SELF DIRECTED LEARNING PACKAGE

PATIENT FALLS PREVENTION AND MANAGEMENT

2 CPD Points

DIRECTIONS

1. Read Self Directed Learning Package

2. Complete Competency Assessment on eLearning

3. Record completed education program on your CPD record sheet

4. Further resources*:*

    - Healthscope Intranet*: Hospitals/ClinicalCluster/Falls Prevention/Falls Prevention Cluster* – resources and useful reading

    - Falls Risk Assessment Measures: An Analytic Review
    - Falls Risk Assessment Tools Compared with Clinical Judgement: An Evaluation in a Rehabilitation Ward Generic Falls Patient Info 2011V5
    - "Predicting Patient Falls" Resource Part 1
    - "Predicting Patient Falls" Resource Part 2
    - "Stop the Drop" Education Package
    - The Effect of Changing Practice on Fall Prevention in a Rehabilitative Hospital: The Hospital Injury Prevention Study
    - "When a Fall Occurs" Resource

    - Healthscope Policy 8.04: Patient Falls Prevention and Management Tool

    - Healthscope Falls Risk Assessment and Management Tool HMR 7.9

The Falls Prevention and Management Program was developed to support all Healthscope hospital sites to reduce the number of patient falls, and minimise the risk of potential falls to our patients. The program also supports the education of patients, carers/family and staff. The Healthscope Falls Prevention Cluster, a national working party of Quality Managers, Allied Health Professionals and Clinical Nurses has developed a suite of falls prevention and management tools, patient brochures, education programs and regularly audits and review falls incidents on behalf of Healthscope.

The overall aim of the Healthscope falls prevention program is to maintain the function and quality of life of our patients as it was on admission and minimise the risk of harmful falls while in hospital.

1. INTRODUCTION

1.1 Definition of a Fall

A fall is an event, which results in a person coming to rest inadvertently on the ground or floor or other lower level **(Healthscope Policy 8.04 Falls Prevention and Management-Patient)**

1.2 Best Practice Guidelines

Best Practice Guidelines have identified three key components of falls prevention:

- Risk Identification
- Falls Prevention
- Injury Prevention Strategies/Interventions

1.3 Background

Falls are the leading cause of injury requiring hospitalisation in elderly people, and may account for 69% of trauma admissions. 40% of older people who experience a fall, fall more than once.

The potential consequences of falls are well documented in the literature. Costs to the patient include diagnostic procedures, surgical interventions and loss of confidence and independence. Costs to the hospital include extended length of stay and increased risk of litigation.

Research suggests that approximately 30% of people over the age of 65 years fall each year. Stevens et al (2006, P 290) states that "*Non-fatal injuries are associated with considerable morbidity including decreased functioning and loss of independence as well as significant use of healthcare services*".

Many falls in hospital can be prevented. Older patients in hospital are at a greater risk of sustaining a hip fracture as a result of a fall than people of the same age living at home.

In hospital the reported rate of falls incidents is approximately 3 times the rate of people living in the community. Half of all older people hospitalised for hip fractures cannot return home or live independently after their injury.

1.4 Falls Prevention

In order to prevent falls in the hospital setting, staff must:

- Be aware that falls are a problem
- Acknowledge that many falls can be prevented
- Understand the risk factors
- Implement assessment protocols
- Put prevention strategies in place when necessary

Early identification of the risk of falls must be a collaborative effort involving hospital staff, patients and their families. This can occur through thorough history taking, early orientation of patients to their environment, early assessment of care needs and providing a safe environment. Through ongoing review of falls risk, and the use of incident reporting as a descriptive tool, problem solving for recurrent fallers can occur.

1.5 Consequence of Falling

The consequences of falling for a patient may include:

- Physical injury
- Restriction of activity – short or long term
- Functional deterioration
- Increased risk of pressure injury (as result of lying on the ground for extended periods)
- Loss of confidence and independence
- Fear of falling in the future
- Becoming a 'Frequent faller'
- Pain

It is known that an injury persists in 20-40 % of patients who fall.

2. RISK IDENTIFICATION

It is very important that falls risk assessment, and the implementation of falls prevention strategies occur early in the admission process and become part of the ongoing care that is planned and delivered for the patient. In order for this to happen, all relevant health team members must communicate effectively to ensure the appropriate assessment and referral procedures are followed.

