A total of 157 patients fell in Rankin Park Centre during the 12 months from April 2005 to April 2006 (38% of total clients). This is consistent with data which suggests that up to 46% of rehabilitation clients experience a fall in hospital (NSW Health, 2003).

The total number of falls in the unit was 226 of which 72 resulted in patient injury.
Falls Working Party

- Despite existing strategies in place a high incidence of falls continued.
- Two key people identified in each ward – motivated and interested.
- Falls working party formed.
- Aim to review IIMs falls data and review strategies.
- Strategies must be practical and possible to implement at Rankin Park Centre.
Previous Strategies

- Attend Patient Needs Assessment Form to identify Falls Risk.
- Apply blue armband to patient’s wrist.
- Apply blue post-it note to patient’s medical file.
- Place adhesive blue dot to patients care plan on bedside chart.
- Refer to Falls Flip Chart for individual strategies and place copy of appropriate falls prevention care plan on patient’s bedside chart.
- Place laminated Falls Management Chart on wall at bedside.
- Use of bed bells and dom care rails.
Peak Times for Falls

- During staff meal breaks.
- During handover.
- After evening meal.
- 6am, on waking.
- Falls were also more common during the first 48 hours of patient admission

Possible Reasons.
- New environment.
- Patient’s attempt to be independent in rehab setting.
- Assessments not yet attended.
Factors Influencing Patient Falls

- Patient Factors.
- Environmental factors.
- Staffing factors.
Patient Factors

Issue – Impaired Cognition

- Position close to nurses station.
- Use of laser alarmed chair.
- Purchase of arm chairs with attachable tables.
- Use of Stand-up floor alarm mats as well as bed and chair alarm mats.
- Plan to create FALLS room- Assistance of volunteers or family members needed.
Patient Factors

Issue - Boredom

- Role of activities officer.
- Availability of games.
- Support of local schools.
Patient Factors

Issue- Fatigue post therapy

- Therapists to assist patients to bed post therapy.
- Restraints reapplied post therapy – care plans in place.
- Call bell and phone within reach.
Patient Factors

Issue - Need for toileting/incontinence

- Patient to be toileted early am.
- Individual toileting regimes - use of T/V charts to identify pattern and need.
- Formation of continence working party to improve management.
Patient Factors

Issue - Poor eyesight

- Ensure glasses worn and appropriate, and cleaned regularly.
- Adequate use of ward lights.
- Use of night lights - electric plug-in most effective.
Patient Factors

Issue- Patients aim to be independent

- Initial orientation to ward to include safety.
- Highlight fact that patient needs to progress to safe level prior to independence.
Environmental Factors

Issue- Footwear

- Highlight need with patient, carer and staff during orientation to ward.

- Staff to monitor and ensure footwear safe.
Environmental Factors

Issue- Location of call bell

- Ensure within reach- use of extension leads and velcro attachment straps.
- Rearrange furniture if necessary.
- Use of more familiar hand bell.
- Other alternatives eg Jelly bean buzzer.
- Noted – no buzzer in solarium. Pendant speaker alarm system trialled and purchased.
Environmental Factors

Issue - Location of personal items and phone

- Orientation re use of phone.
- Relatives made aware if patient unable to answer safely.
- All items within reach.
Environmental Factors

Issue- Location of furniture

- Individualise area.
- Rearrange furniture.
- Move bed against wall for climbers.
- Ensure bed at lowest level when staff not attending.
Environmental Factors

Issue- Clutter

- Relatives to take home excess.

- Round after supper - remove wheelchairs, excess equipment and clutter, clear toilet areas, ensure pts have call bells and required items within reach.

- Mobility aides only to be left within reach of independent patients.
Environmental Factors

Issue - Air mattress

- Remove as soon as no longer necessary.
- Risk of pressure areas vs. risk of falls.
- Slippery quilts - Use of quilts now discontinued.
Environmental Factors

Issue- Unfamiliar environment

- Patient orientation.
- Picture and word signs for toilet and bathroom supplied by OT.
Issue - Staff Awareness

- Alert staff of high risk patients at handover and briefly highlight strategies.
- Mobility method recorded on whiteboard above beds.
- Laminated coloured tags on mobility aides.
- Use of blue bedside magnets as well as wrist bands - softer name bands now used.
Staffing Factors

Issue- Reduced ward coverage at handover and mealtimes

- Coverage by wards person in am
- Timely handovers
- Ensure coverage at pm handover- 6am nurse finishes at 2:30PM – Casual staff finish 1pm
- Evening patient round- staff to work at opposite ends of ward.
- Flexible staff meal times.
Staffing Factors

Issue- Delay in physiotherapy assessment

- Notify therapists of admissions ASAP.
- Nursing staff to assess re mobility when physiotherapist not available.
Falls Notice Board
Falls Notice Board
Falls Notice Board
WHAT MAKES A SHOE UNSAFE?

- Lack of laces means your foot can slide out of the shoe.
- Soft or stretched uppers make your foot slide around in the shoe.
- Narrow heels make your foot unstable and can cause ankle sprains.
- High heels should be avoided as they impair stability when walking.
- Slippery or worn soles are a balance hazard.
WHAT MAKES A SHOE SAFE?

- Laces ensure the shoe 'holds' onto your foot when walking.
- A thin, firm, midsole so you can 'feel' the ground underneath.
- A textured sole to prevent slipping.
- A broad, flared heel to maximise contact with the ground.
- A bevelled heel to prevent slipping.

Falls Notice Board

Hunter New England NSW Health
Falls Notice Board
Falls Reduction

- RPC Falls Working Party—meets second monthly.
- Review of all falls data.
- At risk patients identified on admission and prevention strategies tailored according to individuals’ risks.
- Falls Marshals drive falls prevention on wards and ensure strategies are implemented early.
- Review and trial of daily care plan.
Increased Awareness

- Falls prevention a standing agenda item at team meetings including discussion of recent case study from IIMS.

- Use of an illustrative ‘falls board’.

- Discussion of high risk patients at handover.

- Nurse Unit Managers promoting awareness of falls management with existing and new staff.
  - Random care plan audits
  - Random “buzzer checks”
The number of falls decreased from 226 in 2005/6 to 139 falls in 2006/7 representing a reduction of 87 falls or 38.5%.
Outcomes

- The number of patients falling was reduced from 38% to 32% - a 6% reduction of patients falling in the 12 month timeframe.
Greater Newcastle Cluster, Rankin Park Centre Clinical IIMS Data, Falls trend (Logarithmic Trend Line)
Outcomes

It's not rocket science