such stakeholders
- Create a culture that removes the fear of reprisal among staff and, especially, fear among patients and families in expressing concerns to staff
 - In its place, leaders must foster and mentor open dialogue, curious inquiry, organizational learning, and solutions mindsets (Boushon et al., 2012)

Define “falls” and “falls with injury” so you can track incidents

- Clearly define what constitutes a patient fall and categorize falls with injury:
 - Leaders must also accept that with clearer definition of patient falls, there will most likely be a reportable increase in falls in the early days of a program
 - High reliability organizations understand that this is not a reflection of staff negligence, but of better data collection policies (HRET 2016)
- Categorize falls with injury. These National Database of Nursing Quality Indicators (NDNQI) definitions can help you standardize the compiling of the data for comparative analysis (National Report Card Metrics, 2012):
 - **None:** Patient had no injuries (no signs or symptoms) resulting from the fall, if an x-ray, CT scan, or other post fall evaluation results in a finding of no injury
 - **Minor injury:** in application of a dressing, ice, cleaning of a wound, limb elevation, topical medication, bruise, or abrasion
 - **Moderate injury:** Resulted in suturing, application of steri-strips/skin glue, splinting, or muscle/joint strain
 - **Major injury:** Resulted in surgery, casting, traction, required consultation for neurological (basilar skull fracture, small subdural hematoma) or internal injury (rib fracture, small liver laceration), or patients with coagulopathy who receive blood products as a result of the fall
 - **Death:** The patient died as a result of injuries sustained from the fall (not from

physiologic events causing the fall)

Use quality improvement (QI) processes

- Actively manage the process of change and transformation. Leaders must be committed and stay committed to fall prevention and protection from injury by clearly communicating their commitment, strategies, and learnings (Boushon et al., 2012; Degelau et al., 2012; France et al., 2017; Miake-Lye, Hempel, Ganz, and Shekelle, 2013)
- Involve employees and representative patients and families through the QI process, including: debriefs, analysis of data, development of action plans, and the acquisition of resources that advance safety
- Use knowledge and management practices to facilitate learning and to promote innovation within the organization. Leaders must apply evidence, innovation, and experimental knowledge to new and existing physical environments, workflow, practice challenges and changes, and decision making (Boushon et al., 2012)
- As you work to advance person and family engagement, there is a need for cultural transformation and heightened sensitivity to cultural indications and needs of the people you're serving. Understanding how best to engage and empower patients and families will strengthen the partnership and communication that advances patient safety
- Use patient and family councils to redesign education, the physical environment, and patient/family partnerships that will reduce injuries (Ryu, Roche, and Brunton, 2009)
- Develop your organizational story and use storytelling to galvanize the organization into action and stay focused on why there is a need for change
- Use patient stories - in written and video form - to help identify gaps and inspire engagement and change in your staff
 - The story of Bill Aydt, as told by his daughter, Karen Curtiss, is an inspiring story about how cascading Never Events, initiated by a fall, led to Bill's preventable death. You can freely view a video of the story here: youtu.be/npAC2DJClgA

Action plan

Create the infrastructure needed to make changes

(Miake-Lye, Hempel, Ganz and Shekelle, 2013)

- Assess the current state of your fall prevention and injury protection program:
 - Determine current processes within specific departments or units
 - Consider using tools, such as process mapping, to understand current practice and where actions could or should happen for fall prevention and protection from injury
 - Determine and understand the organizational context of the current program, such as lessons learned and barriers identified
- Review the assessment tools your program currently uses:
 - Include patient representatives in this assessment
 - Consider if the tools are used to triage or screen for the likelihood of a fall
 - Consider tools to evaluate patients for muscle strength, gait, and other contributing factors
 - Competency assessment of clinicians who utilize the tool should be done on an ongoing basis to ensure accuracy and knowledge application of the tools

