HOSPITAL FALLS PREVENTION STRATEGIES

FALLS SCREEN On admission determine if patient is at risk of a fall: record in patient notes

- Identify falls risk patient using agreed flagging/handover/rounding procedure

FALLS RISK ASSESSMENT and MANAGEMENT PLAN (FRAMP)

Identify specific risk factors and implement appropriate actions for any risk factors, record in patient notes and care plan

- Falls risk assessment and management plan completed
- Action list of interventions to minimise falls risk: plan developed and documented
- Complete on admission, post fall, change of condition or when appropriate.

FALLS PREVENTION STRATEGIES

Please refer over the page for the Standard care requirements for all patients - Patients are unwell and in an unfamiliar environments and it is important to familiarise patients with their new environment

HISTORY OF A FALL

- Increases risk of a fall in hospital,
- Reason for falls (e.g. loss of consciousness, syncope, blackout, osteoporosis) – medical review

MENTAL STATUS

Is the patient confused, disorientated, agitated or depressed?

- Monitor and assess any changes in cognitive function (fluctuating restlessness, behaviour or aggression)
- Conduct or refer for a cognitive screen (e.g. AMTS, SIS, MMSE, RUDAS)
- Assess for delirium. Use the Confusion Assessment Method (CAM) tool
- Treat underlying cause of delirium (sepsis, infection, constipation, urinary retention, medication, pain, dehydration)
- Implement delirium care pathway
- Increase observation and supervision in bathroom/toileting
- Locate near nurses station if possible
- Liaise with family/carers - engage them and the patient in plan of care.
- Use alarms (bed/chair), lo-lo beds with confused patient, including those with delirium
- Refer for allied health review (if available or appropriate)

VISION

- Ensure there is adequate lighting including night lights.
- Provide CEC Eyesight flyer
- Refer for allied health review

TOILETING

- Individualised (supervision/assistance) toileting plan e.g. regular toileting, hourly rounding
- Patient to be supervised when mobilising
- Patient not to be left alone in the toilet/bathroom
- Refer for continence nurse and/or allied health review
- Place patient near toilet facilities with visual prompts and night lights
- Provide a commode or urinal if toilet is not close by and provide assistance

TRANSFER/ MOBILITY

- Refer for P/T for mobility and O/T for self care assessment (if possible)
- Provide patient with equipment to assist mobility/transfer/selfcare
- Assist patients with poor balance and mobility to the bathroom
- Provide assistance with personal care
- Encourage mobility aids used at home to be brought to hospital
- Locate mobility aids on the side of the bed preferred for the patient to exit
- Encourage mobilisation and participation in daily activities
- Ensure that patient is wearing non–slip well fitting footwear

MEDICATION

- Refer to treating medical officer for medication review
- If the patient has postural hypotension refer to treating medical officer
- Avoid night sedation or use of centrally acting medications unless clinically necessary
- Consider Vitamin D and calcium supplementation for those people with known osteoporosis and for older frailer people
- Ensure appropriate pain management and check patient is mobilising safely.
- Talk to patient/family and carers about their medications

RESTRAINTS

- Causes of agitation, wandering and other behaviours should be investigated and reversible causes (delirium) should be treated before restraint is considered
- Minimise the use of restraints (physical and chemical) and bed rails
- Refer to hospital restraint policy

DISCHARGE

- Refer patients with balance and mobility problems for exercise program on leaving hospital
- Ensure GP is informed of falls risk and any changes in medication
- In transfer care plan – note falls risk

For ALL patients who fall in hospital: follow CEC POST FALL GUIDE: (observe, notify, communicate, reassess, revise care plan)

Ref: Australian Commission on Safety and Quality in Health Care, *Preventing Falls and Harm from Falls in Older People:* Best Practice Guidelines for Australian Hospitals, 2009

Care actions for all patients

These care actions are relevant for all patients and are a component of ongoing clinical care at all times.

- Orientate patient to bed area, toilet and ward
- Educate patient and family, providing culturally appropriate information about the risk of falling and safety issues
- Instruct patient on the use of the call bell, ensure it is within reach and advise to call for assistance if required
- Ensure frequently used items (including mobility aids) are within easy reach, on appropriate side of the bed, in good working order and are adjusted for the patient
- Bed and chair are at appropriate height for the patient – instruct patient on use of bed control (if appropriate)
- Ensure bed brakes are on at all times and chair brakes are on when not mobilizing
- Position over-bed table on the non exit side of the bed
- Place IV pole and all other devises/attachments (as appropriate) on the exit side of bed
- Ensure attachments (such as catheters, wound drainage, IVs) are secured
- Remove clutter and obstacles from room
- Ensure patient wears appropriate footwear when ambulant
- Establish patient's level of personal care and need
- Ensure adequate night lighting

Provide patient/family/carer with falls prevention information.

Clinical Excellence Commission Falls Prevention flyers available at www.cec.health.nsw.gov.au

Acknowledgement to:

The Australian Commission on Safety and Quality in Health Care, Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals, 2009.

For further information scan this with your smart phone

Email: falls@cec.health.nsw.gov.au
Web: www.cec.health.nsw.gov.au

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