SA Health

Fall Injury Prevention and Management Clinical Guideline

Version 1.0

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Government of South Australia
SA Health

Fall Injury Prevention and Management Clinical Guideline

Contents

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1. Name of clinical guideline

Fall Injury and Prevention and Management

2. Key points

This clinical guideline contains the exact information from the 2016 Falls Prevention and Injury Management Clinical Directive and has been moved into the Clinical Guideline template for administrative purposes.

The content of this clinical guideline is currently under review. For queries, please contact health.dhwclinicalgovernanceenquiries@sa.gov.au

3. Guideline statement

Purpose of guideline

- Establish a consistent, embedded approach to the prevention and management of falls across SA Health services that is:
    - In accord with the national guidelines
    - Supports services to meet accreditation requirements.
    - Supports least restrictive care.
- Increase the awareness among clinical and non-clinical workers, consumers, and the public of the importance of being proactive in the prevention of falls, and the risk to consumer safety, and to the organisation, when this is not achieved.
- Describe governance and clearly outline workers' and health services' responsibilities in relation to the prevention and management of falls.

Roles and Responsibilities

SA Health Chief Executive (CE) will:

- ensure that the management of the risk of falls and harm from falls across SA Health is in accordance with this clinical guideline.

Director of Safety and Quality – Department for Health and Wellbeing will:

- establish, maintain and review the effectiveness of the Fall and fall injury prevention and management Clinical guideline Directive.
- support the implementation of the national guidelines through facilitating the development, dissemination and implementation of training, tools, resource materials and evaluation of these.
- support the development of a suite of data indicators relating to falls and fall injury that will be used to monitor trends and inform planning. This will include, but not be limited to incident data, hospital, ambulance, and emergency department data.
- review reported falls incidents and investigation reports, conducting trend analysis and develop and disseminate statewide strategies for system improvement.
- provide advice to health services in response to specific queries about falls prevention and management.

Local Health Network Chief Executive Officers will:

- allocate sufficient human and material resources to enable effective falls prevention and management programs to operate across all areas within their area of control, and appropriate data is gathered and analysed to inform planning and evaluation.
- delegate the day-to-day responsibility for establishing and monitoring the implementation of this clinical guideline to the relevant senior managers.
- ensure that services delivered to SA Health consumers, and purchased from providers other than SA Health, are in accord with this clinical guideline.
- ensure that available evidence and expertise is included in the design and planning of service delivery, to maximise cost effectiveness and impact on the population served.
- use available best evidence in falls prevention for new service developments, structural design, changes in work practices and purchase of new equipment and conduct environmental hazard assessments in existing facilities and managed the identified risk.
- ensure the health services within their area of control have systems in place which facilitate the effective management and notification of fall incidents (in accordance with the SA Health incident management policy and guideline)
- ensure that all fall related incidents that have the potential to result in substantial liability and/or have the potential to attract significant media attention are immediately escalated to the Chief Executive – SA Health.

General Managers, Directors, heads of service/departments and other senior managers will:

- develop, implement, and monitor local systems and procedures, including staff training and governance structures, that support employees and other persons providing health services on behalf of SA Health to achieve effective management of risk of falls and harm from falls. This includes embedding the identification and management of falls and fall injury risk factors in practice.
- create an environment where any incident related to a fall is notified and active management of the consumer and the incident is fostered, ensuring the learning gained from any investigation process is fully implemented and monitored. This includes:
    - investigation of falls and near misses
    - implementation of the actions necessary to reduce the likelihood of recurrence of a similar incident, and evaluation of the effectiveness of those actions taken.
- create an environment where the involvement of patients/carers in falls prevention and management processes is actively supported by clinical and non-clinical staff.

Patient/Client Safety and Quality Risk Managers will:

- promote this falls prevention clinical guideline and accompanying guidelines.
- assist others to ensure that the health service meets its obligations under this clinical guideline.
- ensure that an evaluation strategy is in place to assess compliance with this clinical guideline and falls prevention and management principles.
- ensure that they have sufficient expertise to be able to provide support and advice to staff in relation to falls related issues.
- establish mechanisms to support implementation of this clinical guideline, including participating in a collaborative, multidisciplinary working group to plan and implement local initiatives, working towards achieving compliance with national guidelines and accreditation.
- develop expertise in presenting data to support continuous practice improvement.

