NSW FALLS PREVENTION PROGRAM

CLINICAL EXCELLENCE COMMISSION

FALLS PREVENTION STRATEGIES

FALLS SCREEN – record in patient notes

- Identify at risk patient using agreed flagging procedure

FALLS ASSESSMENT – record in patient notes

- Falls risk assessment completed
- Referrals completed and actioned
- Management plan developed and documented

FALLS PREVENTION STRATEGIES

MOBILISATION

- Mobility status identified, recorded (if the patient is mobile ensure they mobilise safely) and communicated to all staff
- Educate cognitively intact patients in the use of their mobility aids
- Encourage mobility aids used in the home to be brought to hospital
- Locate mobility aids on the side of bed from which the patient prefers to exit
- Ensure patient is wearing non-slip footwear whilst mobilising
- Avoid excessive daytime napping – encourage activity and include family/carers.
- Encourage mobilisation and participation in daily activities
- Supervise and assist high risk falls patients

TOILETING

- Offer regular toileting
- Assist patient to toilet and showering and remain with those at high risk
- Place patient near toilet facilities with adequate night lighting and visual prompts
- Provide commode or urinal if toilet not close by or patient requires assistance with toileting
- If above measures are not sufficient, refer to Continence CNC (may consider use of continence aids as a trial management strategy)

MEDICATIONS

- Avoid night sedation or use of centrally acting medications unless clinically necessary
- Medical/Pharmacy review of medications on admission and on discharge, arrange for Home Medication Review if necessary.
- Instruct cognitively intact patients on correct use of their medications.
- Consider Vitamin D supplementation with calcium as a routine management strategy for housebound or institutionalised older people – reduces fractures
- If known to have osteoporosis, ensure calcium and Vitamin D supplementation
- Check appropriate pain management is in place

COGNITION

- Assess for delirium- use the Confusion Assessment Method (CAM) tool
- Increase observation for people who are confused
- Monitor and assess any changes in cognition
- Consider alarms (bed/chair) in confused patients, including those with delirium
- Patients with cognitive impairment, liaise with family/ carers regarding medication, mobilisation and equipment, toileting requirements, hydration and nutrition, footwear and clothing and establish care plan

WARD AREA

- Check room is kept free from clutter and floor surfaces are kept clean and dry
- Adequate lighting is available, particularly at night eg. night light
- The patient can safely access personal possessions (eg. glass, jug, glasses etc)
- Patient is instructed on call bell use and call bell is within easy reach
- The bed and bedside chair are set at an appropriate height for the patient, with wheels and brakes locked
- Bed at lowest level, use of lo-lo beds

RESTRAINTS

- Minimise the use of restraints (physical and chemical) and bedrails (refer to hospital policy)

Adapted from *Preventing falls and harm from falls in older people- best practice guidelines for Australian Hospitals* - Safety and Quality Council, 2005, Courtesy of North Coast Area Health Service, July 2006.