Engage staff, patients, and families

- Review interventions for fall prevention and protection from injury:
 - Use visual cues to indicate high-risk fall patients for staff members, in addition to ambulation equipment:
 - Examples of visual cues: color coded gowns, wristbands, socks, and external magnets
 - Share this information with patients and families to raise their awareness of fall risks and your steps to prevent them
 - Solicit their agreement to help prevent falls as part of your care team (see CampaignZERO.org for an example fall prevention checklist you can share)
- Ensure those involved in medication regimes, including administration, understand their roles in fall prevention and protection from injury (Beasley and Patatanian, 2009)
- Preventing Patient Falls video

Collect and communicate data about falls

- Decide how information about patient fall risk factors is communicated, documented, and shared, then communicate this information to patients at risk and their family member care partners
- Decide how to integrate practice changes in current workflows
- Determine staff knowledge and possible biases about fall assessment and prevention
- Use consistent data collection methods before and after changes are made to your fall prevention and injury protection plan:
 - Clearly define within your institution what constitutes a patient fall (see Measuring outcomes later in this APSS)
 - Note that defining falls may cause the measured number of falls to rise at first. High-reliability organizations understand that this is not a reflection of staff negligence, but of better data collection policies

Factors associated with patient falls

Factors associated with patient falls can be divided into 4 areas of influence. This table (**Table 1**) outlines the factors that can help you develop interventions and practice actions after assessing your current processes (Morgan, Mathison, Rice and Clemmer, 1985).

Table 1: Factors associated with patient falls

Patient-specific	Environmental	Situational	Organizational
Impaired gait	Furniture on wheels	Leaning forward	Staffing:
Impaired cognition <ul style="list-style-type: none"> Acute (e.g. delirium) and chronic (e.g. dementia) 	Cluttered pathways	Reaching up	Number
Forgetfulness	Poor lighting	Transferring on/off bed/chair	Knowledge
Poor judgment	Slippery floors		Skill mix
Impulsiveness	Height of furniture		Attitudes
Sedation/recent surgery	Unit layout making it difficult to see patients from nurses' station		Types of Policies:
Impaired vision	Medical devices (IV poles, indwelling urinary catheters)		Hourly rounding
Weakness, especially legs			Toileting schedules
Hypotension			Type of fall prevention program
Depression			Available Equipment purchases:
Urinary incontinence			Bed/chair alarms
Acute event (e.g., MI, PE)			Transfer equipment
Certain medications (sedatives, opioids, SSRIs)			Surveillance video monitoring
History of vertigo			Low/very low beds
Low/drop in oxygen saturation rate			Seating
Normally uses a cane or walker to get around			
On a new med with potential side effects including dizziness or confusion			

Clearly define what constitutes a patient fall

- Leaders must accept, that with clearer definitions of patient falls, there will most likely be an increase in falls in the early days of the program. **High-reliability organizations understand that this is not a reflection of staff negligence, but of better data collection policies.**
- Define the types of falls:
 - **Physiological (anticipated):** Most in-hospital falls belong to this category. These are falls that occur in patients who have risk factors for falls that can be identified in advance, such as altered mental status, abnormal gait, frequent toileting needs, or high-risk medications
 - **Physiological (unanticipated):** These are falls that occur in a patient who is otherwise at low fall risk, because of an event whose timing could not be anticipated, such as a seizure, stroke, or syncopal episode
 - **Accidental:** These falls occur in otherwise low-risk patients due to an environmental hazard. Improving environmental safety will help reduce fall risk in these patients but is helpful for all patients
- Categorize falls with injury:
 - **No apparent injury**
 - **Minor injury:** Bruises or abrasions as a result of the fall
 - **Moderate injury:** an injury that causes tube or line displacement, a fracture, or a laceration that requires repair
 - **Major injury:** injury that requires surgery or a move to intensive care unit for monitoring a life-threatening injury
 - **Death**

Build a safety team

- Develop a multidisciplinary team to create, implement, and sustain fall prevention and protection from injury initiatives. This team should include, but is not limited to:
 - Executive sponsor, environmental manager, risk manager, physical therapist, occupational therapist, medical doctor, unit manager, frontline nursing staff, or certified nursing assistant
 - Current or former patients or patient advocates to represent the patient voice
 - Patients who are at high risk for falling and family member Care Partners for loved ones at risk
- Certified Nursing Assistant, Patients who are themselves at risk of falls, and family member Care Partners to loved ones who are fall risks. Efforts should be made to get as many representatives from all shifts.
- The multidisciplinary committee should meet on a predetermined basis to review fall prevention and protection from injury initiatives for areas of improvement

