Falls Prevention
Best Practice

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Falls Prevention – A case study: Mr Tony Topples
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November 2011

NSW Government
Illawarra Shoalhaven Local Health District
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
Falls Prevention Best Practice

Four key components:

- Assess the risk
- Plan of care
- Monitor
- Reassess
# Falls Prevention Best Practice

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

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<tr>
<th>Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals 2009</th>
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<td>Ministry of Health Policy: Falls - Prevention of Falls and Harm from Falls among Older People: 2011-2015</td>
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<td>NSW Falls Prevention Network</td>
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<td>CEC Summary of ACSQHC Falls Evidence-based Guidelines 2009 Hospital Falls Prevention Strategies</td>
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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?
Case Study: Mr Topples

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**
- **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
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
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
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
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.
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
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
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*
Case Study: Mr Tony Topples

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
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
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/Geriatrician regarding **Vitamin D and calcium** blood levels/supplements
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
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
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**