

Falls Prevention and Management for People admitted to Acute and Subacute Care

Care of Adult Inpatients

Part 1: Roles & Responsibilities and Assessing Falls Risk

August 2018



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Introduction

This procedure outlines the processes required to prevent & manage falls for people admitted to both acute & sub-acute facilities across the South Western Sydney Local Health District (SWS LHD).



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Statistics

- Falls are the most commonly reported adverse event in hospitals.
- In 2016, 38 patients died in NSW public hospitals following a fall-related incident.
- In addition, there were 458 fall-related incidents resulting in serious patient harm

A 'fall' is defined as

“an event which results in a person coming to rest inadvertently on the ground, floor or other lower level”



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Principles

This procedure applies to all groups identified as at risk across all facilities in SWSLHD including;

- women receiving maternity care and neonates
- children
- mental health
- drug and alcohol patients

Does not include outpatients & those under the care of community health services, this will be covered by new separate guidelines for SWSLHD



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Principles

Aim:

- to reduce the incidence of patient falls
- to minimise harm from falls for patients in our care

Best practice for preventing falls in hospital includes 4 key components:

1. Identification of falls risk
2. Implementation of standard prevention strategies (e.g. call bell in reach)
3. Implementation of strategies targeting identified risks to prevent falls (e.g. issuing a sensor mat for cognitively impaired patients)
4. Prevention of injury to those people who do fall

The intention of this procedure is to ensure that a patient's falls risk is recognised promptly, appropriate action is taken & documentation is completed.



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Nursing Role

- Completion of mandatory MHL online Falls Prevention & Management modules
- Complete online falls risk assessment within 4hrs of admission to your ward
- Highlight falls risk on patient care boards
- Complete FRAMP for patients with any identified risk (i.e. scoring ≥ 9 on the fall risk screen or from clinical reasoning)
- Implement strategies identified on the FRAMP



Image: NSW government



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Nursing Role (continued)

Repeat the falls risk screen, & review the FRAMP:

- immediately following a fall
- when a patient is relocated to a different ward
- post operatively
- when clinically indicated (e.g. a change in the patient's condition or cognitive status)
- weekly if there has been no change in status

Implement falls risk strategies and discuss falls risks in partnership with patients & their families. Use interpreters either face to face, or by telephone if necessary for people of CALD backgrounds



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Nursing Role (continued)

- Provide patients/carers with resource material in their preferred language
- Communicate falls risk & management strategies as a part of bedside clinical handover
- Record all falls incidents on IIMS
- Complete all post fall observations & interventions in line with the CEC Post Fall Guide
- Complete the post fall management form on eMR2 or post fall sticker for facilities not using eMR2



Nursing Role (continued)

- Falls risk status & ongoing management strategies must be included in the nursing discharge summary / handover for all patients discharged or transferred
- Inform the Nursing Unit Manager of any equipment requirements or identified hazards
- Contribute to the review of falls incidents as required at ward / department meetings



Image: NSW government



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Allied Health Clinician Role

- Completion of mandatory MHL online Falls prevention & Management modules
- Conduct discipline-specific assessments and interventions
- Highlight falls risk on patient care boards
- Communicate identified high falls risk to nursing staff immediately following assessment
- Contribute to the multidisciplinary FRAMP when appropriate



Image: monash.edu



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Allied Health Clinician Role

- Discuss falls risk & develop interventions in partnership with patients, families & carers
- Provide resource material to patients & their carers on preventing falls and harm from falls
- Record fall incidents in the IIMS
- Contribute to the review of fall incidents at ward/department meetings
- Participate in safety huddles and post fall huddles to monitor and recommend falls prevention strategies



Allied Health Clinician Role

- Consider referral to appropriate services on discharge
- Communicate any referrals made to the medical team for inclusion in the discharge summary
- Complete discipline-specific discharge summaries for patients discharged to community health services, off-site rehabilitation or residential aged care facilities and highlight any falls risk factors identified



Image: South Eastern Sydney LHD



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Role of Ward Falls Champion

- Attend face to face SWS CEWD educational workshops
- Raise & maintain the profile of falls prevention at a ward/service level
- Motivate staff by modelling best practice & asserting a positive attitude towards falls prevention
- Contribute to the review of all fall incidents at ward/department meetings & facility falls prevention committee meetings as required
- Communicate relevant information & actions arising from the facility falls prevention committee and/or quality & safety meetings to the NUM



