



***Foundation Education Resource
For Health and Social Care Workers***

Core Learning - Session Four

Falls in the Acute Setting

Aim:



To provide staff in the Acute Setting with the information and knowledge on the screening assessment and management process for falls and bone health

Why Do Patients Fall in a Hospital Setting?

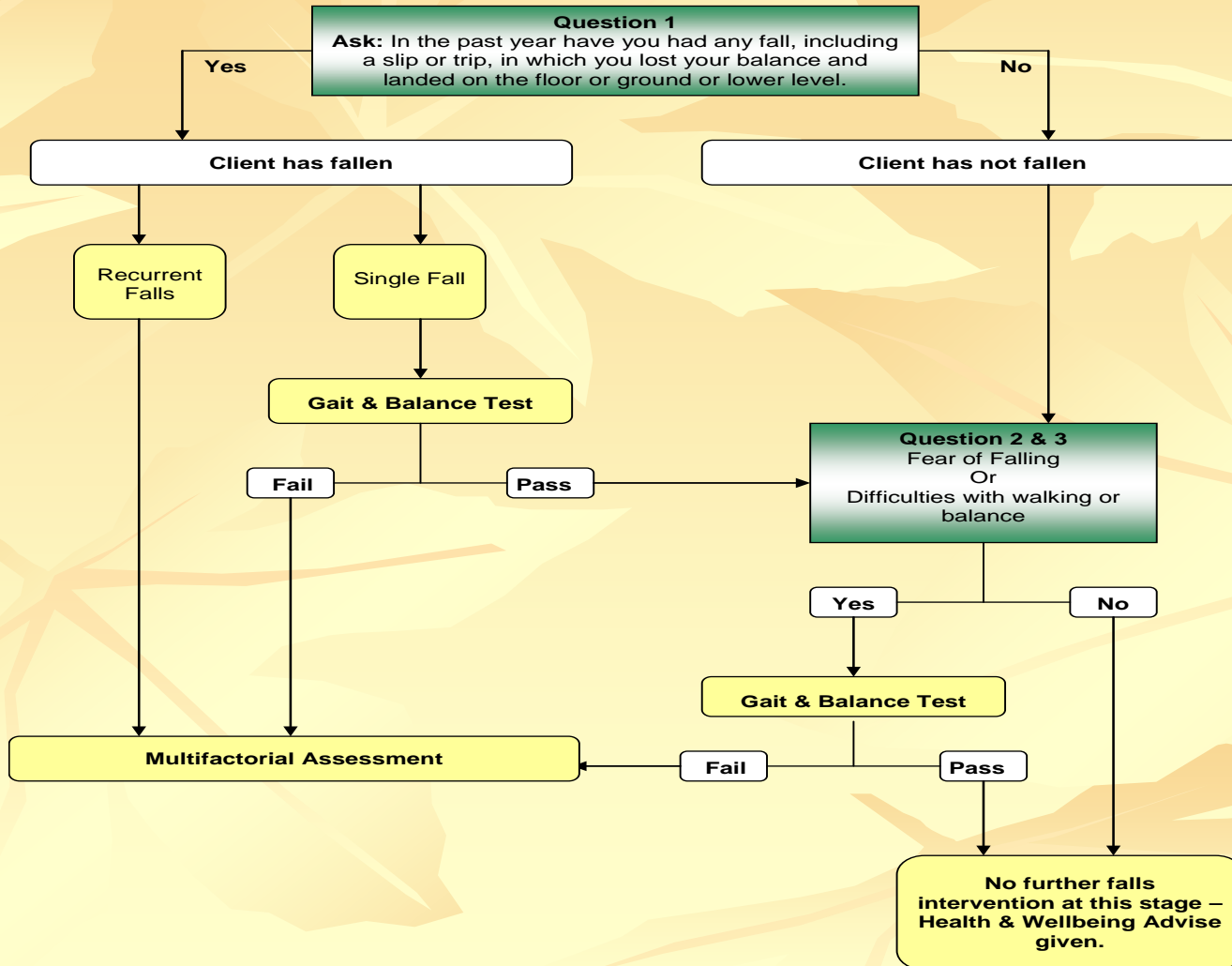
- Hospital patients are at greater risk of falling than people in the community (NICE, 2004).
- Some reasons might include that they may have recently undergone surgery that affects their memory or mobility, and they may have cardio-vascular problems or need medication, which may increase the risk of falling.
- Dementia also increases the risk as these patients are less likely to recognise environmental hazards, less likely to recover their balance and are often unaware of their limitations.
- All patients in hospital, whether suffering from dementia or not, have to adapt to a different environment and to changes in their strength and mobility (NHS, 2010).

