

Falls Prevention Best Practice

Prepared by **Denise Tomassini**
Falls Prevention – A case study : Mr Tony Topples
ISLHD Clinical Quality Manager
Clinical Governance Unit
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Falls Prevention Best Practice

Best practice in fall and injury prevention includes:

- implementing standard falls prevention strategies
- identifying fall risk
- implementing targeted individualized strategies that are resourced adequately
- and monitored reviewed regularly*

*Australian Commission on Safety and Quality in Healthcare: *Preventing Falls and Harm from Falls in Older people: Australian Hospitals 2009*



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Falls Prevention Best Practice

Four key components:

- Assess the risk
- Plan of care
- Monitor
- Reassess



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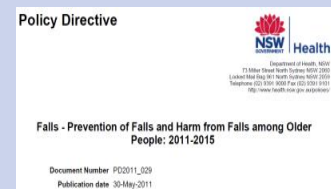
Falls Prevention Best Practice

Always refer & use **Falls Prevention Best Practice Guidelines**

Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009



Ministry of Health Policy: Falls - Prevention of Falls and Harm from Falls among Older People: 2011-2015



NSW Falls Prevention Network



CEC Summary of ACSQHC Falls Evidence-based Guidelines 2009 Hospital Falls Prevention Strategies

<http://www.cec.health.nsw.gov.au/programs/falls-prevention>



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Case Study: Mr Tony Topples

Segment One

On admission to hospital what would be the first steps you would take to reduce Falls Risk?



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Segment One

On admission to hospital what would be the first steps you would take to reduce Falls Risk?

1. Obtain a thorough **patient history** – obtain key information from **family & relatives** or the **facility** where patient resides:
 - **Past medical history (Hx)** including current diagnosis
 - Hx of **previous falls** - has patient had any falls in last 12 months?
 - Hx of **Dementia, confusion** or **delirium**



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- **Current medications** especially anticoagulants (at risk of a bleed if they fall)

Medications linked to falls risk:

- sedatives, antidepressants, diuretics, antipsychotics or opiates.

Is Pt taking 5 or more medications?

Has Pt had 4 or more changes to medications in last 12 months?

- **Check mobility status** & walking aids
- **Usual home environment** - orient patient to new environment
- **Toileting routines** of patient – many falls occur on the way to and from the toilet/bathroom
- Nutritional status
- Vitamin D
- Calcium levels



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What other information would you require about Mr Topples?

Engaging with family

- Hx of patients reaction with **anaesthetic**
- **Age** of patient
- **Dehydration** due to unwell state
- Investigate any **increased confusion** → delirium:
underlying UTI/Sepsis
- **Fever** → could be an early sign of sepsis.
- Increased **pain** → could cause patient to become restless
& agitated



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2. Conduct a **Falls Risk Screen** using a validated tool:

- Ontario Modify Stratify tool (OMS), OMS with Sydney Scoring

1. History of falls
2. Mental state
3. Vision
4. Toileting
5. Transfer score
6. Mobility score

or

- Conduct **Falls Risk Assessment** using:

- FRAT for Sub Acute
- RAC in some LHDs



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When should you complete the falls risk screen/assessment?

➤ **Inpatients** - Conduct falls risk screen/assessment soon after **initial admission**

➤ **ED patients** over 65 yrs – falls screen in eMR

Rural EDs- OMS completed soon after **initial triage**

ASET teams – conduct falls screen for patients >70yrs

➤ **Patient reassessment** and falls management plan **must** be updated if there is:

➤ A change in patients clinical condition

➤ Patient sustains a fall



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What is the next step once the Patient is assessed 'At Risk' ?

3. Implement a **falls prevention management plan**
4. **Document** Falls Risk as an '**Alert**' in the patients health care record/eMR
5. **Use good clinical judgement**
6. Discuss falls risk with patients **family & involve** in managing the identified risk
7. **Regular review** of Falls Management Plan e.g. daily care plans
8. Patient/Carer may benefit from **written falls prevention information**
9. Patient **falls risk status** - communicated to staff at handover of care.
10. Make appropriate **multidisciplinary referrals** e.g. Occupational Therapist, Dietician, Physiotherapist, Medical Officer, falls clinics.



