Preventing falls and harm from falls in hospital

Falls Prevention is everyone’s business
What is a fall?

An event which results in a person inadvertently coming to rest on the:

• ground
• the floor or
• other lower level

This can be from:

• standing
• a bed
• a chair
Falls in hospital – some facts

• 1 in 3 of all patient incidents in our hospitals involve a fall

• Most people who have a fall in hospital are over 65 years of age

• 20% of falls occur outside of aged care wards.
Falls in hospital – some facts

NSW average 4.1 falls/1,000 occupied bed day (2012):

- 30-40% will result in a physical injury
- 60-80% are un-witnessed
- 70% occur around or from the bed
Consequences of Falls

• Death

• Serious injury

• Increased stay in hospital

• Loss of independence - changes in living arrangements on discharge
Medical Conditions
- Stroke
- Incontinence
- Parkinson’s disease
- Dementia
- Delirium

Medications
- Psychoactives
- Four or more medications

Psychosocial & Demographic
- History of falls
- Depression
- Advanced age
- Living alone
- ADL limitations
- Female gender
- Inactivity

Sensorimotor & Balance
- Muscle weakness
- Impaired vision
- Reduced peripheral sensation
- Poor reaction time
- Impaired balance

Environmental
- Poor footwear
- Home hazard
- External hazard
- Inappropriate spectacles

Falls
Adult risk factors for falls in hospital

- History of falls
- Patient is confused, agitated or disorientated
- Has poor vision, such that everyday function in the ward is impaired
- Needs to go to the toilet frequently or is incontinent
- Unsafe mobility and transfers
- Takes medications associated with increased risk of falls.
**Confused older person is at increased risk of a fall**

Disorientated due to an unfamiliar environment or noisy ward

**Due to Delirium**

- watch for: fluctuating changes in cognition: increased agitation, restless, lethargy, aggression
- screen for delirium – complete a CAM

**Look for:**

- acute infection – treat Sepsis
- confusion post – operatively due to sedation
## Identifying patient falls risk in hospital

<table>
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<tr>
<th>Screen</th>
<th>Falls risk screen in ED, or on admission to ward</th>
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<tr>
<td>Assessment</td>
<td>Falls risks assessed and identify actions</td>
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<td>Manage identified risk</td>
<td>Implement actions in consultation with family and carer, document in care plan and patient health record</td>
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<tr>
<td>Communicate falls risk</td>
<td>Falls risk and interventions in place communicated to staff eg at handover</td>
</tr>
<tr>
<td>Post Fall</td>
<td>Follow CEC Post Falls Guide, notify falls in IIMS &amp; notify family/carer</td>
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<tr>
<td>Incident investigation</td>
<td>Post fall ‘huddle’ and review of serious incidents - implement recommendations</td>
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<tr>
<td>Discharge</td>
<td>Referral for follow-up services &amp; provide falls information</td>
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</table>
National Safety & Quality Health Service Standards – Standard 10

Preventing Falls and Harm from Falls
National Safety & Quality Health Service Standards

• Key requirements of Standard 10

  • All Adult Patients to be screened for falls risk
  • Assessment and management of falls risk factors
  • Regular audits of patient records and ward environment
  • Patient/Carer involvement in care and provided with falls prevention information
Falls Risk Screen

• All patients are to be screened for falls risk on admission, post fall, transfer, change of condition

• Falls Risk Screen Tool
  
  Ontario Modified Stratify (Sydney Scoring)

• Patients with indentified falls risks will require further assessment and management
Ontario Modified Stratify (Sydney Scoring)

Implement care actions

<table>
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<tr>
<th>Any identified Falls Risks</th>
<th>All Patients</th>
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<td>FRAMP</td>
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Care actions for all patients

- Document and communicate patients falls risk status to other staff
- Implement all care actions
- Discuss patients falls risk with patient/family/carer
- Ensure falls risk management is included as part of regular hand over
Falls Risk Assessment

• All patients with falls risks require further assessment

• Falls Risk Assessment tool

Falls Risk Assessment & Management Plan (FRAMP)

• Complete and implement the appropriate action/s
Falls Risk Assessment

Complete and implement the appropriate action/s in the FRAMP from the falls risk factor/s identified in the Ontario Falls Risk Screen

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<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Action</th>
<th>Date</th>
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<tr>
<td>1. History of Falls</td>
<td>Implement a Falls Risk Assessment and Management Plan (FRAMP)</td>
<td>Date</td>
</tr>
<tr>
<td>2. Mental Status</td>
<td>Complete or refer for a Falls Risk Assessment and Management Plan (FRAMP)</td>
<td>Date</td>
</tr>
<tr>
<td>3. Use of Medication</td>
<td>Complete or refer for a Falls Risk Assessment and Management Plan (FRAMP)</td>
<td>Date</td>
</tr>
</tbody>
</table>

FRAMP:
- Complete the FRAMP for each patient.
- Review the FRAMP at least every 6 months or as needed.

Additional Comments:
- Provide patient education on falls prevention.
- Encourage active participation in daily activities.
- Monitor progress and adjust the FRAMP as necessary.