Acute Hospital

All acute hospitals should have:

- A falls policy. Sample policy (**Appendix 9**)
- A multidisciplinary Falls Group.
- A process for screening assessment and interventions for service users at risk.
- A process for reporting falls and fall related injuries.
- A structure for educating staff on falls and fracture prevention.

Screening and Assessment



Falls Screening and Assessment

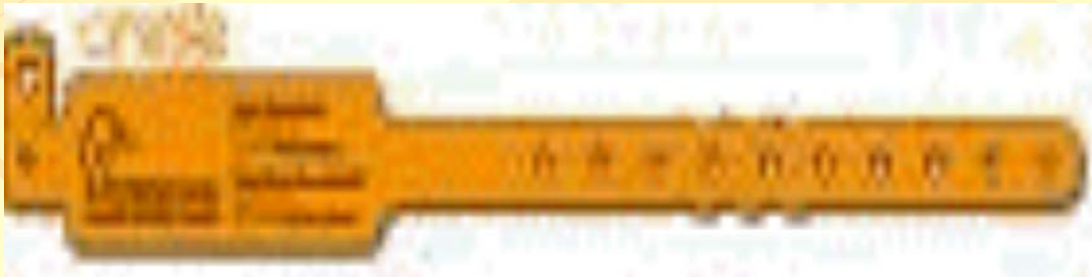
All patients 65 or older who are admitted to hospital should be considered for a multi- factorial assessment, for their risk of falling during their hospital stay.

Screening (Appendix 2)

- **The Aim** of screening for falls in older people is to identify those who are at risk of falls
- Older persons in contact with Health care professional or their care givers should be asked the following at least once a year
- Have you fallen during the past years
- If the older person has fallen, ask about the frequency and characteristics of their falls
- Has the older person a fear of falling?
- Has the older person experienced difficulties in walking or with their balance?
- If the older person answers **no** to all of the screening questions give advice on health and wellbeing Tips on healthy Aging and Tips on Bone health

Falls Screening and Assessment

- If the patient answers **yes** to any of the screening questions apply orange band or other alert. Carry out a falls risk assessment and initiate a Falls Care Plan.
- If the patient has a single explained fall i.e. tripped over object, clothing etc, test for Gait and balance (**Appendix 7**)
- **Pass:** Give advice on health and wellbeing and bone health
- **Fail:** Perform a multi factorial risk assessment and apply orange alert band



Falls Screening and Assessment

- **Assessment (Appendix 3)**
- **The Aim** of the multi factorial assessment is to identify the falls risks. A fall risk assessment Multi factorial falls risk Assessment should be performed for older people living who (**Appendix 3**)
- Report recurrent (2 or more) falls in the past year
- Report difficulties with gait and balance
- Report fear of falling
- Seek medical attention because of a fall
- The multi factorial risk assessment should incorporate the following:
- History of falls
- Characteristics of fall – was it a slip, trip or fall, fear of falling, questioning in relation to any difficulties in walking or with their balance.

Falls Screening and Assessment

- Medications
- Environmental Issues
- Feet and Footwear
- Vision Impairment
- Related Medical History
- Social Factors
- Dietary intake including hydration
- Any team member can complete the Multi factorial Fall Risk assessment.

