



HOSPITAL FALL PREVENTION STRATEGIES



FALL SCREEN On admission determine if patient has risk factors that may cause a fall: record in patient notes

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

FALL RISK INTERVENTION PLAN

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

- Action interventions to minimise fall risk: develop and document : communicate fall intervention plans at clinical handover and safety huddles
- Complete on admission, post fall, change of condition or on transfer to another setting or as a clinical judgment

FALL PREVENTION STRATEGIES

HISTORY OF FALLS

- Increases risk of a fall in hospital,
- Reason for falls (e.g. loss of consciousness, postural hypotension, syncope, blackout, osteoporosis) – indicates need for 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), or 4AT 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.
- Consider 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.
- Refer for allied health & or medical review
- Enquire if patient has macular degeneration, cataracts, glaucoma
- Ensure patient has clean glasses

TOILETING

- Individualised toileting plan e.g. regular toileting, intentional rounding
- Patients who are confused will require supervision when toileting/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

- Assess patients mobility requirements
- Encourage patient mobilisation
- Assist and supervise patients with poor balance and mobility to the toilet/bathroom
- Refer for P/T for mobility and O/T for self-care assessment (if possible) when patient has poor mobility and self-care needs
- Provide patient with equipment to assist mobility/transfer/self-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
- Ensure that patient is wearing non-slip well-fitting footwear
- Ensure patient is wearing clothing at appropriate length

MEDICATION

- Refer to treating medical officer for medication review when patient is on antipsychotics, benzodiazepines, antidepressants, opioids.
- Avoid night sedation or use of centrally acting medications unless clinically indicated
- Consider Vitamin D and calcium supplementation for those people with known osteoporosis and for older frailer people
- Ensure appropriate pain management
- 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
- Bed rails should not be used for patients with a fall risk
- Refer to hospital restraint and bedrail policy

DISCHARGE

- Ensure GP is informed of fall risk and any changes in medication
- In transfer care plan – note fall risk
- Refer patients with balance and mobility problems for exercise program on leaving hospital e.g. P/T, Stepping- On
- Provide patient/family/carer with fall prevention information

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

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

Safety Care Actions for all patients at all times

- Orientate patient (family and carer) to bed area, location of bathroom & toilet
- Engage with patient family and carer about planning safe care and provide information
- Instruct patient, family and carer on the use of the call bell – and ensure that it is always in reach
- Look to ensure that frequently used items such as glasses, continence aids, water are within easy reach
- Look to ensure that mobility aids (walking frames/stick) are within easy reach, located on appropriate side of the bed, in good working order and adjusted to right height.
- Look at the bed, chair, over-bed table and adjust to the right height for the patient. Show patient how to use the bed controls
- Look to ensure that the bed brakes are on and chair brakes are on when not mobilising/transferring
- Position the over-bed table on the non-exit side of the bed
- Locate IV pole and other devices are on patients exit side of the bed and that attachments (such as catheter, wound drainage etc) are secure.

Provide patient/family/carers 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

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