Ongoing evaluation and re-assessment is required to ensure that the patient's needs are being met, and that the strategies in place remain effective as patient conditions change.

Barriers to effective delivery may arise due to:

- Poor communication between team members at clinical handover
- Changes in patient condition or treatment
- Changes in patients ward environment
- Workload and skill mix of staff caring for patients
- Poor documentation of falls risk and management interventions
- Poor assessment skills of staff
- Issues with flagging or identifying patients at high risk

2.1 Assessment for Falls Risk

Healthscope Policy 8.04 – Falls Prevention and Management-Patient

All patients will be assessed and reassessed for falls risk using the:
Healthscope: **FALLS RISK ASSESSMENT AND MANGEMENT TOOL** (**FRAMT HMR 7.9)**

2.2 Successful Assessment Tools

The following characteristics of successful tools have been documented in the literature:

- Open and flexible enough to incorporate the risks of a wide range of other disease states and conditions
- Quickly differentiates and identifies those who are at an increased risk of falls and fall related injures
- Quick and simple to use

2.3 Minimum Data Set

It is difficult to capture every known falls risk factor in one tool, while also keeping it simple and easy to use. The falls risk tool should only flag those patients at a high risk of falling who would benefit from additional strategies being put in place, and not capture too large a target group.

Factors reported in the literature as being important indicators of heightened falls risk include:

- History of falls at home or within the person's regular environment e.g. social club, shopping centre, public transport, regular walking route
- Confusion or altered mental state
    - Depression can decrease attention span and reduce concentration
    - Anxiety can cause sleep disturbance, irritability and poor concentration leading to syncope and falls
    - Those with cognitive impairment may have difficulty recognising risks and decreased problem solving ability, leading to problems interacting safely with the environment
- Sensory impairment
- Altered urinary or bowel symptoms
- Mobility/balance impairment
    - Poor balance and gait can contribute to fear of falling
- Medication
- Syncope
- Postural hypotension
- Number of days since admission
- Age
- Nutrition / Weight / Calcium intake
- Altered sleep patterns
- Visual impairment
- Chronic illness
- Incontinence

2.4 Healthscope Falls Risk Assessment and Management Tool

The Healthscope Falls Risk Assessment and Management Tool (**HMR 7.9 FRAMT**) has been developed by the Falls Prevention Cluster and is based on best practice and the latest research.

The tool is to be completed at the following times:

- **At the time of patient admission/transfer**
- **Post surgery/procedure**
- **Following change in physical or psychological condition**
- **Following a fall**
- **A change in ward/room**
- **Weekly in the rehabilitation environment**
- **Daily if the patient is deemed a high risk of falling and condition is erratic**

The FRAMT allows the nurse to document the patient risk assessment and management intervention strategies on the one form. The risk score ratings are low (1 -3), medium (4-5) and high (6-10). The implementation strategies are listed for each risk rating category.

Once a patient is identified as being at **HIGH** risk of falling, a multidisciplinary, multifaceted approach is required. Interdisciplinary approaches to care help to promote a holistic appraisal of the patient's individual and comprehensive needs.

Effective communication is important between members of the health team, as input is required from a wide variety of sources.

Medical Staff

- To assess and review patient condition, treatment and medication

Nursing Staff

- To plan, implement and review strategies, implement referrals, educate patients and relatives and encourage use of injury prevention strategies

Allied Health Professionals

- To implement education programs about falls, exercise programs, conduct mobility assessments and provide assistance with use of mobility aids

- To assess and improve patient's hospital environment, use of aids for activities of daily living, and provide patient/carer education on falls prevention strategies

Clinical Pharmacist (if on staff)

- To review medications in conjunction with the treating Medical Practitioner and, provide guidelines on the usage of medications

Podiatrist (if available)

- To assess, review and treat foot problems identified for a patient

Family and Relatives

- If appropriate to the Hospital site (for example, rehabilitation hospitals) information on falls at home and assessment of the home environment may be provided to family members/carers
- Discharge planners and social workers have access to Government funded brochures on the prevention of falls & safety in the home for patients and family members

2.5 Documentation

An individual patient's falls risk status and appropriate falls prevention strategies must be documented on the **Healthscope Falls Risk Assessment and Management Tool HMR7.9** and on the nursing care plan/pathways.