Clinical Educators will:

- ensure that workers are enabled to deliver effective fall and fall injury prevention and management by providing an education program in collaboration with trained Falls Prevention Leaders and the relevant governance committee that includes.
    - annual analysis of training needs, to determine which workers require training and education, and what skills, knowledge, attitudes, values and abilities they require.
    - delivery of learning programs, including the frequency of refreshers or updates, to meet training needs.

- development of learning programs that will support workers to effectively contribute to a reduction in falls and fall-related injury.
- evaluation of the learning programs in enabling desired outcomes

All SA Health employees will:

- adhere to the principles and aims of this clinical guideline and ensure that they provide care in accordance with its associated guidelines.
- ensure that all fall incidents are reported the Safety Learning System in accord with the SA Health Clinical Incident Management Policy.
- participate in education or training to ensure that they have knowledge and skills relevant to their role in preventing falls and harm from falls.

4. Background

Governance

- With the implementation of this clinical guideline, all SA Health organisations and services will meet the requirements of accreditation against national standards (1) and ensure that:
  - Governance structures and systems with management, clinical, and procurement representation are in place.
  - Health workers have access to policies and procedures, education and training.
  - Referral information and other relevant resources.
  - Clinical governance will provide:
  - Development, implementation and monitoring of organisation-wide falls and fall injury prevention systems of care, that are based on local needs and include internal procedures, equipment provision and referral pathways.
  - Advice to management and clinical governance committees around service design, staff training needs, environment, equipment, and relevant resources
  - Leadership of quality improvement activities and use of administrative data (incident reports and coded data), clinical data (audits) and research evidence to plan, measure, monitor and improve the effectiveness of systems of care and clinical practice in reducing falls incidents and rates of harm.

Further information: Tool 1 Example Terms of Reference (TOR) for a health service's Fall Prevention Committee.

5. Definitions, acronyms and abbreviations

Admission assessment	a comprehensive assessment completed for each patient on admission, including a holistic assessment of risk, and designed to inform the development of an initial care plan
Decision-making capacity	a person's decision-making capacity related to their ability to make a particular decision, and this can fluctuate over time. Decision-making capacity is required in order to provide informed consent to medical treatment. A person has decision-making capacity, in relation to a specific decision, if they can: ▪ Understand information about the decision. ▪ Understand and appreciate the risks and benefits of the choices. ▪ Remember the information for a short time. ▪ Tell someone what the decision is and why they have made the decision.

Fall	an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. If a consumer is found on the floor or lower level, it should be assumed that a fall has occurred unless there is reasonable evidence of a sudden onset of paralysis, epileptic seizure, loss of consciousness or overwhelming external force (being pushed).
Fall and fall injury risk assessment means	A detailed assessment that identifies the individual's risk factors for falling and for fall related injury. This will assist with clinical decision-making by indicating which interventions should be included in the care plan.
Fall risk screen, or screening tool	A brief test that gives an indication of the patient's overall level of risk of falling. This may indicate the need for more detailed assessment
Incident	any event or circumstance which could have (near miss) or did lead to unintended and / or unnecessary psychological or physical harm to a person and / or to a complaint, loss, or damage (SA Health Clinical Incident Management Policy)
Interventions	○ Single intervention means: an intervention targeting one risk factor, such as a balance and strength exercise program, medication adjustment, vision improvement, home/environmental modification, footwear adjustment or educational program. ○ Multifactorial intervention means: an intervention made up of a set of interventions that are intended to address some or all of the specific risk factors that were identified through an individual's fall injury risk assessment. This is ideally provided by a multidisciplinary team.
Least restrictive	an environment or intervention which places the least amount of restriction on freedom of movement while maintaining the safety of the person and others (Mental Health Act, 2009).
Mobility or functional assessment	An assessment of the person's mobility and function – gait, balance, strength, transfers –which considers a subset of the factors included in a fall and fall injury risk assessment, but in more depth, for example an analysis of balance or transfers
Near miss (for falls)	an incident where a fall was likely but averted through the action of staff or by the consumer themselves, or other
Older person	a person 65 years of age or over, or 50 years and over for those of Aboriginal or Torres Strait Islander background.
Restrictive Practices	all the types of restraint, care and control, reasonable force, and seclusion.
Risk factors for falling	factors that increase a person's probability of falling. Usually described as. ○ **Intrinsic risk factors mean** these relate to a person's condition and can include, but are not limited to, poor vision, poor balance, incontinence and muscle weakness. ○ **Extrinsic risk factors mean** these relate to a person's environment or their interaction with their environment and include but are not limited to slipping or tripping hazards. ○ **Medication risk factors means** these relate to the medications that a person is taking that are known to be associated with increased falls risk,

