PATIENT ADMINISTRATION

FALLS RISK ASSESSMENT AND MANAGEMENT OF PATIENT FALLS

Keywords: In-hospital fall, fall, falls risk, fall management, Datix, CIMS

AIM

• To reduce the risk of falls and fall related injuries at KEMH.

KEY POINTS

1. All maternity and gynaecology inpatients at King Edward Memorial Hospital shall have the Minimum Standards for Fall Prevention implemented.

2. All patients admitted to the gynaecology and obstetric areas, Mother and Baby Unit and Day of Surgery Unit (DOSA Gynaecology patients only) shall be assessed for risk of falls and if Minimum Standards for Fall Prevention are not adequate the Fall Risk Management Tool be used.

3. Patients are at risk for a variety of reasons, and this risk is not limited to inpatients or the elderly.

4. A person’s risk of falling increases as their number of risk factors accumulates.

5. For each patient who has been assessed as being at a high risk of falling, a fall prevention plan must be prepared and individually tailored to the patients specific set of risk factors.

PROCEDURE FOR FALLS RISK MANAGEMENT AT KEMH

• The Fall Risk Management Tool (FRMT) MR260.02 shall be completed on all women on admission to ASCU, Mother and Baby Unit or the Day Surgery Unit (DOSA Gynaecology patients only).

• If the patient meets any of the screening criteria on the FRMT, a full assessment of each of the components (in the shaded boxes on the second page) shall be performed and documented.

• A full assessment shall occur if a patient meets any of the following criteria:
  ➢ Has had a slip, trip or fall in the past 6 months.
  ➢ Is unsafe when walking or transferring
  ➢ Is confused
  ➢ Has a neuraxial blockade or has received a schedule 8 medication.

• Identify the appropriate interventions required to prevent falls and transfer to the Nursing Care Plan or Obstetric Clinical Pathway.

• If no criteria are met, ensure minimum standards are in place, but do not complete the assessment interventions.

• A full re-assessment shall be repeated in the following circumstances:
  ➢ Following a fall
  ➢ Where there is a change in the patient’s condition (cognitive, functional or environmental)
  ➢ On any ward transfer

• For Obstetric patients with a Neuraxial catheter, please refer to Clinical Guideline, Anaesthetics: Labour Analgesia: Epidural Analgesia in Labour.

MINIMUM STANDARDS TO BE IMPLEMENTED FOR ALL PATIENTS

• Orientate the patient to the bed area, toilet facilities and ward.

• Educate the patient and family and provide information about the risk of falls and safety issues.

• Demonstrate the use of the call bell to the patient and ensure it is in reach of the patient.

• Ensure frequently used items including mobility aids are within easy reach of the patient.

• Provide appropriate mobility assistance.
• Ensure the bed and chairs are at an appropriate height for the patient.
• Ensure bed brakes are employed at all times when the bed is stationary.
• Position the over–bed table on the non-exit side of the bed when possible, taking into consideration the siting of IV cannulas and wound drains.
• Place the IV pole and all other devices/attachments (as appropriate) on the exit side of the bed when possible.
• Remove clutter and obstacles from the room.
• Ensure the patient is using appropriate aids such as glasses or a hearing aid.
• Ensure the patient wears appropriate footwear if ambulant especially if wearing graduated compression stockings (TEDS)
• Use bed rails as appropriate. When bed rails are used, the reason for this choice shall be documented in the patient’s notes.

FALLS MANAGEMENT
See WNHS Falls Risk Management Policy

POST FALL MANAGEMENT
An immediate decision should be made for patients with a high risk of bleeding post fall.

• Patients on an anticoagulant( including but not limited to warfarin, heparin or enoxaparin), anti-platelet therapy( including but not limited to aspirin, aspirin plus dipyridamole or clopidogrel) and / or patients with a known coagulopathy (alcohol dependent persons, persons with liver disease and people with bleeding disorders ) are considered at an increased risk of intracranial, intrathoracic or intra-abdominal haemorrhage.
• The risk versus harm of continuing anticoagulant therapy post fall should be considered by the treating team.
• There may be late manifestations of head injury up to 72 hours.
• Fall incidents resulting in surgical intervention are assessed as Datix CIMS SAC 1 (Severity Assessment Code) and are to be reviewed within 24 hours.

IMMEDIATE POST FALL PROCEDURES

• Activate a Code Blue Medical if the patient meets the criteria for prompt care.
• Do not move the patient initially but reassure her.
• Call for assistance.
• Immobilise the cervical spine if head and / or neck pain is reported or suspected.
• Check for other potential injuries.
• Perform vital signs observations – blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level (if applicable), temperature and pain score.
• Perform neurological observations and assessments, including Glasgow Coma Scale, speech, eye movements and pupil abnormalities, facial asymmetry, power, reflexes and plantar responses.
• If there are any doubts about the appropriate investigations and management contact the Senior Registrar.
• Observe for delirium and new or worsening confusion, headaches, amnesia, vomiting or change in the level of consciousness.
• Clean and dress any wounds – consider immunisation status for tetanus.
• Notify the medical team and request a review.
• Notify the Unit Manager / After Hours Hospital Clinical Manager.
• Consider the need for analgesia as indicated.
• Conduct relevant investigations as required. Consider blood tests, ECG, x-rays, CT head scan.
• Report the fall on the Datix CIMS database.
RECOMMENDED ACTIONS WITHIN 6 HOURS POST FALL AND ONGOING CARE

