



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**St Mary's Hospital
&
Phoenix Park Community Nursing Units**
Phoenix Park
Dublin 20

Falls Prevention and Management Policy

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Document developed by Falls Prevention & Management Committee (appendix 1)	
Applicable to All staff either directly or indirectly employed in St Mary's Hospital and Phoenix Park Community Nursing Units	
Responsibility for implementation Heads of all Departments Frontline Managers Practice Development Falls Prevention & Management Committee	
Responsibility for review and audit Falls Prevention & Management Committee	
Pages: 30	

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1. Policy Statement

St Mary's Hospital and Phoenix Park Community Nursing Units (CNUs) are committed to preventing falls where possible, and where not possible to minimise their incidence and impact.

2. Purpose

The purpose of the falls prevention and management programme is to:

- Identify patients/residents at risk for falls.
- Initiate preventative approaches.
- Provide appropriate strategies and interventions directed to patients/residents, environmental factors and staff.
- Provide learning opportunities.
- Monitor and evaluate patient/resident outcomes.
- Monitor and evaluate incidents, trends and outcomes of hospital falls.

3. Scope

This policy applies to all patients/residents and staff; including contract workers and agency staff, in St Mary's Hospital and the Phoenix Park CNUs.

4. Legislation / Other Related Policies

This policy should be read in conjunction with the following:

- 4.1** Strategy to Prevent Falls and Fractures in Ireland's Ageing Population (HSE et al., 2008)
- 4.2** A Guide to Falls Screening and Multi-factorial Falls Risk Assessment in Primary Care (HSE, 2012)
- 4.3** St Mary's Hospital Rehabilitation Policy
- 4.4** Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009
- 4.5** Individual department's falls preventions policies and procedures (e.g. Occupational Therapy, Physiotherapy)

5. Glossary of Terms and Definitions

5.1 Fall

A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

5.2 Multi-disciplinary Team (MDT)

A group of healthcare and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programmes for complex medical conditions. A MDT includes a range of healthcare professionals such as Medical Staff, Dietitian(s), Nurse(s), Occupational Therapist(s), Physiotherapist(s), Speech and Language Therapist(s) and Social Worker(s).

5.3 Older person

Anyone over the age of sixty five years

5.4 Young disabled adult

A person between the ages of 18-64, with a disability and for the purpose of this policy-residing in Cuan Aoibheann

5.5 Patient

A person who normally resides at home but who is admitted to St. Mary's Hospital for the purpose of rehabilitation

5.6 Resident

A person who is residing in the Phoenix Park Community Nursing Units

5.7 SBAR Analysis

SBAR analysis (Situation, Background, Assessment and Recommendation) is an effective and efficient way to communicate important information. SBAR offers a simple way to help standardize communication and allows parties to have common expectations related to what is to be communicated and how the communication is structured.

S = Situation (a concise statement of the problem)

B = Background (pertinent and brief information related to the situation)

A = Assessment (analysis and considerations of options — what you found/think)

R = Recommendation (action requested/recommended — what you want)

Roles and Responsibilities

Team Members

Roles & Responsibilities

Hospital Management	<ul style="list-style-type: none">▪ Ensure that fall and fall-related injury prevention is a standard of care in the hospital▪ Ensure that staffing (numbers, experience and skill mix) is sufficient/compatible with falls prevention▪ Ensure that the environment is safe and compatible with falls prevention▪ Ensuring that equipment in the hospital is working properly and receives scheduled maintenance▪ Ensure that all staff receive education and/or information about the falls prevention programme and understand their responsibilities in relation to it▪ Enforce the responsibilities of staff to comply with falls prevention interventions
Risk Manager	<ul style="list-style-type: none">▪ Collect data, analyse statistics and identify trends of falls in the hospital▪ Support staff in the management of risk
Falls Prevention and Management Steering Committee	<ul style="list-style-type: none">▪ Draft hospital falls prevention & management policy, and review/revise and audit it as necessary▪ Review data, analyse statistics & trends, and evaluate outcomes of falls in the hospital▪ Make recommendations on falls prevention and management to Hospital and CNU Management
Nursing	<ul style="list-style-type: none">▪ Complete a fall-risk assessment on all patients/residents with any degree of mobility (immobile residents/patients are exempt) on admission, and re-assess at least every 3-months or sooner if indicated (e.g. following a change in status or a fall)

	<ul style="list-style-type: none"> ▪ Initiate care plan for patients/residents identified as at high risk of falls ▪ Make referrals to MDT members as appropriate ▪ Ensure that appropriate procedures/interventions for high risk resident/patients are in use ▪ Provide education to patient/resident/family about falls prevention strategies ▪ Evaluate the care plan on an ongoing basis
Link Nurses	<ul style="list-style-type: none"> ▪ Ensure that all staff on the ward have read and signed the policy ▪ Attend falls prevention and management committee meetings ▪ Provide information from the committee to the staff on the ward ▪ Ensure the resource pack is kept up-to-date ▪ Ensure all falls that occur within the ward have been reviewed using the Post Fall Review using SBAR Analysis (appendix X)
Health Care Assistants	<ul style="list-style-type: none"> ▪ Follow care plan and procedures for high falls risk patients/residents ▪ Monitor patients/residents ▪ Assist patients/residents when transferring or mobilising ▪ Recognise and report patient/resident verbalisations and behaviours indicative of discomfort which may potentially lead to falls ▪ Report any falls risks identified ▪ Report all falls and near misses to the CNM/Nurse-in-Charge
Doctor(s)	<ul style="list-style-type: none"> ▪ Identify and modify risk factors for falls. ▪ Review medications which may be contributing to falls risk ▪ Assess Bone Health <ul style="list-style-type: none"> → Review need for Vitamin D supplementation → Assess for risk factors for osteoporosis and follow-up as necessary → Consider DXA scanning
Occupational Therapist(s)	<ul style="list-style-type: none"> ▪ Conduct activities of daily living (ADL), cognition and/or perceptual assessments for high risk patient/resident referrals as appropriate ▪ Assess, develop a treatment plan and implement rehabilitative interventions as appropriate for patients undergoing active rehabilitation programme ▪ Make appropriate recommendations as necessary for patients/residents undergoing maintenance rehabilitation programme ▪ Engage and/or advise on appropriate meaningful occupation or diversional activities for the patient/resident ▪ Assess and recommend assistive devices and equipment as necessary (e.g. wheelchairs) ▪ Educate patient/resident, family and staff on how to use