If the patients mental or physical condition changes the falls risk assessment tool must be reviewed, and the care plan revised for the patient. This is particularly important if the patient has a fall or there is a substantial change in the patient condition.

2.6 Education

Education is important for health care professionals, patients and family/carers.

The goal is to increase the awareness of falls risks and prevention strategies, thus helping to decrease the number of falls and injuries resulting from falls. Education may improve the patient's self-confidence, therefore reducing the fear of falling.

The **Healthscope 'Keeping A Step Ahead of Falls'** brochure is provided to patients at moderate or high risk of falling, or any other patient who may benefit from the information e.g. all patients admitted into the rehabilitation setting. Some of the information may be useful to the patients at home. The patient's family/carer will be provided with a brochure if the patient is unable to read or cognitively understand the information at the time.

Rehabilitation Hospitals within Healthscope provide Education Sessions on falls management to inpatients on a formal and regular basis. These are usually advertised via a timetable scheduled available to each ward and are usually conducted by an Allied Health professional.

3. FALLS PREVENTION STRATEGIES

3.1 Medication

Medications have been identified as a modifiable risk factor. All patients need to be evaluated regarding the need for continued use of therapeutic agents and for falls risks.
The use of 4 or more medications has been linked to an increased risk of falls and up to a 9 fold increase in risk of cognitive impairment.

To lessen the risk of falls:

- Medication should be reviewed by a Medical Practitioner, in consultation with Pharmacist:
  - On admission
  - Whenever there is a change in medication including dose adjustment
  - At discharge
- Documentation should include:
  - Outcome of the medication review for falls assessment following each review
  - Patient education regarding the effects of medication including any methods for avoiding falls
- Patients taking drugs causing dehydration (diuretics and laxatives) need to be monitored as risk is increased
- Simplification of medication regimens should occur where possible

3.2 Foot Wear

Many older people wear poorly fitting shoes, believing them to be adequate. Identifying and addressing foot impairment and/or inappropriate footwear in older people may assist in the prevention of falls.

Safe Shoe Checklist

Heel	▪ Have low heel to ensure stability and better pressure distribution on the foot ▪ Have broad heel with good ground contact ▪ Have firm heel counter to provide support for the shoe
Sole	▪ Have cushioned, flexible, non-slip sole ▪ Rubber soles provide better stability and shock absorption than leather soles
Weight	▪ Shoe be solid but of light weight
Toe box	▪ Have adequate width, depth and height in the toe box to allow for natural spread of the toes
Fastenings	▪ Have laces, buckles, elastic or Velcro to hold the shoe securely onto the foot
Uppers	▪ Be made of accommodating material
Safety	▪ Protect the feet from injury

Shape	▪ Be the same shape as the feet, without causing pressure or friction on the foot
Purpose	▪ Be appropriate for the activity being undertaken ▪ Slippers generally provide poor foot support and may only be appropriate when sitting

Allied Health Team (If available)
To review and improve patient's hospital environment, use of aids for activities of daily living e.g. **Grip Socks**

- Patients at high risk of falling (score of 6-10 on the scale), should be assessed specifically for the consideration of providing them with a pair of grip socks, if suitable 'safe' shoes are not available
- Importantly, grip socks are NOT appropriate for ALL patients at high risk of falling, due to individual gait pattern variations and abnormalities. A Physiotherapist or Nurse is therefore designated as having the ultimate decision as to which patients will be provided with these socks.

Podiatrist (If available)

- To assess, review and treat foot problems identified in patients

3.3 Exercise

Modifiable falls risk factors in older people include impaired balance and loss of muscle strength. It is generally agreed that a broad based program that includes balance training, muscle strengthening and low impact fitness training is most effective in reducing falls.

Allied Health Team (if available) or Physiotherapist

- To implement education programs about falls, exercise programs, mobility assessment and assistance with use of mobility aids

3.4 Continence Management

Incontinence has been identified as a risk factor for falls. Incontinence may increase the risk of falls due to the patient needing to make multiple trips to the toilet. Often performing a secondary task, such as walking and concentrating on getting to the toilet is difficult for the patient.