Role of Ward Falls Champion

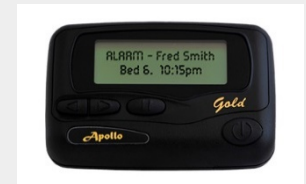
- Assist NUM & ward staff to facilitate a MDT post fall 'huddle'
- Assist the process of safety huddles at handover
- Work with staff to engage patient, family & carer in falls prevention initiatives
- Participate in the annual 'April Falls Month' activities
- Support staff with process of screening & documenting patients at risk of falls in eMR2 (at relevant sites)



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Role of Ward Falls Champion

- Work with Nursing Unit Manager/CNC/CNE & team to ensure staff are competent in the use of falls prevention devices/alarms on the ward
- Maintain equipment log, including monthly audits



Role of the Patient, Carers & Families

Patient's family and carers have an important role throughout the process of managing falls prevention in any facility

On Admission:

- Carer's & Families provide valuable patient information such as previous falls, strategies to manage challenging behaviours and recommendations on how to reduce the risk of falling
- Top 5 initiatives should be implemented for patients with a history of dementia
- Ensure families are aware of the REACH program by displaying information & discussing the process with them



R	Recognise
E	Engage
A	Act
C	Call
H	Help is on its way



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Top 5



Role of the Patient, Carers & Families

During Admission:

- Alert staff to changes in the patient's condition or behaviour
- Reinforce the falls prevention messages to the patient during their visits
- Work collaboratively with staff to develop strategies to reduce the patient risk of falling

Post Fall:

- Where possible include families & carers in post fall safety huddles as well as the patient
- Reflection on how the incident occurred & ideas on strategies to prevent future falls can be discussed



Role of Patient Carers & Families

On discharge:

- Inform families and carers of the reason the patient is at high risk of falls
- Provide information on how to reduce the patient's risk once discharged from hospital
- Inform them on which referrals have been made & any recommendations on strategies to reduce the patient's risk



Image: usnews.com



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Falls Risk Screening Tool

All adults admitted to SWSLHD acute & sub-acute facilities (excluding women receiving maternity care) will be screened for falls risk

Women receiving maternity care are considered a special at-risk group. A separate education package on the procedure in Maternity Units is available.

All admitted Haematology patients must have their Hb checked and if symptomatic of anaemia and/or a platelet count of $< 50 \times 10^9/L$ that they be classified a +9 high risk

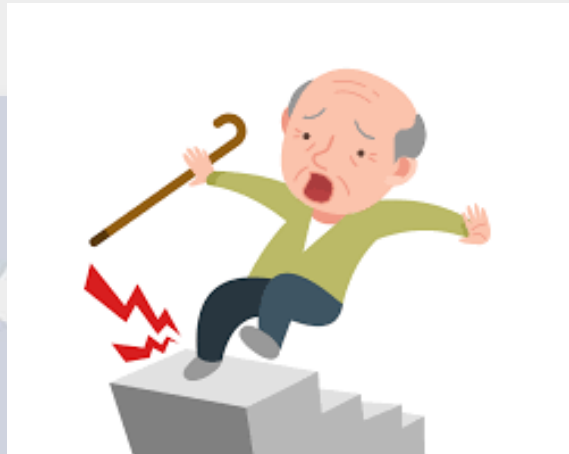
In the event of fall in the patient with a low platelet count $> 50 \times 10^9/L$ the risk of significant injury is high



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Falls Risk Screening Tool

- The falls risk screen is a guide for staff & does not replace clinical judgement
- If staff judge an inpatient to be clinically at risk of a fall, this always overrides an individual risk score
- A comprehensive assessment & management plan is required in these cases



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Falls Risk Screening Tool

When

Procedure

Emergency Department

- All patients that are admitted to hospital must be screened **within 4 hrs** of admission.
- The falls risk screen may be completed in the ED or in the inpatient unit, if they are transferred **within the 4hr timeframe**.
- ED must communicate to the ward in advance of a transfer if a patient is identified as being at risk of falls i.e. if 1:1 nursing is required.

Falls Risk Screening Tool

When	Procedure
Admission to acute, subacute or rehabilitation services	<ul style="list-style-type: none">• All adults who are admitted to hospital will be screened for falls risk within the first 4 hours of their admission to a ward.• Risk assessment must be repeated when the patient is received from ED/ theatres/ ICU/ interventional units or on transfer from another bed/ward/unit.
Following a fall	<ul style="list-style-type: none">• All patients who fall in hospital must have a repeat falls risk screen within 4hrs of the fall.