	assistive devices and/or equipment safely
Physiotherapist(s)	<ul style="list-style-type: none"> ▪ Evaluate and re-assess patient/resident's status as appropriate ▪ Conduct balance and mobility assessment for high risk patient/resident referrals as appropriate ▪ Assess, develop a treatment plan and implement rehabilitative balance and mobility interventions as appropriate for patients undergoing active rehabilitation programme ▪ Make appropriate recommendations as necessary for patients/residents undergoing maintenance rehabilitation programme ▪ Advise patient/resident and staff on transferring techniques ▪ Assess and recommend mobility aids ▪ Educate patient/resident, family and staff on how to use equipment safely ▪ Assess and recommend footwear ▪ Evaluate and re-assess patient/resident's status as appropriate
Dietitian(s)	<ul style="list-style-type: none"> ▪ Assess patients/residents as referred, identifying their nutritional needs ▪ Devise appropriate nutrition care plan for referred patients/residents including prescription of oral nutritional supplements and liaising with members of the MDT as appropriate ▪ Identify and implement training and education for nursing, medical, other clinical staff and household staff relating to the nutritional care of patients/residents and provision therapeutic and texture modified diets ▪ Work in partnership with nursing staff to identify and implement programmes for screening, identification and monitoring patients/residents at nutritional risk
Speech & Language Therapist(s)	<ul style="list-style-type: none"> ▪ Conduct communication and/or dysphagia assessment for high risk patient/resident referrals and follow up as appropriate ▪ Assess the patient/resident's ability to comprehend and follow instructions
Activity Department	<ul style="list-style-type: none"> ▪ Involve the patient/resident in group or one-to-one activities and/or social programs ▪ Recognise and report patient/resident verbalisations and behaviours indicative of discomfort ▪ Report patient/resident changes to nursing
Social Worker(s)	<ul style="list-style-type: none"> ▪ Provide support for patient/resident's psychosocial needs ▪ Counsel and support families
Multi-disciplinary Team	<ul style="list-style-type: none"> ▪ Hold MDT meetings to discuss/agree falls prevention plans & interventions for individual high risk patients/residents and review outcomes ▪ Make such referrals as necessary to other health care professionals (e.g. Audiologist, Chiropodist, Optometrist,

	Pharmacist, Podiatrist...)
Maintenance / Housekeeping	<ul style="list-style-type: none"> ▪ Conduct post fall reviews following individual falls and action related recommendations/interventions as appropriate ▪ Support a safe environment of care (e.g. clean/dry floors, environmental checks, preventative maintenance...)
All staff, agency and/or contract workers (both clinical and non clinical)	<ul style="list-style-type: none"> ▪ Report all defects to management ▪ Ensure that all defects are reported (e.g. complete "blue docket" for maintenance requests) and that any faulty equipment is clearly marked as such and removed from use pending its repair/replacement ▪ Pause to check the safety of any patient/resident displaying either a amber or red leaf whenever passing by (see appendix II for details of 'forever autumn' program) and alert or seek help from ward staff if in doubt or if in any concern
Family	<ul style="list-style-type: none"> ▪ Work with staff and patient/resident to support the care plan ▪ Attend family meetings / case conferences as appropriate

7. Procedure

A summary of the procedure is illustrated in the algorithms in appendix III.

7.1 Falls Risk Assessment

7.1.1 A Doctor assesses all patients/residents on admission to identify and modify risk factors which may increase the risk of falls. Medications which may increase falls risk will be reviewed. The Doctor will also assess bone health and screen for risk factors for osteoporosis and will consider Vitamin D supplementation and the need for DXA scanning. Patients/residents will be re-assessed and followed up by the Doctor as necessary.

7.1.2 A Nurse assesses all patients/residents with any degree of mobility within **2 hours** of admission (and thereafter re-assess at least every 3-months or sooner if indicated) for their risk of falls using the Falls Risk Assessment Tool (see appendix IV for Falls Risk Assessment Tool and Appendix V for instructions on its use):

7.1.2.1 Scores of 5-11 indicate a low risk of falls

7.1.2.2 Scores of 12-15 indicate medium risk of falls

7.1.2.3 Scores of 16-20 indicate high risk of falls.

7.1.3 Patients/Residents identified by the Doctor or Nurse as being at medium or high risk of falls are referred by them to other members of the multi-disciplinary team (e.g. Dietitian, Occupational Therapist, Physiotherapist, Social Worker, Speech & Language Therapist) or other relevant professionals (e.g. Audiology Nurse, Audiologist, Chiropodist, Optometrist, Pharmacist, Podiatrist) as appropriate for full assessment and follow-up as indicated. See individual department falls prevention and management policies and/or procedures for further details.

7.2 Interventions/Strategies to Reduce Risk of Falls

- 7.2.1** For patients/residents identified as being at low risk of falls, standard fall risk reduction interventions (see appendix VIII) are put in place to ensure the person's safety is maintained.
- 7.2.2** For patients/residents identified as being at medium or high risk of falls, a falls risk reduction care plan is initiated by the Nurse; see appendix IX for a non-exhaustive list of additional falls prevention interventions that maybe implemented as individually appropriate. The Nurse also refers the patient/resident to other relevant members of the multi-disciplinary team for assessment and follow-up as necessary; the falls risk score is included on the referral form.
- 7.2.3** The patient/resident is discussed at a multi-disciplinary meeting and plan of action agreed and documented. All interventions are evaluated and outcomes documented.
- 7.2.4** Patients/Residents identified as at risk of falls are placed on the 'Forever Autumn Programme' (see appendix II for details).
- 7.2.5** Comfort checks take place frequently during daytime shifts to address all of the patient's/resident's needs. The patient/resident is checked to see that their needs are met (e.g. toileting, pain, positioning, social stimulation and the environment). Each Care Team is responsible for the comfort checks for their assigned patients/residents.
- 7.2.6** The falls risk score of every medium/high risk patient/resident is reported on all nursing handovers to ensure that all staff members coming on duty are aware of who is at risk on the ward regardless of whether they will be directly responsible or not for the named patient/resident during that shift.

7.3 Post Fall Management

- 7.3.1** The Healthcare Professional assesses the patient/ resident for any apparent injuries using a secondary survey (appendix IV):
 - 7.3.1.1** If in doubt the patient/resident is not moved (unless in a life threatening situation) until the Doctor reviews the patient/resident.
 - 7.3.1.2** In the case of suspected spinal cord injury or other serious injury, the Senior House Officer contacts the Registrar. The Registrar contacts the Acute Hospital and then notifies the ambulance service. The patient is not moved, unless in a life threatening situation, until the ambulance arrives.
 - 7.3.1.3** In the case of possible hip fracture:
 - St Mary's Hospital patients requiring x-ray between the hours of 9am and 5pm are transported to St Mary's Hospital x-ray department on a trolley (N.B. not in a wheelchair)
 - St Mary's Hospital patients requiring x-ray after 5pm are transferred to the Acute Hospital for X-Ray and further evaluation. Every effort is made to avoid time delay in organising X-Ray and assessment in these cases.

