Department	Acute Care & Residential	**Procedure Number:**	Prompt Doc No: UMH0000866
Responsible Officer:	Jenna Bond/ Nadine Morrisson	**Approving Committee**	Clinical & Aged Care Governance
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FALLS PREVENTION, RISK ASSESSMENT AND MANAGEMENT- RESIDENTIAL CARE

Description

All UMHCS staff responsible for directing and delivering patient care within the residential care environment will use guidelines to:

- Identify high falls risk residents and situations
- Assist residents to prevent a fall from occurring in high risk situations
- Take appropriate action when a fall incident or injury occurs to minimise harm to the resident and prevent further falls from occurring.

Procedure Applies To

- Clinical Staff including: General Practitioners, Nursing Unit Manager, Allied Health, Nursing Staff, Personal Care Assistants, Allied Health Assistants, Volunteers
- Non Clinical Staff including: Maintenance, Domestic and Hospitality staff.

Purpose and Scope

- Clinical Staff- will use screen tools and refer residents for assessment to minimise the likelihood of a fall that results in an injury from occurring within a residential setting.
- Clinical staff will record all falls on VHIMS which flags the Falls Prevention working party to complete a multidisciplinary assessment.
- Non Clinical Staff are responsible for identifying patients at a risk of falling and are required to take action to prevent a fall incident or injury from occurring.

Definitions & Abbreviations

FRAT
Falls Risk Assessment Tool

Fall
A fall is an event, which results in a person coming to rest inadvertently on the ground or floor or other low level (World Health Organisation)

Procedure Standards

Training
All staff will be trained in and able to implement the falls risk screening and falls prevention strategies. Training will occur on commencement of employment and be ongoing, with a minimum of an annual update for clinical staff.

Screening (FRAT) and Assessment
All residents must be screened for falls risk within 24 hours from admission, preferably at the first point of contact, using FRAT. The patient must be re-screened:

- Regularly (every 6 months)
- When a change in functional status is evident
- After a fall

Referral to appropriate health professionals for Falls Risk Assessments will be completed on every resident admitted into residential care so that individual prevention and management plans can be put into place to reduce the risk of falls.

Documentation/ Communication

Documentation and Flagging

- All screening, assessments & interventions related to the resident's fall risk and risk factors must be documented in the resident's medical record/ care plan.
- A mechanism must be put in place at the bedside to identify residents at risk
- A UMHCS pink 'high falls risk' sticker must be used in documentation to flag high risk patients. The sticker may be used on other items at staff discretion.
- The guidebook for preventing falls and harm from falls in older people should be used as a guide for developing strategies and action plans.

Communicate to staff

- Resident's increased risk status must be communicated to all personnel involved in care
- All falls and falls risks must be noted at nursing handovers, as well as residents' risk and management strategies that are in place to prevent falls.
- All falls, slips and near misses must be recorded on VHIMS.

Communicate to the resident & carer including education

- The resident's risk of falling & intervention strategies to prevent falls must be discussed with the resident & their carer.(Interpreters should be used when appropriate).
- Education to residents and their carers will be provided as they both need to understand the falls risk factors and actions they need to take to address them. Resources include:
  - The "Don't fall for it- falls can be prevented" booklet (Booklet available from physio department and online- http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_fallsfacts/$File/30471-Residents.PDF)
  - "I want to stay independent"

http://www.health.gov.au/internet/main/publishing.nsf/Content/8DE953DBDE1B850CCA256FF100275AA1/$File/Falls_full%20version.pdf

Provide increased supervision/ assistance

High falls risk residents need to receive increased supervision and/or assistance. This may require:

- Moving them closer to areas of high staffing
- Co-locating residents at increased risk
- Encouraging and empowering family/ carer or volunteers to help with care and supervision where appropriate

Make the patient's environment as safe as possible

Standard fall prevention includes:

- All residents areas kept free from clutter, trip hazards and spills
- Floor surfaces kept clean and dry. Wet floor signage is sued where appropriate
- Residents are orientated to the bed area, room and ward facilities, including how to use the call bell & any other equipment. Personal belongings will be placed within reach.
- Furniture will be positioned and adjusted to allow ease of access and safe use: Bed height at lowest, chair height to optimise ease of transfers (resident's hips at 90-100˚)
- All areas use appropriate lighting, including the use of night lights
- Brakes must be applied on all equipment when stationary
- Walking aids will be located on the side of the bed the resident will exit from
- Bed rails will NOT be used as a standard falls prevention strategy
- Monthly environmental checks should be undertaken.

Manage altered mental status appropriately

The following strategies must be completed if there is a change in residents' mental state i.e. disorientated, confused, agitated:

- Referral to Occupational Therapy for completion of MMSE if cognitively capable of completing one as per Procedure.
- Increase supervision and provide reassurance to the resident
- Ensure resident is reviewed by the medical team
- Ensure environmental considerations (as above) are implemented
- Encourage family/ carers to be involved with fall prevention strategies where appropriate
- Consider referral to CNC Aged Care and Geriatrician.