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Falls Risk Assessment and Management Plan (FRAMP)
How to use the FRAMP

• Falls risk factor/s identified in falls screen - implement the appropriate action/s in the FRAMP

• Complete on admission, review after a fall, change of condition or when appropriate

• Use clinical judgement to inform care plan
  – develop care plan in consultation with patient/family/carer

• Date and initial actions undertaken and sign form when completed
  – use ‘Comments’ sections for additional information

• Document referrals, necessary actions in patient health record

• Communicate relevant actions/strategies at handover.
Communicate falls risk

- At staff-handover and change of shift
- Document falls risk in patient care plan
- Alert in notes/by bed - e.g. falls stickers
- Discuss falls risk with patient/family/carers & involve in care planning
CEC Post Fall Guide

• The causes of falls are complex
• Post fall assessment and management with clinical review will help reduce the degree of harm to the patient
• A post fall ‘huddle’ is encouraged for staff to review the incident and facilitate appropriate falls prevention strategies
CEC Post Fall Guide

The post fall guide aligns with the CEC
Between the Flags program

Between the Flags
Keeping patients safe
A statewide initiative of the Clinical Excellence Commission
CEC Post Fall

CEC POST FALL GUIDE

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Emergency Response Systems and if at any time a staff member is concerned about a patient they can call for a Clinical Review.

Basic life support
Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABC)

Rapid assessment
Pain: Bleeding, Injury, Fracture
Do not move until assessed: examine cervical spine and immobilise if there is an indication of injury

Observations
BP, P, T, SpO2, Pain Score, Neuro Observations, RGI (if indicated)

• At least hourly for a minimum of 4 hours
• Every 4 hours for the next 24 hours or as clinically indicated, then
• Review ongoing observations as required

Check for SeppiS
• Does this patient have separable risk factors or signs of symptoms of infection?
• Yes Follow SeppiS Pathway
• No Continue Care

Check for Delirium
• Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion?

Check for Head Injury
• Does this patient have a head injury?

Ongoing Observations and Monitoring
BP, P, T, SpO2, Pain Score, Neuro Observations, RGI (if indicated)

• At least hourly for a minimum of 4 hours
• Every 4 hours for the next 24 hours or as clinically indicated, then
• Review ongoing observations as required

Communicate

• Measure the patient and explain all treatment and investigations.
• If all patients fail to be reported to medical officer for review.
• Notify the person responsible (family/carer/friend) with permission and inform them about the fall.
• If the person is not able to communicate effectively engage with the substitute decision maker.
• Discuss appropriate treatment options and clarify if there is an Advance Care Directive in place - symptom management is important.
• Implement plan of care and inform staff of care plan.
• Communicate at clinical handover - observations, falls risk and interventions in place.

Document

• Treatment, palliation/resuscitation process and outcome documented in the clinical record.
• Change falls status to: HIGH RSK and record in clinical record and complete revised care plan.
• Complete INM report and note incident and INM number in the clinical record.
• Complete a review of fall event with ward clinical leadership team.
• Complete CEC Incident Review for any serious injury/outcome from fall.

Post Fall Management

- Notify fall in the Incident Information Management System (IIMS)
- Notify family/carers
- Serious falls to be investigated and recommendations implemented
Post fall incident reporting - IIMS
SAC2 Fall Incident Investigation Form

- Gather information about the fall incident
- Help identify human & system factors & process issues
- Guide recommendations to prevent further falls
Transfer of Care/Discharge planning

Communicate falls risk status and care plan to:

- Patient/family/carer
- GPs
- Residential Aged Care facilities
- Community Health Services: nursing, allied health
- Other health providers
- Community Service Providers
- Physical activity provider

www.activeandhealthy.nsw.gov.au
Falls Policy
PD2011-029

NSW Health Prevention of Falls and Harm from Falls among Older People 2011-2015
Falls best-practice guideline

Preventing falls and Harm from Falls in Older People

• Guideline
• Guidebook
• Implementation guide

Australian Commission on Safety & Quality in Health Care

www.safetyandquality.gov.au
CEC Falls Prevention Resources

Hospital Falls Prevention Strategies

Available from CEC website
CEC Falls Prevention one page flyers for patients and consumers


Healthy eating

In Hospital

Home exercises

How to get up if you have a fall

Foot care and safe footwear

Eyesight

Medications

Bone health

In public places

Strength and balance exercises
CEC Falls Prevention one page flyers for patients and consumers.


- Home Safety
- Information for those at risk of a fall
- Information following a fall at home
- Discharge information following a fall
- Key messages for maternity units
- Maternity services
- For children in Hospital
- In Progress
A selection of falls prevention flyers are available in:

- Arabic
- Simplified Chinese
- Traditional Chinese
- Vietnamese
- Greek
- Italian
www.activeandhealthy.nsw.gov.au

Find an exercise program

All programs include strength and balance exercises to help prevent falls
Resource booklet

*Staying Active and On Your Feet*


- Health and lifestyle checklist
- How to get up from a fall
- Exercises to do at home
- Home safety checklist
NSW Falls Prevention Network

- Network list serve
- Newsletters & updates
- Annual Network forum

http://fallsnetwork.neura.edu.au
Thank you

For further information:

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www.cec.health.nsw.gov.au