- Initially record vital signs and neurological observations every 30-60 minutes for 4 hours on the MR 337, and then review by the Medical Officer.
- Any observations that fall outside of the acceptable parameters on the observation chart should prompt escalation as per the Recognising and Responding to Clinical Deterioration guideline.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal- motor/ sensory changes.
- Continue the investigation and treatment of any injuries sustained.
- Notify the next of kin and carer (if applicable) subject to the patient’s consent or condition if the patient is unable to give consent themselves. Document all attempts to make contact in the medical notes.
- If not already identified as at high risk of falls injury, flag on the Falls Risk Management Tool MR 260.02 and note on the Clinical Handover sheet in the ‘situation’ section. It should also be documented on the Nursing Care plan MR 286.02 on the ‘mobility’ section (Ward 6).
- Complete preliminary patient, family and carer education on falls risk management.
- The Medical Officer should complete a post fall review:
  - Talk to relevant staff and patient about the nature of the fall, the symptoms arising from the fall and the Fall Management Plan
  - Document the fall in the medical record. Details should include:
    - the mechanisms of the fall
    - location
    - time and circumstances
    - evidence of injury
    - any loss of consciousness
    - relevant environmental information
    - what falls risk strategies were in place at the time of the fall and
    - actions taken
- Reassess the patient’s fall risk, discuss the management plan with the patient and document the agreed actions.

RECOMMENDED ACTIONS 6-12 HOURS POST FALL

- If the fall was not witnessed and / or the patient hit their head or is on anticoagulants/ anti-platelet medication complete the following observations
  - Continue neurological observations based on the patient’s condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable.
  - Refer all variances to the Medical Officer for further review.
- If the fall was witnessed and the patient is not on anticoagulants / anti-platelet medication complete the following observations
  - Continue vital signs observations at least 4-6 hourly for 72 hours or until discharge from the time of the fall, then review by the Medical Officer.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal motor / sensory changes.
- Ensure strategies have been put in place to prevent further falls as far as is practicable.
- Review the results of blood tests and x-rays with the Medical Officer for treatment options. Ensure the Medical Officer is aware of any abnormalities in the results.
- Modify the environment to reduce further falls and ensure the continued safety of the patient, including safe and easy access to personal belongings and equipment.
RECOMMENDED ACTIONS 12-48 HOURS POST FALL

- If the fall was not witnessed and / or the patient hit their head or is on anticoagulants/ anti-platelet medication complete the following observations
  - Continue neurological observations based on the patient’s condition; 4 hourly if stable.
  - Refer all variances to the medical officer for further review.
- If the fall was witnessed and the patient is not on anticoagulants / anti-platelet medication complete the following observations
  - Continue vital signs observations at least 4-6 hourly for 72 hours or until discharge from the time of the fall, then review.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal motor / sensory changes.
- Ensure all tests results have been reviewed by a Medical Officer and actioned as required.
- Continue the investigation and treatment of any injuries sustained.
- Ensure falls prevention strategies are appropriate for the patient’s particular risk factors and documented in the care plan – if there are any concerns, reassess and implement strategies.
- A review by other relevant staff is recommended within the following timeframes post fall:
  - Physiotherapist within 36 hours
  - Occupational Therapist within 36 hours
  - Pharmacist review within 36 hours
  - Dietician review if the patient is malnourished
  - Specialist nurse (e.g. urology) if indicated.
- Continue patient, family and carer education on falls risk management.

RECOMMENDED ACTIONS 48-72 HOURS POST FALL

- If the patient is considered stable at 72 hours, return to the pre-fall level of observations.
- All specialist and allied health reviews must be completed and a plan of care/ treatment documented in the patient’s notes for falls risk management

FURTHER CONSIDERATIONS WITHIN 72 HOURS POST FALL

- Optimise secondary prevention of further falls using the following strategies where applicable and age-appropriate:
  - Consider Vitamin D testing.
  - Consider a bone mineral density scan if the patient is at risk of osteoporosis and is deemed appropriate by the medical officer.
  - Continued patient, family and carer education on falls risk management.
  - Consider fear of falling and refer to a Social Worker or Clinical Psychologist.
  - Plan the discharge with consideration of the patient’s ongoing fall risk and the need for home assessment and equipment.
  - The discharge documentation shall include information about the fall occurring.
REFERENCES / STANDARDS


National Standards – 1- Care provided by the clinical workforce is guided by current best practice

Legislation - Occupational Safety and Health Act 1984
Occupational Safety and Health Regulations 1996

Related Policies –
- OD 0442/13 Post Fall Management Guidelines in WA Healthcare Settings
- WNHS Policy W132 Falls Prevention and Falls Management

Other related documents –
- Stay On Your Feet WA
- Falls Prevention Health Network

RESPONSIBILITY

Policy Sponsor | Nursing & Midwifery Director OGCCU
Initial Endorsement | July 2008
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Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.