→ Residents in the Phoenix Park Community Nursing Units (regardless of time) are transported by ambulance directly to an acute hospital for x-ray

7.3.1.4 In the case of probable hip fracture the patient is sent (via ambulance) to the Acute Hospital and is x-rayed there (i.e. probable hip fractures are not x-rayed in St Mary's prior to going to the Acute Hospital).

7.3.1.5 In the case of less severe injuries appropriate first aid is applied and the patient/resident is moved according to manual handling best practice and guidelines (to either a chair or bed as appropriate).

7.3.1.6 The Doctor-on-call and Nursing Person-in-Charge (PIC) or delegate/Assistant Director of Nursing are notified of the fall without delay.

7.3.1.7 The Doctor assesses the patient/resident as soon as possible following each fall; even in the cases where there is no apparent injury.

7.3.1.8 Neurological observations are done for 24 hours following an unwitnessed fall.

7.3.2 Once the patient/resident is made comfortable, the patient's/resident's significant other or first point of contact is notified in line with the patient/resident's wishes

7.3.3 An Incident Form is completed and processed as appropriate; in the case of nursing the yellow copy of the form is sent to the Nursing Person-in-Charge (PIC) or delegate/Assistant Director of Nursing, while in the case of any other department/service area the yellow form is sent to the Hospital Manager & the white copy is sent to the Risk Manager

7.3.4 A Post Fall Review (see appendix X) is completed ideally within 30-minutes of the fall (or as soon as possible on the same shift) by the available ward or MDT members on duty at the time of the fall. The original is filed in the patient's/resident's medical record and copy is sent with the incident form

7.3.5 When a patient/resident falls, their falls risk status automatically becomes **HIGH**.

7.3.5.1 The risk assessment tool should be re-administered to identify any changes in function/status that may have caused the fall and actioned/followed-up as appropriate.

7.3.5.2 For patients/residents not previously identified as at risk of falls, a fall risk care plan is initiated and for those previously identified as at high risk their existing care plan is reviewed and amended as appropriate.

7.3.6 If indicated (i.e. significant change since last assessed) re-referrals are sent to multi-disciplinary team members as appropriate requesting re-assessment in light of the new fall.

7.3.7 The patient/resident is discussed at a multi-disciplinary meeting and a new plan of action agreed and documented. All interventions are evaluated and outcomes documented.

8. Implementation Plan:

- 8.1** Soft copy of this policy will be disseminated via e-mail to each head of department and from there onto individual department employees. Hard copy will also be made available at ward level and in each clinical department's main office.
- 8.2** Education and training will be provided at department meetings and/or in-services as required.

9. Revision and Audit

- 9.1** The collection of falls and falls related data (e.g. numbers, trends, outcomes etc) will be central to falls prevention and management audit.
- 9.2** Evaluation of this policy will be ongoing with a formal review every 2 years or when procedural, legislative or best practice changes occur.

10. References / Bibliography

- i. Aged Care in Victoria (2009). *Falls Risk Assessments and Management Plans*. Aged Care Branch, Wellbeing, Integrated Care and Ageing Division of the Victoria State Government, Department of Health, Australia. Available at: <http://www.health.vic.gov.au/agedcare/maintaining/falls/providers/rac/plans.htm> [accessed 2nd November 2011].
- ii. Hodkinson, H. M. (1972). Evaluation of a mental test score for assessment of mental impairment in the elderly [i.e. Abbreviated Mental Test Score, AMTS]. *Age and Ageing*, 1(4), 233-238.
- iii. HSE (2012). *A Guide to Falls Screening and Multi-factorial Falls Risk Assessment in Primary Care*. Prepared by Care of the Elderly and Primary Care Programmes, Project Manager Dr Joe Clarke
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- v. New South Wales (NSW) Falls Prevention Network (2009). *Falls Prevention Resources*. Available at: <http://fallsnetwork.neura.edu.au/resources/index.php> [accessed 2nd November 2011]
- vi. Peninsula Health Falls Prevention Service (2009). Falls Risk Assessment Tool (FRAT). Available at: http://www.health.vic.gov.au/agedcare/maintaining/falls/providers/rac/plans_frat.htm [accessed 2nd November 2011].
- vii. Registered Nurses Association of Ontario (RNAO) (2011). Best Practices Toolkits: Falls Prevention and Management. Available at: <http://ltctoolkit.rnao.ca/resources/falls> [accessed 2nd November 2011].
- viii. Toronto Falls Best Practice Long-Term Care Working Group (2006). *Policy and Procedure: Falls Prevention and Management*. Developed by Toronto Best Practice in LTC Initiative; Sept 2006. Available at: <http://rgp.toronto.on.ca/torontobestpractice/Policyprocedurefallspreventionmanagement.pdf> [accessed 2nd November 2011].

Appendix I: Falls Prevention and Management Policy Development Members

Chair Person

Anne Marie Payne Nurse Tutor

Committee Members

Alicia McCabe	Clinical Nurse Manager II
Bindumol Thomas	Clinical Nurse Specialist – Gerontology
Charina Hogan	Clinical Nurse Manager II
Daragh Rodger	Advanced Nurse Practitioner
Deborah Behan	Risk Manager
Eithne Kenny	Occupational Therapy Manager
Elizabeth Griffin	Senior Physiotherapist
Eoghan McDonald	Occupational Therapist
Eucharía Igboeli	Clinical Nurse Manager II
Fiona Dunne	Nurse Practice Development
Frances McCarthy	Consultant Geriatrician
Hazel Catalan	Clinical Nurse Manager I
Hazel Viagedor	Staff Nurse
Hilda Griffin	Senior Dietitian
Jomol Shain	Staff Nurse
Kathleen Lynch	Liaison Nurse
Marian Glynn	Physiotherapy Manager
Rosemary Reynolds	Person-in-Charge; Teach Iosa
Varghese Joy	Staff Nurse

Appendix II: Forever Autumn Programme

On admission all patients/residents who have any degree of mobility are assessed for their falls risk and an appropriate coloured leaf (green, amber or red) is displayed to indicate their risk as follows:



The green leaf signifies the person has a low risk of having a fall. Minimum Falls Prevention Standards will be put in place. A leaf will not be on display but will be placed next to the person's name on the white board in the Clinical Nurse Manager's Office