Be Aware that screening methods may under or over estimate an Individual's risk of falling therefore clinical judgement is also required

Interventions

The **multi-factorial interventions** would include:

- A falls risk assessment followed by intervention, to modify the identified risk (deficit), is the most effective strategy to reduce both the risk of falling and incidence of falling in older people.
- Strategies that combine interventions and target more than one risk that have been shown to reduce falls are:
- individualised exercise programme that includes a combination of resistance. (strength) training, gait, balance, and co-ordination training.
- Medication review and withdrawal of psychotropic and other medications, if appropriate.
- Home environment assessment and modification, carried out by a health care professional.

Interventions

- Managing postural hypotension.
- Vision assessment and referral for intervention.
- Assessment of vitamin D deficiency and insufficiency and treat if identified.
- Identification of foot problems and appropriate treatment.
- Behavioural modification and educational programmes should be considered. (A Guide to Falls Screening and Multi factorial Falls Risk Assessment in Primary Care 2012)

Safety Pause

- The aim of the safety pause is to enhance communication, prioritise patient safety and experience and embed quality improvement in daily practice
- It can be used in any ward, department, clinic, unit or service e.g., prior to medical rounds, at the beginning or end of the handover and is wider than the nurse handover
- It should be multidisciplinary and take no longer than 5 minutes. It is a method of alerting staff to patient safety issues for the shift/day and actions needed. The HSE safety pause Information Sheet.

www.hse.ie/go/clinicalgovernance

Additional Safety Precautions for High Fall Risk Patients

- Move the patient closer to the nurse's station where possible.
- Have the bed down low, with the brakes locked.
- Keep floor surfaces dry and uncluttered.
- Have the patients belongings and drinking water within their reach.
- Ensure footwear is non-slip and well-fitting.
- Ensure clothes/nightwear are not trailing, causing a tripping hazard.
- Monitor regularly throughout the day/night.

Intentional Rounding Or Comfort Checks

Aim to provide a regular routine of individualised checks at times agreed within the acute setting. This enables staff to interact with patients every hour or every 2 hours depending on needs. (**Appendix 10**)

- The idea around this is for staff members to check in on patients in order to address any needs they may have, which are linked with Pain, their Position, their Personal Needs and Placement. “Four P’s
- The patients at risk or who have had a fall should be rounded on.
- This may only be required at certain times of the day when there is less staff/patient activity.
- Each ward can identify which parts of the day when there is less staff supervision of the patients and intentionally round at those times.
- All staff have a role to play in this the “Four P’s”
- **Positioning:** Making sure the patient is comfortable and assessing the risk of falls or pressure ulcers.
- **Personal Needs:** Scheduling patient trips to the bathroom to avoid unsafe conditions.
- **Pain:** Asking patients to describe their pain level on a scale of zero to 10.
- **Placement:** Making sure the items a patient needs are within easy reach, such as water, tissues, television remote control and the telephone.

Falls Risk Alert Symbols and Signs

If on admission a patient is identified as being at risk of falling “an appropriate risk alert symbol”, (e.g. orange wrist ban or other) should be put in place and a falls risk assessment carried out and a falls care plan initiated. These symbols/alerts are visual reminders to staff that the patient is at risk of falling.

- Orange is generally considered the national colour for falls risk. They are used in the form of stickers, bracelets or signage placed above the patient's bed, on the patient's door, or on the patient's chart.

Safety Cross: (Appendix 4)

- This is a monthly visual alert which is kept at the nurses station which indicates on a daily bases if any falls have occurred

An orange wristband

- An orange wristband indicates a patient who is at increased risk of falling. ***It is used in the acute hospital setting only.*** The older person should have the band placed around their wrist while they remain at risk. If reassessment identifies that they are no longer at risk the orange risk band should be removed

Post Fall Care

Post Fall Care (Appendix 12)