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Case Study: Mr Tony Topples

Segment Two

Mr Topples Hx of Dementia and increased confusion post operatively

- **Preoperative assessment** of physical and mental status,
- **Cognitive function** - Mini Mental State Examination (MMSE) or Rowland Universal Dementia Assessment Scale (RUDAS) screening tools

Delirium

- is an **acute confusional** state - a common condition in older people.
- Patients who develop delirium have:
 - a higher mortality,
 - institutionalisation and complication rates, and
 - longer lengths of stay than non-delirious patients.
- Incidence rate can be as high as **30%** in older patients
- **Dementia** is a risk factor for developing **Delirium**

The Prevention, Diagnosis and Management of Delirium in Older People in Acute Care ISLHD CLIN PROC 07



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Post-surgical delirium

- Delirium after general anaesthetic is **common** in the older people
- **Pain** and **confusion** post surgery can lead to patient not able to communicate with staff
- Ensure patient is well **hydrated** pre and post surgery
- Medications – looking for anticoagulants and sedatives/psychotics



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Risk Factors for the Development of Delirium

- Advanced Age
- Dementia
- History of previous delirium
- Severe illness
- Multiple medications
- Admission with infection or dehydration
- Visual and hearing impairment
- Sleep deprivation
- Surgery e.g. fractured neck of femur or cardiac.
- Alcohol excess
- Renal impairment

Causes of Delirium

- Immobility
- Use of physical restraint
- Use of bladder catheter
- Addition of more than 3 new medications.
- Infection.
- Malnutrition
- Dehydration.
- Electrolyte Imbalance.
- Alcohol and Benzodiazepine withdrawal.
- Pain
- Constipation
- Urinary retention

*The Prevention, Diagnosis and Management of Delirium in Older People in Acute Care ISLHD CLIN PROC 07



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Segment Two

What assessment and interventions would you put in place?

- **Inform** the patient/carer of the patients fall risk status
- **Falls prevention brochure** to the patient and their carer
- Reinforce to the patient/carer that they should **not mobilise alone**
- Referral to **Physiotherapist** for a mobility assessment/exercise regime
- Supervise patient when in the toilet and the bathroom. **Do not leave Patient unattended** at night
- **OT referral** if a functional assessment is required



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What assessment and interventions would you put in place?

- Ensure patient can **call for assistance**
- Clutter free **environment** e.g. wet floor, patient equipment blocking walkways
- **Maintenance of mobility equipment** used by the patient
- **Investigate confusion** to establish the cause and an appropriate management
- **Geriatrician referral** for appropriate management of behaviours/dementia
- **Closer observation** for patients with confusion – move closer to nurses station especially
- Consider **volunteer companion observer** or special nurse or use of carer/relatives



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What assessment and interventions would you put in place?

- Limit use of chemical and mechanical **Restraints and Bedrails**
 - follow local policy
- **Audible alerts** for patients with a cognitive impairment e.g./ bed alarms, sensor
- **Dietician assessment** to monitor nutritional input
- **Medical Officer review** for patients if taking medications linked to falls risk
- Osteoporosis - refer to MO/Geriatician regarding **Vitamin D and calcium** blood levels/supplements



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What assessment and interventions would you put in place?

- Provide regular toileting & investigate **urinary incontinence**
- Monitor **lying & standing BP** and if postural hypotension present refer to MO
- Ensure patients **sensory aids** are in-situ e.g. hearing aids, glasses
- Non-slip, well fitting, supportive **footwear** - **No TED stockings** without footwear
- Check **patient clothing** e.g. long dressing gowns
- **Height adjustable beds** e.g. High-Lo and Lo-Lo beds



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Segment Three

What communication and discharge strategies would you put in place?

- **Communication** with the family prior to patient transfer and at time of transfer
- **Clinical handover/ transfer information** sent with patient including:
 - **Admitting diagnosis** and **current diagnosis**
 - **MMSE** results for **cognitive impairment**
 - **Falls risk** status
 - **Falls prevention interventions** implemented
 - Hx of any **falls** that have occurred in current care
 - Communication with staff regarding **family assistance** able to provide patient including assistance with meals
 - Arrange for **multidisciplinary referral** on arrival to new facility



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What communication and discharge strategies would you put in place?

- **Medications** reconciliation – on admission & currently taking
- **Mobility status** and **walking aids**
- **Dietary** requirements & **weight** – has patient lost weight?
- **Fluid & IV** access information - ?infection/sepsis
- **Interpreter** - ? required to improve communication
- **Scans** or **X-rays** patient may have had
- **Blood results**