The amber leaf signifies a medium risk of the person having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a yellow 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf will be placed next to the person's name on the white board in the Clinical Nurse Manager's Office

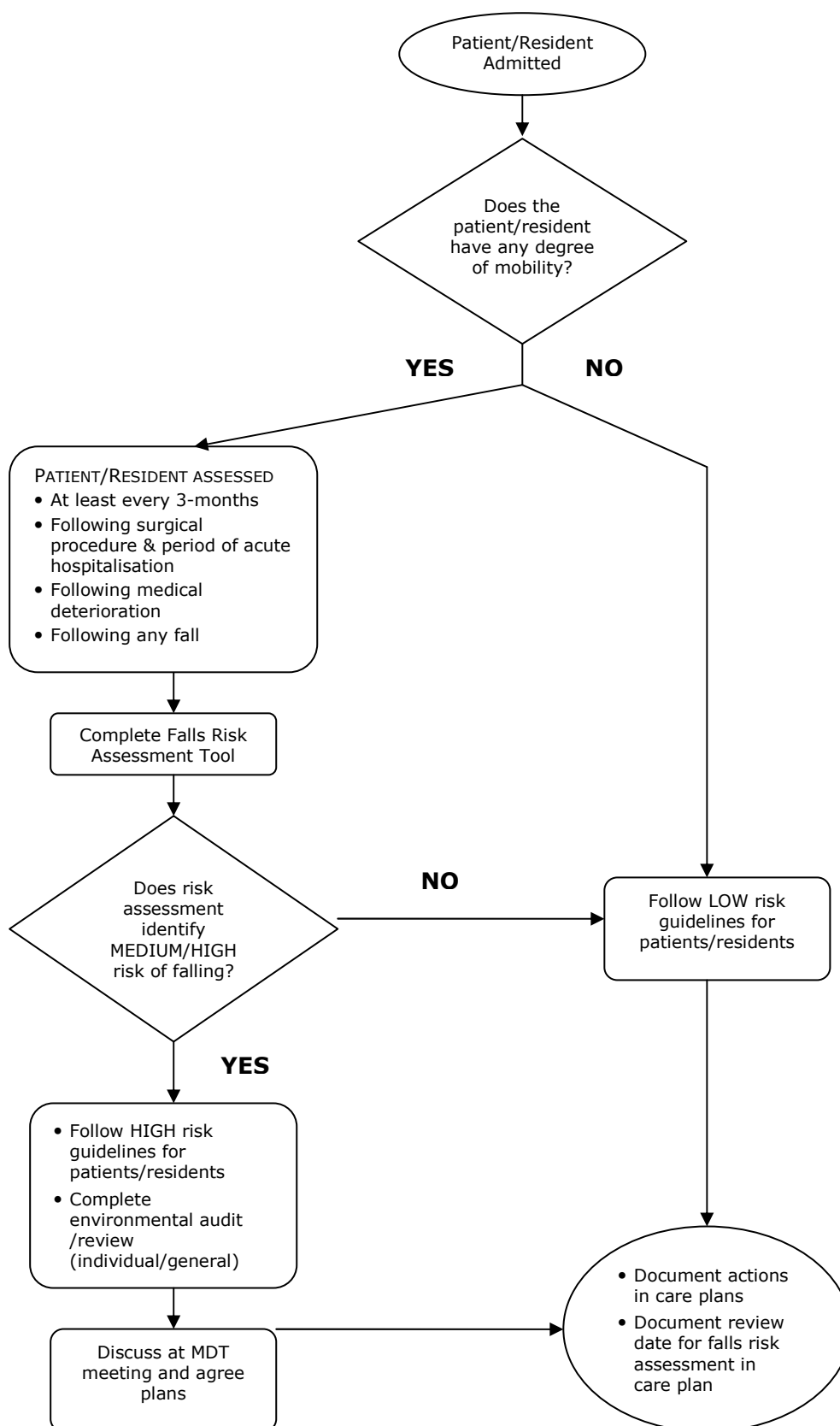


The red leaf signifies this person has a high risk of having a fall. This leaf will be placed outside the door & over the bed in multi-occupancy rooms and a red 'grip' will be placed on the individual's mobility aid or wheelchair. A leaf will be placed next to the person's name on the white board in the Clinical Nurse Manager's Office

If anyone on the ward sees these symbols, they are asked to look in on the person to ensure that they are safe. If the door of the patient/resident's room is closed please take into account the right to privacy and dignity by knocking and waiting for response before entering the room. If there is a problem they either stay with the person until help comes or intervene if they are qualified to do so.

