St. Mary's Hospital

Phoenix Park, Dublin 20

Policy No. 12

Falls Prevention Policy (Nursing)

Department: Nursing

Approved By

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Table of Contents PG.

Policy

St. Mary's Hospital recognises that falls present a significant risk to long-term health. In view of this, St. Mary's Hospital is committed to reducing the risk of falls for all people who avail of services in the facility. All Patients/Residents in St. Mary's Hospital who have had a fall in the last year must be assessed using a Falls Risk Assessment Chart, Fall Risk Reduction Care Plan and a Falls Monitor Record, which upon completion are included in the individual nursing care plan.

Aim

This policy aims to:

- Raise the awareness of techniques to reduce the risk of falls to the patients/residents in St. Mary's Hospital
- Provide the nursing staff with the tools to identify the person who is at risk of falls and prevent further falls in persons who have had a fall either before or after admission to St. Mary's Hospital.

Purpose

To minimise the risk of falls within St. Mary's Hospital.

Objective

To ensure a comprehensive assessment is completed and interventions are put in place to minimise the risk of falls.

Definition

'A fall is an incident in which a patient/resident suddenly and involuntarily comes to rest upon the ground or surface lower than original station.'

Guidelines

St. Mary's Hospital recognises that falls are a main cause of injuries in the older person. People with dementia or acquired brain injuries are especially vulnerable regardless of their age. Therefore, St. Mary's Hospital has put in place guidelines that will inform practices in reducing the risks of falls. Furthermore, the incidence of falls will be audited on an ongoing basis to ensure the effectiveness of this policy.

Nursing Responsibilities

1. On admission each Patient/Resident will have a Falls Risk Assessment Chart completed see **Appendix 1.**

Note: An educational poster entitled Falls: the assessment and prevention of falls in older people, Clinical Guideline 21 available in every ward/department will assist nursing staff with their assessment.

1.1 Using the Falls Risk Assessment Chart, the risk score is totalled.

1.1a The score of 0-24 indicates low risk and the Patient/Resident's care is maintained at the present status.

1.1b The score of 25-51 indicates the Patient/Resident is at a high risk of sustaining a fall or falling again, the nurse must initiate the Falls Risk Reduction Care Plan see **Appendix 2.** and implement measures to reduce the risk of further falls.

2. If a Patient/Resident has a fall after admission:

2.1 The Nurse assesses the Patient/Resident for any apparent injuries, if there are injuries the Patient/Resident is made comfortable and the Doctor on call is notified.

2.2 When moving a Patient/Resident with a suspected injury the Nurse must apply First Aid (as necessary) and the Patient/Resident is moved according to Manual Handling Guidelines. The Nurse may contact a Manual Handling Instructor if unsure of the safest technique to employ.

2.3 In the advent of a suspected Spinal Cord Injury or in the case of severe injury the Ambulance Service must be contacted.

NOTE: *If there are no apparent injuries the following steps are taken:*

3. If the Patient/Resident is able to rise off the floor with minimal assistance the Nurse/Care assistant may assist the patient.
   - **3.1** If the patient is unable to rise off the floor, the patient is hoisted onto either a chair or a bed.
   - **3.2** The Doctor on call, Nursing Administration and the Family/Next of Kin are all notified by the nurse in charge
   - **3.3** An Incident form is completed and the top two copies are forwarded to Nursing Administration.
4. All falls and near misses must be documented on the Falls Monitor Record *see* **Appendix 3.** The time of day when the fall/near miss occurs must be shaded on the 24 hour clock on the Falls Monitor Record, Black ink for a near miss and Red ink for an actual fall.

5. Low Risk Interventions
   - **5.1** Ensure wheels are locked on the bed and wheelchair at all times.
   - **5.2** Assess the Patient/Resident's co-ordination and balance/gait before assisting with transfers and mobility activities.
   - **5.3** Assess Patient/Resident's footwear and refer to the Physiotherapy Department if necessary.
   - **5.4** Ensure the Patient/Resident wears footwear when out of bed.
   - **5.5** Ensure the Patient/Resident's ambulatory aids are accessible.
   - **5.6** Ensure the Patient/Resident's bedside/ward environment is free from obstacles.

References

Cooper G. (2003) Developing an evidence-based approach to falls-risk assessment. *Professional Nurse* **19**(1), September, 19-23.

Moreau D. (2003) ***Elder Care strategies: Expert Care Plans for Older People.*** Springhouse, P.A. Lippincott, Williams and Wilkins.

National Institute for Clinical Excellence (2004) ***Clinical Guideline 21, Falls: the assessment and prevention of falls in older people,*** **National Institute for Clinical Excellence.**

Oliver D., Britton M., Martin F., Hopper A. (1997) Development and evaluation of an evidence-based risk assessment tool (STRATIFY) to predict which elderly inpatients will fall: case control and cohort studies, *British Medical Journal*, **315:** 1049-1053.