Create consistent data collection processes

- Without reliable data metrics, you can't reliably compare validity before and after:
 - Falls per 1,000 patient days is the most reliable metric
 - Falls with injury per 1,000 patient days should also be noted

Review your current fall assessment tools

- Include representatives of fall-risk patients in this assessment:
 - You should be clear on the tool's purpose and the outcomes you want from it. Is the tool being used to triage or screen for the likelihood of a fall? Do you have tools to evaluate patients for muscle strength, gait, and other contributing factors?
 - Assess the competency of clinicians who use the tool on an ongoing basis to ensure accuracy and knowledge application of the tools
- Other tools and resources can be found in **Appendix B**

Review your fall prevention and protection from injury interventions

- To indicate high-risk fall patients for staff, use ambulation equipment and also visual cues, such as color-coded gowns, wristbands, socks, external magnets, and other visual cueing. This notifies staff that a patient is at risk and requires greater monitoring.
 - Share this information with patients and families to heighten their awareness of fall risks and your proactive prevention cues
 - Solicit their agreement to help prevent falls as part of your care team. Share a simple checklist such as at [CampaignZERO.org](https://www.campaignzero.org)
- Tailor interventions to specific fall risk factors
 - Share this information with patients and families to heighten their awareness of fall risk factors and potential ways to collaborate with you to prevent falls

Review environmental risk factors

- Consider provisions for avoiding environmental risk factors:
 - Keep beds in the lowest position
 - Use glare reduction windows, such as with polarized coatings
 - Install window treatments that reduce or eliminate glare, such as tinted mylar shades, which can remove glare without loss of ambient light
 - Avoid gloss flooring – the glares it causes can reduce sight
 - Install highly-visible handrails in the room, walkways, and bathrooms
 - Inspect and service all ambulation and patient-transferring equipment

Provide education and training

- Educate staff on new fall prevention and protection from injury initiatives
 - These should be run by the fall champions and encourage feedback
 - Include representative patients and families
- Ensure that rotations of students, volunteers, and new employees understand the importance of the fall prevention and protection from injury actions
- Consistently educate newly-admitted patients and their advocates on the importance of their partnership in reducing and avoiding falls. Clearly define their role and actions.
- Patient and visitor education is vital to any fall prevention and protection from injury initiative. Get input from patients and families who, themselves, are managing conditions which put them or a loved one at risk for falls.

Create a post-fall huddle protocol

- Include guidelines on how to care for a patient that has fallen:
 - Once the immediate medical concerns of the fall have been addressed, perform a non-punitive root cause analysis, including the patient who fell, and any family member who may have witnessed the fall
 - There are 2 different types of root cause analyses: aggregate and individual
 - Organizations should consider having both processes in place to assure maximum learning and improvement. Highly reliable institutions create a safe environment for staff members, patients and their advocates to report any potential patient safety concerns.
 - Without this safe reporter environment, true root causes will never be found, thus creating negative patient safety outcomes indefinitely

Technology plan

These suggested practices and technologies have shown proven benefit or, in some cases, are the only known technologies for certain tasks. If you know of other options not listed here, please complete the form for the PSMF Technology Vetting Workgroup to consider:

patientsafetymovement.org/actionable-solutions/apss-workgroups/technology-vetting/

Leaders must plan for and incorporate a technology strategy to maximize the utilization of AI within their organization to create safer environments.