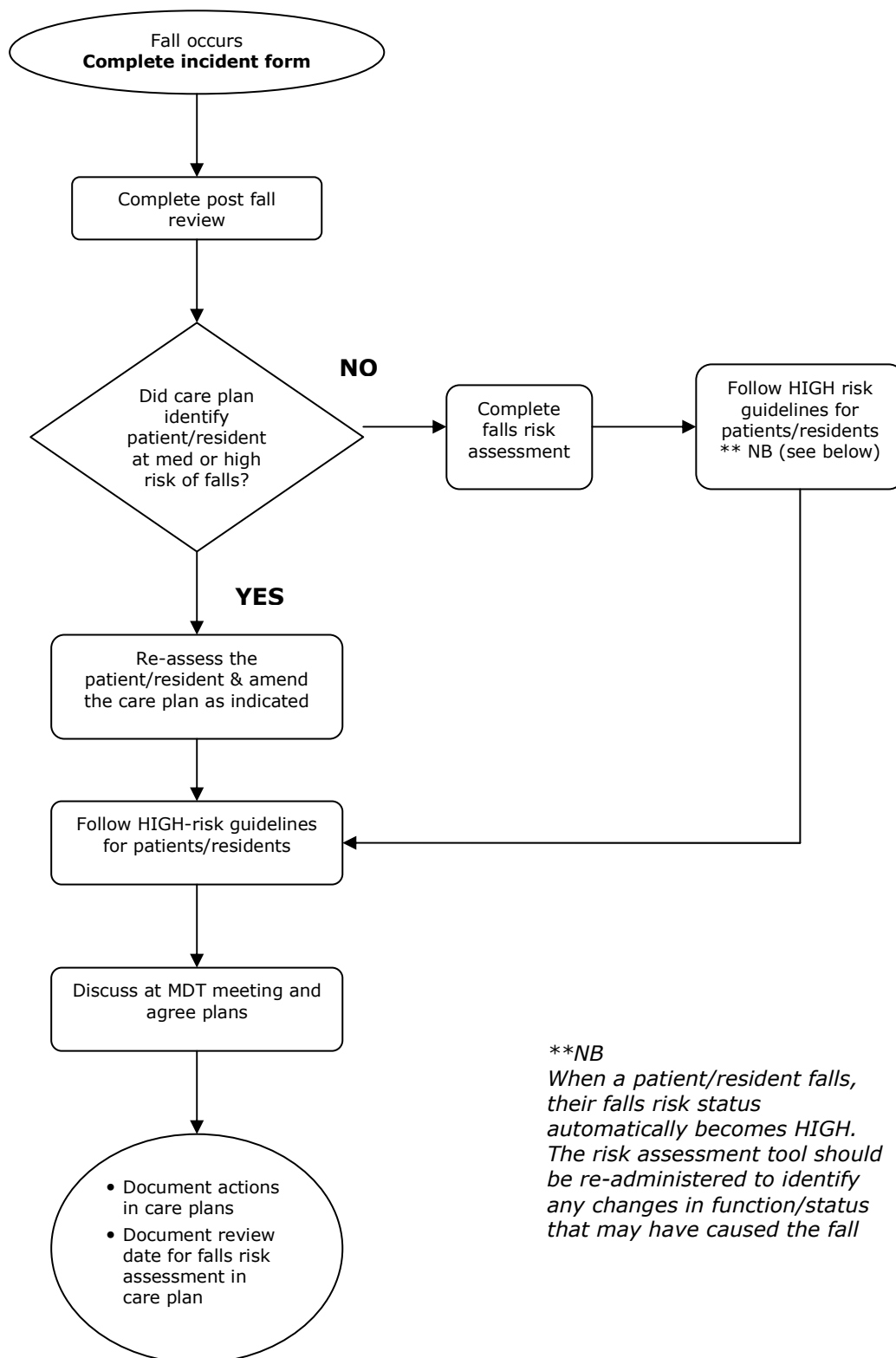
Appendix III: Falls Algorithms see Section 7 for full details

FALLS RISK PROCEDURE ON ADMISSION



FALLS RISK PROCEDURE AFTER FALL OCCURS

See Section 7 for full details



Appendix IV: Secondary Survey

Secondary Survey to be completed following any fall

- Ask them how they feel.
- Ask if they have any pain
- Look for swelling, pale skin, deformities
- Conduct a head to toe examination
 - **Head-** assess breathing and pulse, pupils and neck. Check their face and head.
Look for bruising, swelling, deformity, bleeding or discharge from the ear or nose.
Is it possible they could have injured their neck?
 - **Shoulders and Chest** – compare shoulders and collar bone. Are there any signs of fractures? Ask the person to take a deep breath. Does the chest move easily and equally on both sides? Does this cause pain? Feel the rib cage on both sides and compare.
 - **Abdomen** - gently feel the abdomen. Check for abnormality or response to pain.
Look for any signs of bruising.
 - **Legs and Arms** - check arms and legs for any deformities (lower extremities look for external/internal rotation) check pedal pulses. Ask the person if they are able to move their arms and legs without pain

Appendix V: Falls Risk Assessment Tool

Falls Risk Assessment Tool (FRAT)

Working together to prevent falls



Risk assessment tool developed by: Peninsula Health Falls Prevention Service

The Peninsula Health Falls Prevention Service developed the *Falls Risk Assessment Tool* (FRAT) for a DHS funded project in 1999, and is part of the FRAT Pack http://www.health.vic.gov.au/agedcare/maintaining/falls/kits_frat.htm. A study evaluating the reliability and validity of the FRAT has been presented at a number of conferences, and is being prepared for publication. The FRAT has been distributed to approximately 400 agencies worldwide.

The FRAT has three sections: Part 1 - falls risk status, Part 2 – risk factor checklist and Part 3 – action plan. The complete tool (including the instructions for use) is a full falls risk assessment tool. However, Part 1 can be used as a falls risk screen. An abbreviated version of the instructions for use has been included on this website. For a full copy of the instructions for use please refer to the FRAT Pack or contact the Peninsula Health Falls Prevention Service.

The FRAT is a validated tool, therefore changes to Part 1 of the tool are not recommended.

Please note: The cognitive status question in Part 1 on the FRAT refers to the Abbreviated Mental Test Score (AMTS). This can be obtained by referring to the following website: http://www.nevdgp.org.au/division/mens/pdf_docs/Mini_Mental.rtf.

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In 2005 the Department of Human Services funded the National Ageing Research Institute to review and recommend a set of falls prevention resources for general use. The materials used as the basis for this generic resource were developed by Peninsula Health Falls Prevention Service under a Service Agreement with the Department of Human Services. This and other falls prevention resources are available from the department's Aged Care website at: <http://www.health.vic.gov.au/agedcare>.

Addressograph or complete below

Name:

Date of birth:

Medical Record no:

Ward:

St. Mary's Hospital / Phoenix Park Community Nursing Units

Falls Risk Assessment Tool

(Adapted from Peninsula Health Falls Prevention Service, 2009)

To be completed within **2 hours** of admission for all individuals with any degree of mobility

History of Falls *Note : For an accurate history consult resident/patient, family and medical records*

☐ Yes ☐ No Falls prior to this admission (home or referring facility) **and or** during current stay

if yes, detailed most recent below

Circumstances of recent falls: Information obtained from:

Date of Last 3 Falls Most Recent 1 st	Reason for Fall							Location/ Comment
	Trip	Slip	Lost balance	Collapse	Leg/s gave way	Dizziness	Unexplained	
1								
2								
3								

Automatic High Risk Score; if 'Yes' is ticked

Recent changes in Functional Status and/or medications affecting safe mobility (or anticipated) ☐ Yes ☐ No

Dizziness / Postural hypotension ☐ Yes ☐ No

Part 1: Falls Risk Status

Risk Factor	Level		Risk Score	
Recent Falls	None in the last 12 months		2	
	One or more between 3 & 12 months ago		4	
	One or more in the last three months		6	
	One or more in last three months whilst inpatient/resident		8	
Medications (Sedatives, Antidepressants, Anti-Parkinson's, Diuretics, Anti-Hypertensives, Hypnotics)	Not taking any of these		1	
	Taking one		2	
	Taking two		3	
	Taking more than two		4	
Psychological (Anxiety, depression, decreased: cooperation, insight or judgment esp. re. mobility)	Does not appear to have any of these		1	
	Appears to be mildly affected by one or more		2	
	Appears to be moderately affected by one or more		3	
	Appears to be severely affected by one or more		4	
Cognitive Status (Hodkinson Abbreviated Mental Test Score {AMTS})	AMTS= 9 OR 10/10	Intact	1	
	AMTS=7-8	Mildly Impaired	2	
	AMTS= 5-6	Moderately Impaired	3	
	AMTS=4 OR LESS	Severely Impaired	4	
5-11 = Low risk		12-15 = Medium Risk	16-20 = High Risk	Part 1: Risk Score