	and includes the type, for example psychotropics, and the number prescribed, for example polypharmacy (five or more medication types). ○ **Behavioural risk factors mean** these relate to a person's behaviour and include but are not limited to inattention, risk-taking and inability to follow instructions.
Risk factors for injury	factors that increase a person's likelihood of injury as a result of the impact from a fall. These include, but are not limited to poor bone strength, poor skin health, low body mass index, anti-coagulant therapy
Risk of a fall	the probability or likelihood of falling.
Risk of Injury	probability or likelihood that an injury will result from the impact sustained during a fall

6. Clinical guidance

Planning care

- Risk screening, risk assessment and review of the care plan to identify the individual's fall and fall injury risk factors and functional mobility must be conducted in accordance with.
    - NSQHS Standard 5 Comprehensive Care criteria Planning for comprehensive care and Preventing falls and harm from falls
    - Australian best practice guidelines.
    - The SA Health Falls Prevention eLearning course includes videos of the assessment process.

Screening and assessment

- Physiotherapists (PT), nursing and medical staff must screen for falls risk, then if required, assess using the SA Health falls risk assessments (MR58, MR58a and 58b, Sunrise EMR) or equivalent. The multifactorial assessment must also identify the risk posed by the surrounding environment on that individual.

Further information is available

- Tool 2 When and how to do fall risk screening, assessment, care planning and discharge planning the SA Health Safety and Quality eLearning course – Falls Prevention.
- There are a range of valid tools for the assessment of mobility, including deMorton Mobility Index (DEMMI) or Johns Hopkins Highest Level of Mobility Scale.
- Physiotherapists and Occupational Therapists (OT) have skills and knowledge about functional mobility and are recommended, when practicable, to conduct mobility and functional assessments and to prescribe in the care plan; activities to improve or maintain functional mobility the supervision or assistance that a patient requires from staff so that they, and staff, are safe when mobilising, transferring and participating in daily tasks, and staff use safe manual handling techniques.
- Assessment and interdisciplinary communication about the level of assistance a patient requires from staff, must be in accordance with Tool 7 Level of patient assistance.

- All patients can be at elevated risk of falls for a time after a procedure, for example involving administration of anaesthetic or that has resulted in pain, visual disturbance or light-headedness that are affecting mobility. Health services must have protocols that include routine supervision of the first time mobilising out of bed after such procedures, and provision of follow up assessment and change to care plan if unsteadiness persists.

Engaging the patient and carers

- Patients who are identified by screening and assessment as being at risk must be engaged (with their family or carer if required) in the development of their care plan and also the discharge plan, to ensure shared decision-making, reduction of fear of falling and continuity of care between settings.
- SA Health services must identify and respond to risk of falls, harm from falls and functional decline in ways that respect the individual's rights, dignity, autonomy, health literacy, cultural and language requirements and decision-making capacity.
- Written information can assist but not replace this engagement. A variety of consumer information is available on the Safety and Quality webpages.

Management of patients who are at risk.

- SA Health services must take action to address the individual's current risk , goals of care and maintain or improve as far as practicable the persons functional mobility. Actions must also.
    - support services to meet requirements of the National Safety and Quality Health Service Standards (second edition) and to minimise the risk of injurious falls that are considered to be Hospital Acquired Complications of Care
    - support least restrictive care in accordance with the Minimising Restrictive Practices Policy and Tool 3 Safe use of bedrails
    - in accordance with the Australian best practice guidelines.
- General falls prevention strategies must be applied for all people (for example removal of tripping hazards).
- There is also evidence for some single interventions, such as cataract removal and reducing psychoactive medication use, and these must be actioned when practicable.
- However, the most effective approach for those at risk in any setting is an individualised multifactorial, multidisciplinary plan of care, aimed at reducing the person's burden (impact) of intrinsic and extrinsic risk factors for falls and for fall injury, where possible.
- In acute settings, an interdisciplinary approach is usually required to address the range of risk factors identified through assessment processes. Recommended actions are listed on the Falls and Fall Injury Risk Factor Assessment form (MR58 or equivalent, or Sunrise EMR) and also in the Safety and Quality eLearning course – Falls Prevention.
- There is evidence for the use of systems of care that reduce risk of unwitnessed falls, for example, hourly or intentional grounding that includes offering assistance with personal needs. For example, this can pre-empt the patient trying to get out of bed without appropriate assistance. Similarly regular toileting or timing of diuretics can reduce the risk of patients falling while attempting to toilet.