Technology in the field of fall prevention and protection from injury has advanced in the utilization of artificial intelligence (AI) with **predictive modeling**:

- Data and data analytic systems capture and utilize patient information through:
 - Wearables (Goodwin et al., 2014)
 - Sensors in garments and footwear
 - Smart technology embedded within beds, chairs, commodes and other durable medical equipment
- Predictive modeling is being embedded into alert systems such as communication and nurse call, and into electronic healthcare records
- Data analytics will drive advances in fall prevention and protection from injury (Baus et al., 2016)

Technology is also advancing into the **physical environment** with systems designed to create safer environments. New advancements utilize high performance monitoring systems to reduce physical sitters needed for individual observation (Mccurley and Pittman, 2014).

In the field of fall prevention and protection from injury, there is a focused approach to **restore muscle strength and balance**:

- In the inpatient arena, technology has influenced advancements in rehabilitation equipment that is supporting earlier mobilization (Knutson, 2017)
- In the outpatient arena, exercising and classes such as Tai chi have provided methods to help individuals at high risk for a fall with an overall approach to strengthen muscles.

While these classes are good, they are problematic for many patients. Emerging is 3D technology and interactive games which have the potential to be customizable to the individual capabilities.

Approach technology use with the understanding that it is multifocal, evolutionary, and not static in both use and understanding. Investments of resources both capital and human are ongoing and need to be planned for as such (Hamm, Money, Atwal, and Paraskevopoulos, 2016).

Electronic Health Records can provide meaningful data that can inform predictive modeling, advances in patient safety and further application of evidence into practice. It is only through interoperability of clinical systems that this can be achieved.

System or practice	Available technology
ONC Meaningful Use Certified EHR system Electronic Health Record (EHR) System	
<ul style="list-style-type: none"> • Bed Connection to Nurse Call with priority for fall alarm 	

*Company has signed some form of the Open Data Pledge. Find more information on the Patient Safety Movement Foundation website: <https://patientsafetymovement.org/partners/open-data-pledges/view-all-open-data-pledges/>

Measuring outcomes

Key performance indicator

Falls with injury

The definitions of a “fall” and a “fall with harm” from the state of Pennsylvania are:

- A fall is defined as any unplanned descent to the floor (or other horizontal surface such as a chair or table) with or without injury to the patient
- A fall with harm is defined as any fall that requires more than first-aid care. Treatment beyond first-aid care includes a laceration that requires physician intervention (e.g., sutures), more serious injury (e.g., fracture), or death.

Outcome measure formula

Numerator: Falls with injury

Denominator: Total number of adjusted patient days

- This measure is usually displayed as Total Falls with injury / Adjusted Patient Days *1,000

Metric recommendations

Direct Impact: All patients

Lives Spared Harm:

$$\text{Lives Spared Harm} = (\text{Falls Rate}_{\text{baseline}} - \text{Falls Rate}_{\text{measurement}}) \times \text{Adjusted Patient Days}_{\text{measurement}}$$

Lives Saved:

$$\text{Lives Saved} = \text{Lives Spared Harm} * 0.055$$

Notes

Adjusted Patient Days is defined as:

$$\frac{(\text{Inpatient Revenue} + \text{Outpatient Revenue} + (\text{Miscellaneous Revenue}))}{(\text{Inpatient Revenue})} \times \text{Total Patient Days}$$

Conflicts of interest disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Some of the APSSs recommend technologies that are offered by companies involved in the Patient Safety Movement Foundation. The workgroups have concluded, based on available evidence, that these technologies work to address APSS patient safety issues. Workgroup members are required to disclose any potential conflicts of interest.