See next page to continue the assessment →

Addressograph or complete below

Name:

Date of birth:

Medical Record no:

Ward:

St. Mary's Hospital / Phoenix Park Community Nursing Units

Falls Risk Assessment Tool

Page Two

Part 2: Risk Factor Checklist <i>May Need to be completed after a period of observation</i>		Y	N
Vision	Reports /observed difficulty seeing objects/ signs, finding way around		
Mobility	Mobility status unknown or appears unsafe / impulsive / forgets mobility aid		
Transfers	Transfer status unknown or appears unsafe i.e. over reaches, impulsive		
Behaviours	Observed/reported agitation, confusion, disorientation		
	Difficulty following instructions or does not wish to follow instructions (<i>observed or known</i>)		
Activities of Living	Observed risk –taking behaviours, or reported from referrer/previous facility		
	Observed unsafe use of equipment		
	Unsafe footwear, inappropriate clothing		
Environment	Difficulties with orientation to environment i.e. Area between bed / bathroom / dining room		
Nutrition	Underweight / low appetite		
Continence	Reported or unknown urgency / nocturia / accidents		
Other			
Part 2: Scores (insert number of Y and N)			

Using clinical judgment; combine the scores from Part 1 and Part 2: What is this person's falls risk?

Fall Risk Score: (circle) LOW MEDIUM HIGH**IMPORTANT:** Initiate Forever Autumn Programme**Part 3: Action Plan** *Please tick one only*

	Low risk	Green leaf symbol on chart and white board in the Nursing office initiate Standard Fall Precautions
	Medium risk	Amber leaf symbol on chart, white board in the Nursing office, on the person's bedroom door and over the bed in multi-occupancy rooms, place yellow grips on all mobility aids used by this person. Initiate a Falls Management Care plan.
	High risk	Red leaf symbol on chart, white board in the Nursing office, on the person's bedroom door and over the bed in multi-occupancy rooms, place red grips on all mobility aids used by this person. Initiate a Falls Management Care plan.

☞ **PLEASE NOTE:** the person's fall risk must be communicated at each handover**Initial Assessment completed by:****Printed Name:****Signed:****Date:** / / 201.....

Appendix VI: Falls Risk Assessment Tool

Instructions for use

Falls Risk Assessment Tool (FRAT)

Instructions for use

Working together to prevent falls

Risk assessment tool developed by: Peninsula Health Falls Prevention Service

The Peninsula Health Falls Prevention Service developed the *Falls Risk Assessment Tool* (FRAT) for a DHS funded project in 1999, and is part of the FRAT Pack http://www.health.vic.gov.au/agedcare/maintaining/falls/kits_frat.htm . A study evaluating the reliability and validity of the FRAT has been presented at a number of conferences, and is being prepared for publication. The FRAT has been distributed to approximately 400 agencies worldwide.

The FRAT has three sections: Part 1 - falls risk status, Part 2 – risk factor checklist and Part 3 – action plan. The complete tool (including the instructions for use) is a full falls risk assessment tool. However, Part 1 can be used as a falls risk screen. An abbreviated version of the instructions for use has been included on this website. For a full copy of the instructions for use please refer to the FRAT Pack or contact the Peninsula Health Falls Prevention Service.

The FRAT is a validated tool, therefore changes to Part 1 of the tool are not recommended.

Please note: The cognitive status question in Part 1 on the FRAT refers to the Abbreviated Mental Test Score (AMTS). This can be obtained by referring to the following website: http://www.nevdgp.org.au/division/mens/pdf_docs/Mini_Mental.rtf.

In 2005 the Department of Human Services funded the National Ageing Research Institute to review and recommend a set of falls prevention resources for general use. The materials used as the basis for this generic resource were developed by Peninsula Health Falls Prevention Service under a Service Agreement with the Department of Human Services. This and other falls prevention resources are available from the department's Aged Care website at: <http://www.health.vic.gov.au/agedcare>.

FRAT instructions for use:

History of falls:

Information obtained by completing this section will enable accurate completion of the scored section, to establish risk status. The history of falls, particularly if occurring in the donor facility, will highlight whether the falls were associated with particular activities, problems or time of day. Information regarding strategies previously used to reduce risk can also be useful when developing the Falls risk Reduction Care Plan in Part 3.

The following information should be obtained:

- Were falls a problem before entering the residential aged care facility and how did they occurs?
- Information from the donor facility or transfer documents regarding previous falls and what seemed to work and not work with regards to risk minimisation.
- The circumstances of the most recent falls, such as time, activity, environment, symptoms and whether a gait aid was used.

It is recommended that the information obtained regarding history of falls is confirmed via a carer or family member.

Part 1:

How to obtain a score:

- Circle one score ONLY in each of the four categories in Part 1.

If the person's condition fluctuates you need to circle the score representing their lowest functional level.

Determine the client's risk classification level (risk status) by adding the four scores from Part 1

Low risk	5-11
Medium risk	12-15
High risk	16-20

- Complete the Automatic High Risk Status section.

This section allows for clinical judgement of risk status that would not otherwise be detected. A tick in either box in this section will categorise the person at automatic high risk. Persons with automatic high-risk status should be reviewed regularly, at intervals deemed appropriate by the assessor, as the risk can change and settle quickly when issues are addressed.

If ticked, circle high risk at the end of Part 1 and list fall alert protocol in the Action Plan in Part 3.

Risk classification:

Low risk:

- Provide standard care and follow general resident safety principles.

Medium risk:

- Provide standard care, but risk factors that have been identified and strategies that have been integrated are to be put in the care plan.

High risk:

- Commence Fall Alert Protocol. Resident has a high likelihood of a fall occurring.

Part 2:

Complete the risk factor checklist by placing a tick in the appropriate boxes.

Risk factors identified need targeting for management by listing in the Action Plan in Part 3.

Part 3:

Tick one box and initiate care according to the guidelines.

Review:

Review does not involve repeating the FRAT tool. The tool is for initial assessment purposes only.

Review should involve discussion with the team regarding whether current status and strategies, should for any reason, be altered.

Questions to ask as part of the resident review include:

- Have any issues or observations of resident led to a need to alter the current risk status and strategies?
- Are there any additional strategies that need to be considered?