Tucker S.M., Canobbio M.M., Paquette E.V., Fyfe Wells M. (2000) ***Patient Care Standards: Collaborative Planning and Nursing Interventions.*** St. Louis: C.V. Mosby.

Appendix 1.

St. Mary's Hospital
Falls Risk Assessment Chart

Patient's Name: _____ Date: __ / ____ / 20__

Chart Number: _____ Ward: _____

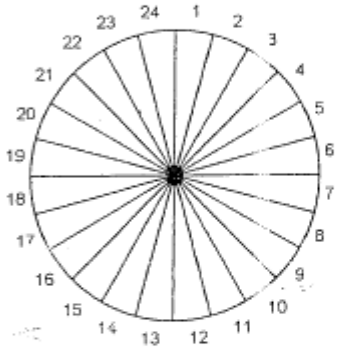
Question 1. History of falls	☐ Yes	☐ No
If yes, please complete the following section		
If yes; score=25	If no; score = 0	

When did the fall(s) begin?
☐ Prior to admission
☐ On admission
☐ > 1 week ago
☐ > 1 month ☐ > 6 month
☐ > a year

How often have the falls occurred?
☐ Once ☐ More then once daily
☐ Daily ☐ twice a week
☐ weekly
☐ Not a regular occurrence

Time of day the falls occur.

Please shade the areas of the 24 hour clock



Where do the fall(s) occur?
You may tick more then one box
☐ Bedside ☐ Toilet
☐ Corridor ☐ Dayroom

What are the contributing factors?
☐ Weakness ☐ Dizziness
☐ Visual Impairment
☐ Medication ☐ Cognition
☐ Safety awareness/ attitude
☐ Continence Status
☐ Identified hazards
Document Details in the Nurse's Narrative Notes

Ambulatory Aid:
☐ None, bed rest, wheelchair, nurse assist
score=0
☐ Crutches, cane, zimmer frame
score=15
☐ Uses Furniture
score=30

Postural Observations
(If the patient is able)
Lying B/P
Sitting B/P
Standing B/P

Gait/Transferring	
	Normal, bed rest, immobile; score=0
	Weak; score=10
	Impaired; score=20

Mental Status
Oriented to own ability; score=0
Overestimates, forgets limitations; score=15

Secondary Diagnosis *(Is there more than one med. diagnosis is listed?)*	
	Yes; score=15
	No; score=0

Other:

Referrals:	
	☐ Medical Team; date:
	☐ Nutritional Advisor; date:
	☐ Physio Therapist; date:
	☐ Occupational Therapist; date:

Total score:

Assessing Nurse's signature: _____

Score	Risk	Action
0-24	Low	Maintain present care
25-51	High	Initiate Falls Risk Reduction Care Plan

The patient who is in the high risk category is reassessed monthly and the Care Plan is renewed every six months

Appendix 2.

St. Mary's Hospital
Falls Risk Reduction Care Plan

Patient's Name: _____ Chart No. _____ Ward _____

The nurse may use the predefined Patient Problem and Desired Outcome or may write their own in the space provided

Patient's Problem

The patient is at risk of injury due to ☐ poor balance ☐ potential falls ☐ history of falls

Desired Outcome

The patient will ☐ be free from injury ☐ be free from falls ☐ have the risk of falls reduced

Please tick the appropriate boxes of the interventions to reduce the risk of fall in this patient

Interventions

Wheels on the bed must be kept locked at all times

Referred to Physiotherapist for ..... ☐ Strength and Balance Training ☐ Seating Assessment
Date: / / 20 By: (Initials) ☐ Foot wear assessment

Referred to Occupational Therapist Date: / / 20 By: (Initials)	Referred to Nutritional Advisor Date / / 20 By: (Initials)
Referred to Chiropodist Date: / / 20 By: (Initials)	Referred to Optician Date / / 20 By: (Initials)

Medication reviewed by doctor (Doctor's Name) Date: / / 20

☐ Identified Hazards reduced; please document in Nurse's Narrative Notes Date: / / 20

☐ Hip Protectors; size:	☐ When out of bed	☐ at all times
☐ Ambulates with a Zimmer Frame	☐ Commode at bedside during the night	
☐ Restraint; must have Restraint Care Plan	☐ Cot sides up	☐ Seatbelt on in wheelchair
☐ Patient's bed closer to the toilet	☐ Raised toilet seat	☐ Uses grab bars

☐ Position chairs in the corridor to enable patient to rest while ambulating

☐ Patient / Family education; Date: / / 20	please document in Nurse's Narrative Notes
☐ Bed in lowest position while patient is in bed	☐ Ensure patient's trousers are not too long and fit well
Type of footwear	Type of Chair ensure wheels are locked

* The evaluation of the effectiveness of the interventions must be documented weekly in the nurse's narrative notes
* An actual fall or near misses must be documented in the Falls Monitor Chart
* Reassessment to be carried out monthly and immediately following another fall