- People with cognitive impairment (for example dementia or delirium) are at higher risk of falls. Falls prevention and harm minimisation strategies must be offered to patients with cognitive impairment in all settings, and strategies modified to suit the individual.
- For community settings, there is also strong evidence for strategies such as tailored balance and strengthening exercises (see ACSQHC best practice guidelines). Community-based services, including but not limited to Falls Prevention Clinics, and community geriatric services can use.
    - primary, secondary, and tertiary prevention
    - population health, and health promotion approaches (for example Stay on Your Feet®).
- In all settings, care must be provided in a way that minimises the use of restrictive practices, that is, least restrictive care. The use of any form of restraint of a person without decision-making capacity may only be considered as a last resort when alternative strategies have failed, and an imminent risk of harm from falling is still present, and the use of restraint is lawful. The application of restrictive practices will be guided by the Minimising Restrictive Practices Policy and Tool 3 Safe use of bedrails.

Care planning, documentation, and handover

- Care plans, including the level of assistance provided, must be reviewed after assessment or reassessment by appropriate multidisciplinary team members, or after a fall incident or a decline in safe mobility.
- Further information is available in Tool 2 When and how to do fall risk screening, assessment, care planning and discharge planning
- The documented care plan for a patient who is at risk must include coordinated interdisciplinary actions to.
    - address the patient's current risk factors for falling and for injury that have been identified by assessment(s) and review.
    - provide a safe environment and appropriate equipment/aids (assistive technology)
    - maintain or improve safe mobility and minimise functional decline, and
    - address the patient's goals of care.
- A patient who are at risk of falls must have a clinical alert added to their health record. Systematic verbal and written communication methods must also be used to ensure that all healthcare workers providing direct and non-direct care are aware of.
    - any fall incidents during the episode of care
    - the level of patient assistance required and relevant precautions (Tool 7 Levels of Patient Assistance)
    - the plan of care for the patient (aimed at reducing fall and injury risk and maintaining safe mobility).
- (NSQHS Standard 5 Comprehensive Care and Standard 6 Communicating for safety, and SA Health Clinical Communication and Patient Identification Clinical Directive).

Discharge planning

- Medication review is recommended prior to discharge. Supplementation with Vitamin D and calcium is recommended for all aged care residents and those in respite, unless there is medical advice to the contrary.
- To ensure seamless care transitions and longer term risk reduction, health services must include falls risk information in discharge information to GPs and refer as required to appropriate service providers after hospital-based and other services (Tool 2 When and how to do fall risk screening, assessment, care planning and discharge planning).
- Where there is ongoing risk of falling, an assessment of the safety of the home environment for the patient is recommended if practicable.

Mobility equipment (assistive technology)

- All health services must ensure that appropriate aids, equipment, and devices are available for safe patient mobility, transfers and injury reduction, and that staff training and procurement processes support their availability and effective and safe use. This includes items for patient use such as walking aids, bed mobility aids, hip protectors, grip socks; and items for staff use, such as shock absorbing bedside mats, surveillance, or alert systems.

Providing a safe environment

- All health services must ensure that as far as practicable, a safe environment in facilities is provided through service design, planning and regular review/audit of the environment. (NSQHSS Actions 1.29 and 1.30).
- A safe environment for an unsteady patient is one where both general and specific risks or hazards are identified and eliminated or modified. General hazards such as slippery floors present a risk to all persons. Specific hazards relate to an individual and must be addressed as far as practicable, for example modifications of lighting for a patient with visual impairment. Further information is provided in the Safety and Quality eLearning course – Falls Prevention.
- Where services are provided in the patient's home by community-based services to a patient at risk, intervention must include assessment and modification of the environment, and use of assistive technology (equipment/devices) and home modifications if required, as agreed with patient and carer.