The key to preventing falls related to incontinence is to undertake a thorough patient assessment aimed at identifying and managing or treating factors causing incontinence.

Potential causes of incontinence:

- Urinary frequency from urinary tract infection / sepsis
- Urinary frequency post prostate surgery in men – falls occur by the bedside with men trying to use the urinal and needing to stand
- Voiding issues post gynaecological surgery

Interventions to assist the patient include:

- Regular 2nd hourly toilet rounds
- Ensure walking aids (if appropriate) are close by
- Ensure the call bell is close to patient at all times
- Lower bed to lowest point at all times
- Ensure vision/hearing is not compromised and glasses/hearing aids are available and working
- Ensure patient has suitable footwear in place and that it is always worn when mobilising
- Ensure regular toileting program (may be more frequent than 2 hourly) is in place for patients who have frequency, incontinence or who are confused
- Bedside commode (if appropriate)
- Discuss patient health concerns with the treating Medical Practitioner for possible treatment options
- Stay with patients at high risk of falls whilst patient is in bathroom/toilet
- Involve and educate the family/carer in falls prevention (where appropriate)

3.5 Nutrition Management

Evidence suggests that malnutrition can increase the tendency of falls. Malnutrition is common in elderly patients. It is frequently associated with decreased muscle mass, weight loss, weakness and gait abnormalities, all of which can increase the risk of falls.
Studies have shown that elderly patients may be at high risk of Vitamin D deficiency.

Nursing staff can assess the current nutrition status on admission for all patients with a planned stay of longer than 24 hours by completing the tool - **Screening Your Patient for Malnutrition HMR 7.6B**. This reviews any weight loss in the last 6 months and documenting the patient's dietary intake. By utilising this form and its simple scoring guide, a need for referral to a dietitian can be determined and the Nurse Manager should be consulted for follow up of an appropriate referral. This result is recorded in the progress notes as well as on the form HMR 7.6B.

Some patients may be placed on a Food and Fluid chart (HMR 7.6A) for continuous monitoring for a period of time and further assessment. Any outstanding abnormality or concern should be flagged with the treating Medical Practitioner as a referral to a Dietitian may be arranged.

Patients are weighed on admission and then weekly, and more frequently if their clinical condition dictates otherwise. (Healthscope Policy 8.27 Dietary and Nutritional Requirements)

Nursing staff must ensure that patients are prepared for each meal and supported at meal times to manage the meals, packets and utensils in order to enjoy the food provided by the hospital.

Allied Health
The role of the dietitian (and sometimes other allied health professionals such as the Speech Pathologist) is to:

- Review patient's appetite – Average? Poor? Nasogastric tube required?
- Review oral intake and ability self-feed – Does the patient have poorly fitting dentures? Do they have difficulty chewing or swallowing? Do they required thickened fluids or pureed food?
- Recommend supplements that may help to increase patient's nutrition levels

3.6 Environmental Hazards

Environmental trip hazards may include:

- Loose cords on the floor
- Wet or slippery floors
- Poor or glary lighting
- Beds or chairs without brakes or brakes engaged
- Bathrooms without handrails
- Walking in TED stockings without slippers/shoes/grip socks
- Gate aides and other equipment not positioned safely

Staff should try and minimise the environmental risks for the patient. This includes checking that hospital equipment such as walking frames, shower chairs and wheel chairs, are in good working order. Any items requiring repair should be decommissioned, isolated, tagged and reported to maintenance.

3.7 Injury Prevention/Intervention – Communication/Documentation

Appropriate falls prevention interventions are determined by the score rating derived on the Falls Risk Assessment and Management Tool (HMR 7.9 FRAMT). The staff member assessing/ reassessing the patient must sign and date when the assessment occurs on the FRAMT.

The assessing nurse should advise and discuss management strategies with the Nurse Unit Manager and/or Team Leader in liaison with the Allied Health Team (if available) for all patients who have been rated into the High Falls Risk category.

A patient's falls risk category must be clearly communicated and documented to all staff providing care to the patient via clinical handover, patient communication boards at the bedside and in pathways and/or clinical progress notes.