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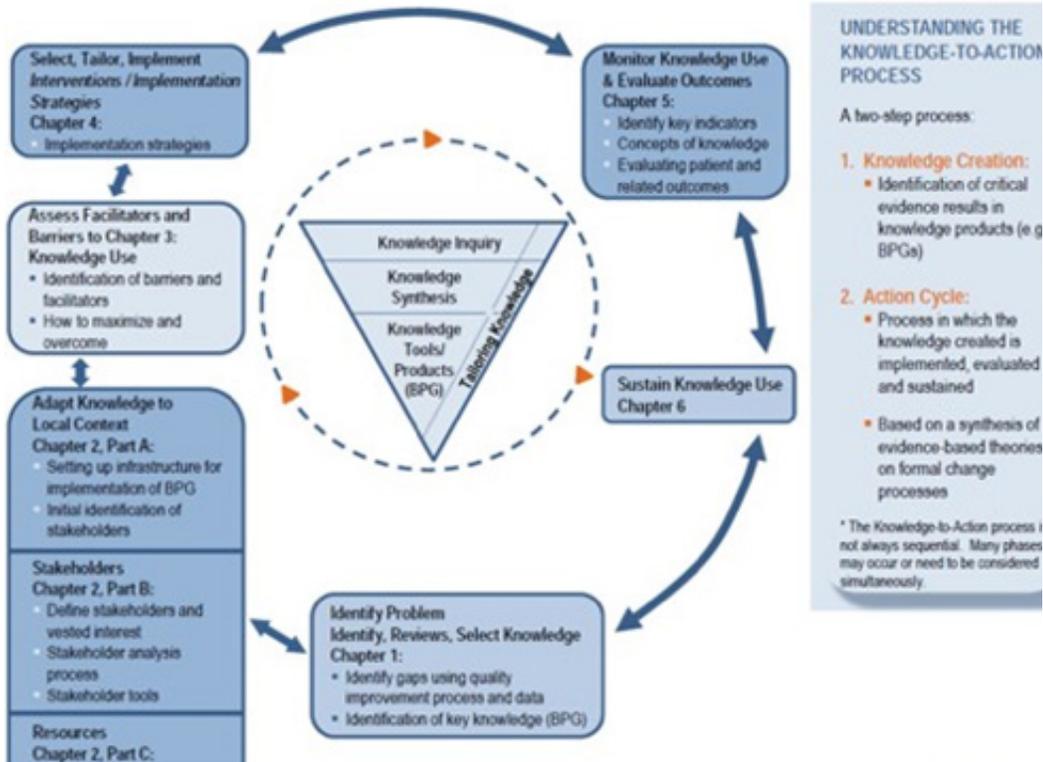
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Appendix A: Revised knowledge-to-action framework

REVISED KNOWLEDGE-TO-ACTION FRAMEWORK



Appendix B: Toolkits and additional resources

- Agency for Healthcare Research and Quality. AHRQ. Preventing falls in hospitals. A toolkit for improving quality of care.
www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/index.html
- Australian Commission on Safety and Quality in Healthcare. Guidebook for Preventing Falls and Harm from Falls in Older People: Australian Hospitals.
www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_FallsGuidelinesCommunity
- CampaignZERO: Families for Patient Safety, www.CampaignZERO.org, Information and checklists for families to help them partner with care providers to prevent falls, infections and other hospital acquired conditions.
- ECRI Institute, Falls. ECRI. www.ecri.org/components/HRC/Pages/SafSec2.aspx
- Health Research & Educational Trust. Preventing patient falls: A systematic approach from the Joint Commission Center for Transforming Healthcare project.
www.hpoe.org/preventingfalls
- Institute for Clinical Systems Improvement. Health Care Protocol: Prevention of Falls (Acute Care). www.icsi.org.
iu.instructure.com/courses/1491754/files/56997226/download?wrap=1
- National Council on Aging. Falls and Fall-Related Injuries Among Older Adults, A Practical Guide to State Coalition Building to Address a Growing Public Health Issue.
www.ncoa.org/wp-content/uploads/Falls-Prevention-Coalition-Toolkit.pdf
- Registered Nurses Association of Ontario. Preventing Falls and Reducing Injury from falls.
rnao.ca/sites/rnao-ca/files/bpg/Preventing_Falls_FINAL_WEB.pdf
- U.S. Department of Veterans Affairs National Center for Patient Safety. Implementation Guide for Fall Injury Reduction.
www.patientsafety.va.gov/docs/fallstoolkit14/falls_implementation_%20guide%20_02_2015.pdf
- Western Australia, Department of Health. (2014). Falls Prevention Model of Care. Falls Prevention Health Network.
www.healthnetworks.health.wa.gov.au/modelsofcare/docs/Falls_Model_of_Care.pdf