Management of patients who have fallen.

Immediate care and management

- Immediate care and management must be provided to any patient who falls, in accordance with the Tool 8 and local Post Fall Management Protocol. This includes diagnosis and treatment of injuries.
- Care provided must also be provided in accordance with the person's wishes as expressed in an Advance Care Directive, or by the Substitute Decision-maker (see Advance Care Directive Policy), and in accordance with a current Resuscitation plan (7 Step Pathway).
- To mitigate the risk of undiagnosed intracranial bleeding, more frequent observations of vital signs (using the appropriate Rapid Detection and Response (RDR) observation chart,

consciousness, behavioural and mental state for at least 48 hours are recommended for patients who may have hit their head and/or are taking anticoagulation therapy and/or are over 80 years old (in accordance with NSQHS Standard 8 Recognising and responding to acute deterioration).

- The fall incident must be noted in handover and documented in the medical record including the circumstances of the fall, any injuries and their treatment, and any changes to the care plan.

Post fall team review, open disclosure, and care plan revision

- After a fall, re-assessment must be completed within the same shift, or as soon as practicable using the Falls and Fall Injury Risk Factor Assessment form or equivalent.
- Changes to the care plan must be documented, communicated to the care team, and implemented. This is demonstrated in the Safety and Quality e-learning course – Falls Prevention.
- Refer to Tool 2 When and how to do fall risk screening, assessment, care planning and discharge planning
- Within 48 hours of a repeat fall or serious fall (SAC 1/ISR1 or SAC 2/ISR2), or other as deemed by senior staff, the multidisciplinary team must participate in a brief Post Fall Team Review (Tool 6). which is the recommended method for review and analysis of a patient fall incident.
- Progress on the implementation of all recommendations generated by a Post Fall Team Review, Root Cause Analysis or other investigations must be documented in the Safety Learning System and monitored in accordance with the Clinical Incident Management Policy.
- Open Disclosure must be provided to patients and families in accordance with the Clinical Incident Management Policy.

Incident reporting, investigation, and quality improvement

- All patient incidents involving a fall or a near miss fall in an SA Health inpatient service, or centre-based service, or residential facility must be reported as a 'Patient Incident' in the Safety Learning System (SLS), within the same shift if practicable. For guidance refer to.
    - Tool 4 SLS Topic guide – Reporting a patient fall incident into Safety Learning System
    - Tool 5 Reporting a patient fall incident into the Safety Learning System (SLS) – Frequently Asked Questions (FAQs)
    - investigated as required by the Clinical Incident Management Policy and action taken to reduce the risk of recurrence.

The post fall team review (section 3.3) results in shared team learning, and recommendations can be made regarding area or service-wide practice changes (quality improvement) for consideration by the Falls Prevention committee or equivalent.

There are requirements for the relevant committee to consider health service incident data as part of planning for quality improvement, and to meet requirements of accreditation against National Safety and Quality Health Service Standards.

- Refer to Roles and Responsibilities this document, and to Tool 1 Example Terms of Reference (TOR) for a health service's Fall Prevention Committee.
- For patients/clients of community services, the fall must also be reported to the General Practitioner. If the fall was related to the health services provided, a risk reassessment including the home environment is conducted, the care plan modified, and the fall reported into the SLS (Tool 5 Reporting a patient fall incident into SLS – FAQ).
- In any setting, where care is provided by an external service (private or non-government) contracted by SA Health, injurious falls must be reported by that service to the SA Health contract manager or liaising health service, who will undertake investigations and open disclosure in collaboration with the contracted service and report the incident into the SLS (indicating that it occurred in a contracted service).
- Any fall incident which is rated as SAC 1/ISR1 must be reported to the LHN CEO using a Clinical Incident Brief (CIB) in accordance with Clinical Incident Management Policy and may be investigated using RCA methodology