Staff are required to maintain patient confidentiality when communicating information related to patient falls risk status by verbal or visual means. The communication should be adequate enough to ensure that staff are aware of a patient's risk of falling, while still respecting their privacy.

4. POST FALL MANAGEMENT

Clinical judgement must be used at all times when assessing a patient after a fall in order to determine the post fall care or intervention that may be necessary.

4.1 How to assist the patient up after a fall

NOTE:
If the patient cannot get up off the floor with minimal assistance from one staff member then you MUST USE THE MECHANICAL LIFTER / HOIST.

Stand-by supervision

Preparation

- Before moving a patient from the floor, the Registered Nurse / Enrolled Nurse must check the patient for injures
- If in doubt or the patient appears to be injured, seek a second nurse for opinion. A medical review and / or a mechanical lift maybe necessary.
- If there are no injuries, reassure the patient and allow the patient to regain composure before attempting to get up

Raising – Get the assistance of a 2nd person

- When the patient is ready, ask them to roll onto their stronger side
- Ask the patient to push themselves up onto all fours
- Hold a chair firmly in front of the patient to they can pull themselves up and then turn and sit on the chair

Walk Belt Lift

Preparation

- Before attempting to assist the patient to get up, the Registered Nurse / Enrolled Nurse must check the patient for injuries and assess if the patient is capable to use this method.
- Each Nurse involved must be competent in using this equipment

The Lift

- When the patient is ready, roll the patient from side to side to place the belt under the patients waist
- Ask the patient to roll onto their stronger side
- The patient should then push themselves up onto all fours with the assistance of a staff member holding the belt
- Seek the assistance of another staff member to place and hold secure a chair so the patient can pull themselves up with the guidance of a staff member holding onto the belt
- When the patient is standing they can be turned around and sat in the chair

Mechanical Lifter

Preparation

- Before moving a patient from the floor, the Registered Nurse / Enrolled Nurse must check the patient for injuries
- Before utilising the lifter check it is working, has a safe weight limit and can accommodate the patients weight, and has power to operate (battery is charged)
- Check that the environment is safe to use the lifter. You may need to use a slide sheet to move the patient to a bigger area or you may need to move furniture out of the way to give you more room.
- Lock the brakes of furniture that you are moving the patient to prevent the furniture moving away from the patient.
- Each nurse involved must be competent in using this equipment

The Lift

- Reassure the patient that they will be safe and secure while being lifted
- Use the lifting machine according to manufacturer guidelines
- Raise the patient a few centimetres and recheck attachments
- Never leave the patient suspended in the lifter. The Nurse should always stay with the patient until the patient is safely lowered onto the bed / trolley.
- Always lower the boom when transferring patients
- Always remove the straps from hoist before the patient

4.2 Patient Care Post Fall

Clinical judgment is used at all times when assessing an individual's fall to determine the post- fall care that may be required.

The Visiting/Treating Medical Officer must be informed of the fall, and a Medical Practitioner must review the patient within 24 hours if clinical observations indicate the need, or earlier as required. Ongoing falls prevention strategies will be derived according to the individual patient's Falls Risk Re-Assessment score.

Other guidelines include:

- Any patient who suffers a **head injury** as a result of a fall **must not be administered narcotic analgesia**.
- **All patients** who have a fall must have the following observations taken:
  - A complete set of neurological observations
  - Routine vital sign monitoring
  - Neurological observations to be performed half-hourly for 4 hours for any patient who has had an UNWITNESSED fall and who has no visible sign of head /facial injury

- A head/facial injury may or may not be instantly apparent as sometimes
  - bruising, swelling or a lump manifests itself later in less visible areas
    - e.g. under scalp or facial hair.
      - Physically and visually checking for a manifesting
        - Head/ facial injury is to occur for at least 1 hour after the injury