Appendix VII: Abbreviated Mental Test Score

Date of test:		Scoring Each correctly answered question scores 1 point.	
Interpretation Scores ≤ 7 is indicative of likely cognitive impairment.			
Tick alertness level: <input type="checkbox"/> Alert/normal <input type="checkbox"/> Vigilant <input type="checkbox"/> Lethargic <input type="checkbox"/> Stupor <input type="checkbox"/> Coma <input type="checkbox"/> Uncertain			
Instrument			
1. Age	0	1	
2. Time (to nearest hour)	0	1	
3. Address (for recall at end of test) Say to patient: I am going to say an address: '42 West Street' Can you say that address please? I am going to ask you to repeat it for me in a few minutes.	0	1	
4. Year	0	1	
5. Name your home address	0	1	
6. Recognition of two persons/objects	0	1	
7. Date of birth	0	1	
8. Year of First/Second World War <i>Correct answer: First World War =1914; Second World War = 1939</i>	0	1	
9. Name of current Taoiseach <i>Correct answer: Enda Kenny</i>	0	1	
10.Count backwards 20-1	0	1	
<i>Ask the person to repeat the address you stated earlier, score above under question 3</i>			
TOTAL SCORE			
Full Signature of Examiner _____			
<i>Source: Commonwealth Dept. Health & Human Services (1996) Dementia Kit. Canberra AGPS</i>			

Appendix VIII: Minimum Falls Prevention Standards - To be implemented for all Patients/Residents

- Orientate patient/resident to bed area, toilet facilities and ward
- Educate patient/resident and family, and provide information about the risk of falling and safety issues
- Demonstrate the use of call bell to patient/resident and ensure it is in reach of patient/resident
- Ensure frequently used items including mobility aids are within easy reach of patient/resident
- Provide appropriate mobility assistance
- Bed and chair at appropriate height for patient/resident
- Ensure bed brakes are employed at all times
- Position over-bed table on non-exit side of bed
- Place IV pole and all other devices/attachments (as appropriate) on exit side of bed
- Ensure patient/resident is using appropriate aids such as glasses, hearing aids etc
- Ensure patient/resident wears appropriate footwear if mobile
- Use bed rails as appropriate (bed rail risk assessment required prior to use)
- Ensure room and ward are clutter free at all times
- Adequate lighting in room and ward area, including night light
- Comfort rounds take place every 1-hour during daytime shifts to address all of the patient/resident's needs. The patient/resident is checked to see that their needs are met (e.g. toileting, pain, positioning, social stimulation and the environment).

Appendix IX: Falls - Identified Needs, Personal Goals & Interventions for Patients/Residents at medium to high risk of falls

Updated: 6/9/2012

*Theses are to be used as guidelines and are not an exhaustive list.
Please insert individualised details in the blank sections*

IDENTIFIED NEED

_____ (insert name) is at risk of injury due to ☐ a falls risk score of _____
☐ poor balance ☐ History of falls
_____ (insert name) has a fear of mobilising due to a history of falls

PERSONAL GOAL

_____ (insert name) will have the risk of falls reduced
_____ (insert name) re-establish their confidence while mobilising

INTERVENTIONS

Refer to another professional for advice

- Refer to Physiotherapist, Occupational Therapist, Chiropodist, Audiologist or Optometrist (*as appropriate, Document on the Referral Record*)
- Assess the patient/resident's ability to comprehend and follow instructions (refer to Speech & Language Therapist and/or Occupational Therapist as appropriate)

Aids & Appliances

- Document details of the recommended mobility aids and appropriate level of assistance required (i.e. document in the interventions section of the plan of care and also in the Manual Handling Plan)
- Document the type of footwear the person is to wear when out of bed
- Document the correct use of appropriate equipment (i.e. posity alarm, roll-mats and/or low bed)
- If hip protectors are used document size, type and when the person is to wear them

Increase supervision

- Instruct _____ to look for assistance for all out of bed activities. Repeat instructions to call for help (*add in how often is necessary for this individual*)
- Document the level of supervision required in toilet and shower
- Document and provide increased supervision strategies (e.g. frequent checks, comfort checks, increased activity programmes, day room activities, etc.)
- Move bed/room closer to nurses station

Falls: Interventions continued... page 2

- Move from single room to multi-occupancy room
- Consider provision of one-to-one special as a means of providing continuous supervision (*Must be ordered by the doctor*)

Personal

- Individualise daily routine (i.e. sleep patterns, time spend in bed, activity pattern, toileting programmes, observation and regular rounds, meeting physical needs...)
- Document patient/resident's normal toileting patterns and implement individual toileting plan (e.g. offer toileting 2-3 hourly)
- Ensure patient/resident has easy access to toilet facilities (e.g. en suite, bottle, commode, etc)
- Ensure the person's toenails are kept short
- Inspect feet for sores, bunions or calluses, refer to chiropodist or the Tissue Viability Nurse if any of these are present (*Document on the Referral Record*)
- Encourage fluids
- Encourage appropriate diet and supplements as necessary
- Commence Behavioural Assessment
- Refer for Dementia Care Mapping (*Document on the Referral Record*)

Promote orientation & safety

- Re-orientate patient/resident to surroundings and reinforce as needed
- Teach behavioural compensatory strategies for physical and cognitive impairments as appropriate. Use of distractive devices for patient/resident (e.g. distraction box or handbag, rocking chair...)
- Reinforce safety and risk information with patient/resident and their family, and actively engage them in all aspects of the falls prevention program. Engage in social activities
- Encourage participation in functional activities and exercise, and minimise prolonged bed rest
- Engage patient/resident in occupational and/or social or divisional activities
- Increase companionship

Environment

- Perform environmental review on each shift to promote safe environment:
 - halls and resident areas well lit
 - night light
 - all areas uncluttered
 - floors dry and free from spills
 - floor free from trip/slip hazards
 - locked doors are kept locked when unattended

Falls: Interventions continued... page 3

- handrails are secure and unobstructed
 - tables and chairs are sturdy
 - bed in low position (after a thorough risk assessment)
 - all assistive aids, devices & equipment are working properly
 - ensure brakes are on beds and equipment
 - provide raised toilet seats and arm rests if appropriate
 - ensure patient/resident's call bell and mobility aid are accessible
 - level of stimulation is controlled especially for the cognitively impaired (e.g. reduce group size, control noise levels, disguise doors...)
 - consider also that excessive lowering of stimuli can lead to sensory deprivation, boredom and subsequent increase in self-stimulating activities such as wandering
- De-clutter room and re-organise surroundings/environment
 - Place bed against wall
 - Assign the patient/resident to a bed that enables the patient/resident to exit towards his/her stronger side whenever possible
 - Avoid use of bedrails if assessment indicates contraindication to their use

Vision

- Check when the person's eyes were examined
- Ensure glasses are the correct prescription
- Glasses are clean and the person wears them as prescribe
- Varifocal glasses may increase risk of falls consider two pairs instead
- Keep area well lit, ensure there is no glare on the floor
- Refer to the optometrist

Communication

- If hearing impaired, describe strategies implemented to improve the effectiveness of communication
- Use pocket talker, word board or notebook to aid communication as appropriate
- Refer to the ear clinic for further assessments and interventions.