Restraints, both mechanical and chemical, including bed rails, are NOT recommended for the prevention of falls, particularly in people with altered mental status.

Assess balance and mobility and encourage safe mobility/ self care

- Every resident's mobility status must be established at time of admission or when a change in functional status is evident.
- Prior to the physiotherapy review, residents at risk of falling must be instructed to ask for assistance when attempting to mobilise
- If resident usually uses a mobility aid, staff should ask the family/ carer to bring it into the hospital
- Use of supervised group or individualised balance and gait exercises to reduce the risk of falls and fractures
- Encourage safe and early mobilisation and resident participation in self-care
- Activities of daily living should be structured to minimise injury risk:
  - High risk residents (particularly those with altered mental status) must be supervised during

self-care activities
- Encourage use of appropriate self-care equipment for the residents at particular fall risk (OT can advise with this)

Manage continence and toileting problems
Strategies must be put in place to manage patients who are incontinent or require frequent toileting including:
- Locate patient close to toilet facilities
- Use a urinal or bedside commode at night
- Planned frequent toileting- eg every 3 hours (except overnight) and immediately prior to nurse handover.
- Consider reducing caffeine intake, while maintaining adequate hydration
- Reduce fluid intake after 6pm if well hydrated.
- High risk patients should not be left unsupervised in the toilet or bathroom
- Other residents should be offered a continence assessment to check for problems that can be modified or prevented i.e. urinalysis to screen for urinary tract infections.

Screen for unsafe footwear
At time of admission, footwear should be checked
- If the resident does not have safe (fitted, flat and non-slip) footwear, the family/ carer should be contacted to bring in appropriate footwear
- If appropriate footwear is unavailable, non-slip socks will be provided
- Walking in loose-fitting slippers or socks and barefoot must be discouraged

Identify and address inadequate nutrition
Residents that are identified as having inadequate nutrition must be referred to the dietician.

Review medications
- Residents in residential care should have their medications reviewed at least yearly after a fall
- Any residents over 5 years on 4 or more medications will have medications reviewed by their treating doctor, with the aim of prescribing the minimum number of medications at the minimum required dose for clinical effect.

Identify and address vision problems
Visual impairment is a risk factor for falls
- Residential care lighting must be optimal to reduce the risk of falls
- On admission, patients should be asked about their vision. If the patient does not have their usual glasses with them, their relatives/ carers will be contacted and asked to bring them for the patient to use in hospital
- Regular eye examinations (every two years) are recommended for older people, with treatment of identified problems undertaken.

Identify, investigate and manage postural hypotension and syncope
Residents found o have postural hypotension, or who complain of dizziness, light-headedness or "blackouts" must:
- Have a medical review (including review of medications)
- Be supervised when changing position and encouraged to sit and stand up slowly from lying or sitting and to wait a short time before walking
- Be encouraged to report episodes of the above symptoms

Identify and treat Osteoporosis

- If an older person or post-menopausal woman is admitted with a fracture or history of falls, they must be investigated for osteoporosis and commenced on a management plan
- Vitamin D and Calcium supplements should be considered as routine management for all older people to significantly reduce the risk of fall injury.

Hip Protectors

Hip protectors may reduce the risk of hip fractures. Hip protectors should be considered for certain patients. Indicators for use:

- The patient already uses hip protectors
- Over 80 years + prolonged hospital stay + history of falls
- Over 80 years + prolonged hospital stay + osteoporosis
- Over 70 years and a recurrent faller

Resident compliance and functional capacity to manage hip protectors need to be considered e.g. significant confidence issues, cognitive status or inability to pull hip protectors up.

Legislation, Acts & Standards

NSQHS : Standard 10

Key Aligned Documents

- Falls Prevention- Agency Wide Procedure
- Falls Prevention- Agency Wide Policy
- Falls Risk Assessment of Community Clients- Agency Wide Procedure

References

- Australian Commission on Safety and Quality in Health Care- Best Practice Guidelines for Australian Residential Aged Care Facilities 2009
- Australian Commission on Safety and Quality in Health Care- falls fact sheet for residents http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_fallsfacts/$File/30471-Residents.PDF
- Australian Government Department of Health and Ageing (The 'Don't fall for it- falls can be prevented!' (resource booklet online) http://www.health.gov.au/internet/main/publishing.nsf/Content/8DE953DBDE1B850CCA256FF100275AA1/$File/Falls_full%20version.pdf
- State Coroner Victoria: Coroner's "Investigation Standards"- Falls related
- Victorian Quality Council- Minimising the Risk of Falls and Falls Related Injuries Guidelines
- World Health Organisation

Governance

Version Control and Change History		
Version Number	**Approval Date**	**Amendment**
2.0	04/06/2014	Title changed and put into new format