        - Oxygen saturation if clinically indicated
        - Blood glucose assessment (as relevant)
    - Patients who sustain a **head injury with no loss of consciousness**:
        - Half-hourly neurological observations for 4 hours post incident or until reviewed by the treating Medical Practitioner
        - Unit review by treating Medical Practitioner
        - A head X-ray or CAT scan as ordered by the treating Medical Practitioner
        - A head CAT Scan if the patient is currently on anticoagulant therapy, if requested by treating Medical Practitioner
    - Patients who sustain a **head injury with loss of consciousness**:
        - Review by treating Medical Practitioner
        - Half-hourly neurological observations for 4 hours, followed by hourly neurological observations until reviewed by the treating Medical Practitioner
        - A head X-ray or CAT scan as ordered by the treating Medical Practitioner
        - A head CAT Scan if the patient is currently on anticoagulant therapy

Also ensure:

- RiskMan Incident entry
- Documentation - ensure that the Medical Record contains detailed facts about the fall.
- **Falls Risk Re-assessment**
- Next of Kin notified
- Communicate to all staff the incident, the outcomes and the revised care plan
- A patient who deceases after a fall (and in Victoria within 12 months of a fall) is referred to the Coroner.
- Ongoing falls prevention strategies

4.3 Falls Reporting

RiskMan is the Healthscope Incident notification database for reporting all incidents involving patients. Reports are able to be compiled from the database and the information reported to internal and external authorities.

All falls that occur must be entered into Riskman as an "incident related to" the National Standard 10. The Falls Extension Data Entry must also be completed.

The number of falls that occur are reported at each site via Quality and/or Patient Care Committees (however named), and internally to Healthscope corporate via the Quarterly Quality Report.

A Falls Summary can be found for Healthscope Hospitals within the public domain on the MyHealthscope website. Falls incidents are also reported to external government agencies and health funds including:

- Department of Veteran Affairs (DVA)
- Department of Health (however named in each state)
- Health Quality and Complaints Commission (however named in each state)
- Australian Council on Healthcare Standards (ACHS) – Clinical Indicators

Entering Falls Incidents into RiskMan

Accurate documentation of the fall is required including:

- Patient details, including:
    - Date and reason for admission
    - Diagnoses
    - Falls Risk Assessment on admission
    - Comorbidities – list all
    - Medications – list all
- Health fund
- Incident date and time
- Details of the actual incident and action taken at the time and people notified i.e.: Medical Practitioner, family, Hospital Co-ordinator as relevant
- Risk status prior to fall and prevention strategies in place prior to fall.
- Reporter's name and any witnesses to the fall such as family, visitor, patient
- Time last seen prior to fall, by whom (name and status), doing what and where
- Activity at time of fall
- Exactly where patient found, in what position, and surrounding environment
- How moved after fall and to where and by whom
- Immediate and subsequent treatment - first aid to skin tears, x-ray, CT Scan
- Observations/vital signs after fall (and prior to fall if relevant)
- Exact details of any injury sustained; treatment of each injury; and outcome of each injury
- Control implemented – what additional strategies were implemented to prevent a fall. Falls risk rating after review and reassessment of patient.

- Investigations - how it happened
- The patient may decease at time of fall, or within hours/weeks/months. The Coroner must be notified if the death is considered to be in any way related to the fall.

Reporting a fall using RiskMan does not replace the need to document the event in the patient's Medical Record, and update the nursing care plan. **DO NOT** include RiskMan # or mention of RiskMan documentation in the Medical Record.

References

- "How to Stay on Your Feet" QLD Health April 2011
- Queensland Health. *Falls Prevention: Best Practice Guidelines for Public Hospitals and State Government Residential Aged Care Facilities*; 2003; Available from: http://www.health.qld.gov.au/fallsprevention/best_practice/default.asp.
- Australian Commission on Safety and Quality in HealthCare : Falls Prevention Guidelines
- Australian Commission on Safety and Quality in Health Care : Fall Facts for the Elderly
- Government of South Australia: Falls and Fall Injury Prevention and Management Policy. June 2013.
- Healthscope 'Keeping A Step Ahead Of Falls' brochure updated 2013
- Healthscope Policy 8.04 Falls Prevention and Management – Patient - 2014
- Shared Learning Report January –March 2014-National Clinical Risk Team Report
- HMR 7.9 Falls Risk Assessment and Management Tool
- HMR 7.6 B Screening Your Patient for Malnutrition
- Healthscope Policy 8.27 Dietary and Nutritional Requirements, 2013

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- Geelong Private Self Directed Learning Package
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- Healthscope's National Clinical Risk Team