Breathing and Circulation

- Monitor O2 saturation every (*provide details*) _____
- Encourage frequent rest when short of breath
- Encourage walks of short duration.
- Position chairs in frequent intervals along corridor to allow the person to sit down when fatigued.

Appendix X:

Post Fall Review

Addressograph or complete below

Name:

Date of birth:

Medical Record no:

Ward:

Post Fall Review

Updated: 8th March 2012

(Using SBAR Analysis)

Within 30 minutes of a fall (or as soon as possible on the same shift), gather all the members of staff on duty (including resident; if appropriate) to complete the following questions.

Situation

Incident ID No.	Date of Fall	Time of Fall	During change of Shift? <input type="checkbox"/> Yes <input type="checkbox"/> No	Staffing Level <input type="checkbox"/> Full Staffing <input type="checkbox"/> Understaffed by _____ <input type="checkbox"/> Unavailable staff due to: <input type="checkbox"/> Emergency <input type="checkbox"/> Meeting <input type="checkbox"/> Breaks <input type="checkbox"/> Other
Tick items that were out of reach? <input type="checkbox"/> Nothing <input type="checkbox"/> Call light <input type="checkbox"/> Phone <input type="checkbox"/> TV remote <input type="checkbox"/> Tissues <input type="checkbox"/> Meal tray <input type="checkbox"/> Waste basket <input type="checkbox"/> Assistive devices i.e.: Zimmer frame <input type="checkbox"/> Other: <i>Please insert</i>				
Where did the fall occur?				<input type="checkbox"/> Witnessed <input type="checkbox"/> Unwitnessed
What footwear did the person have on?				
Do they Have a Low-Low Bed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has this contributed to the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do they Have a roll out mat? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has this contributed to the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Trip Hazards? <input type="checkbox"/> Clothing <input type="checkbox"/> Shoes <input type="checkbox"/> Tubing <input type="checkbox"/> Cord <input type="checkbox"/> Obstructed path to bathroom <input type="checkbox"/> None Other:				
Slippery Floor <input type="checkbox"/> Y <input type="checkbox"/> N		Adequate lighting? <input type="checkbox"/> Y <input type="checkbox"/> N		Equipment malfunction? <input type="checkbox"/> Y <input type="checkbox"/> N
What do we <input type="checkbox"/> think or <input type="checkbox"/> know the person was doing at the time of the fall? <input type="checkbox"/> getting up on their own <input type="checkbox"/> from a chair <input type="checkbox"/> from the bed <input type="checkbox"/> trying to get to the bathroom <input type="checkbox"/> trying to get _____ <input type="checkbox"/> reaching for something <input type="checkbox"/> leaning on something <input type="checkbox"/> using furniture to ambulate <input type="checkbox"/> other:				
Insert time the person was last observed			What were they doing?	
Ask the person (if possible) "What happened this time that was different from the other times you have done this activity?"				

Background

Falls Risk factors (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Impaired mobility | <input type="checkbox"/> Impaired cognition | <input type="checkbox"/> Prior fall history (at home/ in care) |
| <input type="checkbox"/> Impaired/alterd elimination (nocturia, urgency, frequency, diarrhoea, incontinence, laxative, bowel prep) | | |
| <input type="checkbox"/> Impaired communication | <input type="checkbox"/> Impaired vision | <input type="checkbox"/> Impaired hearing |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Fever | <input type="checkbox"/> Altered heart rate |
| <input type="checkbox"/> Low BP | <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Psychotropics | <input type="checkbox"/> Hypnotics | <input type="checkbox"/> benzodiazepine |
| <input type="checkbox"/> Hypotension | <input type="checkbox"/> Hypoglycaemia | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Other: | | |

Medications administered in the last 12 hours prior to the fall:

Appendix X:

Post Fall Review

Assessment			
Is this person a diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; what was the glucometre reading?			
Was there an injury? <input type="checkbox"/> none <input type="checkbox"/> minor <input type="checkbox"/> moderate <input type="checkbox"/> severe			
If injured, what contributed to the injury?			
Recommendations			
What can we do to prevent this from happening again? Care Plan recommendation not currently implemented before this fall. The Care Plan is reviewed and interventions are added or deleted as required			
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Medication Review	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Toileting Plan	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Posey™ Alarm	<input type="checkbox"/> Y <input type="checkbox"/> N Referrals:
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Urinalysis Section	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Clear path to Toilet	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N One To One Supervision	
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Assessed for constipation	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Hip Protectors	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Postural Blood Pressure Obs. Section _____	<input type="checkbox"/> Y <input type="checkbox"/> N Education
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Falling Leaf Symbol	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Call bell in reach	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Environment Review	<input type="checkbox"/> Y <input type="checkbox"/> N Other: _____ _____ _____ _____
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Non-Slip Footwear	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Have Items in reach	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Family Meeting	
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Frequent Checks	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Remove Clutter	<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Move Closer to Nursing Station	<input type="checkbox"/> Y <input type="checkbox"/> N 3 rd fall within six weeks If yes, MDT meeting called: Insert date: _____/_____/201____
<input type="checkbox"/> In place <input type="checkbox"/> Y <input type="checkbox"/> N Bed positioned to facilitate exiting onto the stronger side			

Post Fall Checklist

- ✓ Perform post-fall monitoring, including neuro checks for unwitnessed falls or suspicion of head injury
- ✓ Revise plan of care to include prevention strategies based on the Review findings
- ✓ Communicate fall & increased risk to doctors, next shift, MDT & family if applicable
- ✓ Retain copy at ward level to increase staff awareness of this individual fall
- ✓ Send this to the Person-in-Charge / Assistant Director of Nursing and the Risk manager to supplement Incident Report

Names of Staff Members at the Review	Title

Appendix XI: Signature Sheet:

I have read, understand and agree to adhere to the attached Policy, Procedure, Protocol or Guideline:

Date	Print Name	Signature	Grade