Educational Framework

- Delivery and attendance at education programs must be supported by allocated time and resources and reported through clinical governance structures.
- Completion of the SA Health Safety and Quality eLearning course – Falls Prevention is the minimum requirement for all clinical staff.
- To build skills and knowledge to support falls prevention and safe mobility, health services must make available orientation and regular education programs that.
    - use the toolkit as key resources or principles.
    - are based on the National Patient Safety Education Framework, and the Australian best practice guidelines
    - are provided to the clinical and nonclinical workforce and are multidisciplinary.
    - are tailored to individual roles and responsibilities.
- Learning and teaching activities will include.
    - risk screening and risk assessment processes, care planning, falls prevention interventions, use of equipment, safe mobility strategies, interdisciplinary roles, clinical alerts and handover/discharge to reduce risk in the short and longer term.
    - care of the fallen person to minimise harm, promote recovery and facilitate open disclosure and complaint management.
    - teamwork including post fall team review, shared learning and structured clinical communication (Clinical Communication and Patient Identification Clinical Directive), and, and person-centred care (Consumer, Carer and Community Engagement Strategic Framework, Guide and Resources)

Implementation and monitoring

- All incidents involving a fall or a near miss in an acute or other inpatient service, or centre-based service, or residential facility are to be reported into the 'patient incident' section of Safety Learning System (SLS) and noted in the medical record. Documentation in the medical record should include a factual summary of events, any injuries and their treatment and resultant interventions and actions.
- For community care, all falls or near misses that occur during the period covering the episode of care that are related to any aspect of the provision of care, are to be reported into SLS, and also noted in case records.
- There are requirements for reporting health service area data to the relevant committee and clinical governance system.
- All fall events must be investigated to the level required by the Clinical Incident Management Policy .
- Any fall incident which is categorised as SAC 1/ISR 1 must be reported to the Department for Health and Wellbeing in accordance with Clinical Incident Management Policy.
- Progress on the implementation of all recommendations generated by the Post fall team reviews, Root Cause Analyses and other investigations must be reported and monitored in accordance with the Clinical Incident Management Policy. SLS includes provision for recording the post fall team review and the actions arising.

For further information, there are three relevant tools:

  - Reporting a patient fall incident into Safety Learning System – an SLS Topic guide (Tool 4).
  - Reporting a patient fall incident – Frequently Asked Questions FAQs (Tool 5).
  - The post fall team review (Tool 6).

7. Associated policies / guidelines / clinical guidelines / resources

Related documents

- Tool 1 - Example Terms of Reference (TOR) for a health service's Fall Prevention Committee Toolkit
- Tool 2 - When and how to do Fall risk screening, assessment, care planning and discharge planning.
- Tool 3 - Safe use of bedrails
- Tool 4 - Reporting a patient fall incident into Safety Learning System – an SLS Topic guide
- Tool 5 - Reporting a patient fall incident – Frequently Asked Questions
- Tool 6 - Post fall team review
- Online eLearning course – Falls Prevention

Medical Records forms

- Fall and fall injury risk assessment and care planning form (MR58 or equivalent)
- Fall and fall injury risk review form (MR 58a or equivalent)
- Fall risk screen (MR 58b or equivalent, including FROP-Com screening tool, NARI)

8. References

1. National Safety and Quality Health Service Standards Australian Commission for Safety and Quality in Health Care
2. Australian Best Practice Guidelines Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care and Community Care (2009) Australian Commission on Safety and Quality in Health Care.
3. Stay on Your Feet® Community Good Practice guidelines Queensland Health
4. Legislation
   - *Advance Care Directives Act 2013 (SA)*
   - *Aged Care Act 1997 (Commonwealth)*
   - *Civil Liability Act 1936 (SA)*
   - *Coroners Act 2003 (SA)*
   - *Health Care Act 2008 (SA) (Part 7 – Quality improvement and Research & Part 8 Analysis of adverse incidents.) Health Care Regulations 2008 (SA)*
   - *Health Practitioners Regulation National Law Act 2009*
   - *Mental Health Act 2009 (SA)*
   - *Work Health and Safety Act 2012 (SA) and Work Health and Safety Regulations 2012 (SA)*
   - *Commonwealth Aged Care Act 1997*

Relevant SA legislation can be accessed at www.legislation.sa.gov.au.

9. Appendices

N/A

10. Document Ownership and History

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Contact: Quality Programs Lead
Approved by: Clinical Guideline Domain Custodian
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Does this clinical guideline amend or update and existing clinical guideline?

It replaces the Fall and Fall Injury Prevention and Management Policy V3 15/01/2016

Does this clinical guideline replace another clinical guideline with a different title? **N**

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30/07/2024	V1	Clinical Guideline Domain Custodian	Original – Content moved directly from 2016 Fall and Fall Injury Prevention and Management Policy Directive