Falls Risk Screening Tool

When	Procedure
<p>Change in the patient's condition (Physical and/or Mental)</p>	<ul style="list-style-type: none">• A repeat falls risk screen must be completed within 4-hrs if there is any change to the patient's physical and/or mental* condition.• * Altered mental status (including confusion, disorientation and agitation) is a risk factor for falls. Consider delirium as a possible cause and refer to the Guideline <u>SWSLHD_GL2016_003 Delirium</u>.
<p>* Considerations for Mental Health patients</p>	<p>Additional considerations in mental health include:</p> <ul style="list-style-type: none">• Electroconvulsive therapy (ECT)• Acute mania or psychosis• The influence of drugs and alcohol• Withdrawal from drugs and alcohol• Depression impairing ability to concentrate or comprehend instructions• Side effects of new medication (including postural hypotension)

Falls Risk Screening Tool

When	Procedure
Post-operative patients	<ul style="list-style-type: none"><li data-bbox="513 375 1727 548">• Patients who have had an anaesthetic should be considered at high risk of falls until a repeat risk screen ascertains their falls risk status.<li data-bbox="513 629 1789 743">• The repeat screen should be done once the patient is at least 8 hours post-surgery & within 24 hours.<li data-bbox="513 825 1798 1058">• Due to differences between individual patients, staff are required to use clinical judgement to determine when sufficient recovery from an anaesthetic has occurred & re-screening is appropriate.

Identifying High Risk Patients - Use of the Override button on eMR

Examples of situations where the override option may be used include:

- Age > 80
- Frail due to a medical condition
- Osteoporosis
- Orthopaedic conditions
- Anticoagulation &/or Coagulopathies such as Haemophilia A and B
- Thrombocytopenia (platelets < $50 \times 10^9/L$)
- Post -surgical (recent)
- Seizures
- Sepsis ([refer to CEC Adult sepsis pathway](#))
- Amputee
- Parkinson's Disease (PD)
- Obesity



Identifying High Risk Patients

- High risk status must also be communicated to relevant clinical staff as a routine part of clinical handover
- To highlight risk when a patient is being transported to another area of the hospital (e.g. radiology), a high falls risk sign needs to be displayed at the end of the patient's bed



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Individualised multidisciplinary falls assessment

The roles suggested are a guide, as each patient will require individualised management strategies

Clinician	Role/s
Dietitian	<ul style="list-style-type: none">• Assess nutritional status, hydration, calcium dietary intake & risk of Vitamin D deficiency.• High risk groups include housebound community-dwelling people & residents of aged care facilities.



Individualised multidisciplinary falls assessment

The roles suggested are a guide, as each patient will require individualised management strategies

Clinician	Role/s
Occupational Therapist (OT)	<ul style="list-style-type: none">• Patients at high risk of falls, admitted to hospital following a fall or who have fallen in hospital should be referred for an OT functional & home environment assessment.• Recommendations for home modifications & prescription of equipment to maximise safety should occur.• OT should participate in safety huddles & post fall safety huddles as part of the MDT.



Individualised multidisciplinary falls assessment

The roles suggested are a guide, as each patient will require individualised management strategies

Clinician	Role/s
Optometrist/ Ophthalmologist	<ul style="list-style-type: none">• People with an increased risk of falling due to visual impairment, or have not had an eye examination >2 years should be referred for assessment on discharge.
Pharmacist	<ul style="list-style-type: none">• Consider a medication review & make recommendations to the medical team about medication changes to reduce falls risk, particularly if taking sedatives, antidepressants, antipsychotics & / or centrally acting pain relief.• Encourage a home medicine review for eligible patients on discharge from hospital.

Individualised multidisciplinary falls assessment

The roles suggested are a guide, as each patient will require individualised management strategies

Clinician	Role/s
Physiotherapist	<ul style="list-style-type: none">• Patients at risk of falls, who were admitted following a fall, or who have fallen in hospital should be referred for a physiotherapist balance & mobility assessment.• The level of assistance & the equipment required for mobility should be clearly documented.• If the patient demonstrates poor sitting balance, a high level of fatigue, impulsivity or difficulty following instructions, ensure this is clearly documented & verbally discussed with the nursing staff• Ensure the patient is not left alone in the bathroom.• Prescription of walking aids & exercise should occur as appropriate.

Individualised multidisciplinary falls assessment

The roles suggested are a guide, as each patient will require individualised management strategies

Clinician	Role/s
Physiotherapist (Continued)	<ul style="list-style-type: none">• Patients who fall in hospital should be (re-)assessed by a physiotherapist if there is a change in level of function.• Physios should participate in safety huddles & post fall safety huddles as part of the MDT.
Podiatrist	<ul style="list-style-type: none">• Where available, refer high risk patients to a podiatrist for inpatient assessment of foot problems & footwear, or consider referral as part of discharge planning.



Conclusion

Falls Prevention is Everyone's Business

This procedure provides best practice guidelines & tools for falls prevention. It describes the governance structures & processes required to deliver a proactive approach to reduce the frequency, severity of falls & injuries resulting from falls.



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