- If a fall occurs while a patient is in the acute setting the nurse on duty will:
- Call for help and administer first aid if necessary.
- Not attempt to move the patient until sufficient help is available.
- Not manually lift the client from the floor unless in an emergency (Ex: fire, explosion).
- In the event of cardiac arrest, resuscitate the patient on the floor.
- If the patient is uninjured and has recovered sufficiently, assist them to get themselves up by rolling onto all fours or into a kneeling position and pulling themselves in a sitting position with the aid of a chair/stool.
- If the patient is unable to get up themselves from the floor, must use a mechanical aid (Ex: Hoist). If the client is in a confined space, a sliding device can be used to move them to a more comfortable area.
- Call the doctor on-call to assess the patient.
- Contact Patient family as soon as possible

Post Fall care

- Will complete Clinical Incident/Near Miss form accurately and submit to the Clinical Nurse Manager.
- Submit Incident Report form/Near Miss forms to the line manager for review and sign off and entry on to the STARS system.
- Encourage staff to perform a post fall assessment of the incident eg huddle
- Use a visual cue to identify that a fall has occurred in the setting. i.e.: The Safety Cross (**Appendix 4**)
- Re-assess Patients falls risk after the fall
- Encourage information re patients at risk of falls or who has fallen during that shift, to be handed over at report times between staff

Post-Fall “Huddle” Tool and/or asking the 5 Why’s

- This is part of the falls care bundle; it is a method used to analysis the reason why the patient fell.
- This tool should be used to guide the immediate post-fall “huddle” and should take only 5 minutes of your time. Gather all available staff, including nurses, NA, and managers.
- As part of the post fall huddle you could use the 5 whys approach.
- Was Assessment undertaken on admission? Risk status- low, moderate, high?
- Why do YOU think the patient fell (based on your nursing assessment of the following):
- Who fell? When did they fall? Where did they fall? What were they doing when they fell?

Actions Plan Post Fall Huddle

- Update fall risk assessment
- Decide on interventions and time frame
- Decide on review date

Discharge

Discharge Home

- The time spent by patients in the acute hospital setting is usually short. It is very important that as part of their discharge plan from the hospital that the falls history, the appropriate treatment and setting for follow-up is included in the letter to the GP, PHN and other relevant health professionals.

Emergency Department

- For older people who experience a fall and attend the Emergency Department it is a very important point of contact. 13%-52% of older people experience subsequent falls (Close, Ellis et al. 1999; Bloch, Jegou et al. 2009) 49% are re-hospitalised (Bloch, Jegou et al. 2009)
- If Falls Risk Screening identifies that the older person is at risk of falling, a falls risk assessment should be completed by hospital staff if patient is admitted or in the community if the older person is discharged home and the appropriate referral for assessment and appropriate intervention initiated

Resources

- **Example of Policy Acute Hospital – Appendix 9**
- **Example of intentional rounding Chart – Appendix 10**
- **Multi-Factorial Assessment and Intervention– Appendix 8**
- **Gait and Balance Test Get up and Appendix 7**
- **Safety Pause Information Sheet www.hse.ie/go/clinicalgoverance**
- **The Fall Safe Care Bundle www.bgs.org.uk/campaigns/fallsafe Pg 116**
- **Safety Alert Form- Appendix 11**
- **Osteoporosis Poster – www.bonehealth.co**
- **Safety Cross – Appendix 4**
- **Fall Safe Care bundle www.bgs.org.uk/campaigns/fallsafe**

List of Appendices with Sample Tools

- [Appendix 1: I had a fall poster](#)
- [Appendix 2: Level 1 Screen](#)
- [Appendix 3: Level 2: Multi-factorial Falls Risk Assessment](#)
- [Appendix 4: Falls Safety Cross](#)
- [Appendix 5: Quick Tips for Healthy Bones](#)
- [Appendix 6: Tips for Healthy Ageing](#)
- [Appendix 7: Get Up and Go Test](#)
- [Appendix 8: Multi factorial Assessment and Intervention](#)
- [Appendix 9: Sample Policy Acute setting](#)
- [Appendix 10: Intentional Rounding Chart](#)
- [Appendix 11: Safety Alert Form](#)
- [Appendix 12: Pathway for care of older person Post Fall](#)
- [Appendix 13: Post Falls assessment management pathway](#)
- [Appendix 14: Nursing Assessment prior to ringing the G.P](#)