Falls Prevention Self Directed Learning Package Hospital Aides

Christchurch Hospital

Produced by the Christchurch Hospital Falls Committee, CDHB
(February 2012)

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- Queensland Department of Health
- Clare Keast - Quality and Risk CDHB
- CDHB Senior Clinical Nurses Group
- Christchurch Hospital Professional Development Unit
- Elder Care Canterbury
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Learning Objectives

This self-directed learning package (SLP) has been developed to assist staff to care for patients that may be at risk of falling while in hospital.. All hospital aides need to complete this SLP.

It is expected that on completion of this package you will be able to:

1. **Understand the importance of falls prevention during and after hospitalisation.**
2. **Demonstrate how you can assist with identifying and minimising the risk factors related to falls in the acute hospital environment.**
3. **Locate read and understand the Falls Prevention Management Policy and associated documentation**
4. **Demonstrate an understanding of falls prevention strategies including sensor systems and non slip socks**
5. **Understand why sensor systems are used and how they operate**
6. **Demonstrate a basic understanding of managing a patient who has fallen**
7. **Understand the consequences for the patient after a fall**

Note: The Nurse Educator (NE), Clinical Nurse Specialist (CNS) or Charge Nurse Manager (CNM) in your area is able to support you in this process, and provide extra resources if needed. Once you have read the SLP and answered the multi-choice questions please forward your multi-choice test and evaluation form (not the entire package) to the NE, CNM or CNS for your area. You will be credited 2 hours professional development time on your individual staff training record for completing this package and achieving a pass rate of 80%.

The Falls Prevention Management Policy can be located on the intranet under Divisions → Medical/Surgical (Christchurch Hospital) → Falls Prevention → Policy and Form; alternatively it can be located in Volume A Policy and Procedure Manual

1. Section 1: Overview

Falls are the leading cause of injury during hospitalisations for older adults (65+ years) and for injury related deaths in this age group.

There is an ongoing serious health issue with the frequency and severity of falls increasing with age:

- 1 in every 3 patients over 65 will fall in any given year
- Half of all patients over 80 have fallen in the past year
- **Only 50% of these patients will regain their pre fall level of functioning**

Falls continue to be an important focus due to the following factors:

- An ageing population in Canterbury
- There are 70,000 people over the age 65 yrs live in Canterbury
- There are 11,000 claims per year to Accident Compensation Commission (ACC) for fall related injuries with associated cost of around $11.4 million
- Falls are the leading cause of injury for the over 65 age group
- Falls reduce a persons ability to live independently in the community
- Falls cause significant social and mental impact for the individual

1.1. Fall Settings

The literature and research for falls prevention is divided into 3 settings:

- Community
- Residential care
- Hospital setting

It is important to know that falls in the different settings will have different risk factors and therefore outcomes and the ways to manage these will vary accordingly. When older people are admitted to hospital they often come with a pre existing fall risk, which may increase their risk of having a fall while in hospital.

1.2. Falls that happen in the Hospital Setting

Occurrence:

- Acute environment 2-5% of falls
- Sub acute rehab environment 46%
- Around 50% of falls occur in the Community Setting
- Stroke units are high risk as decreased mobility and increased dependence means there is a greater challenge in minimising the risk of falling
- Patients 65 and older account for 40% of all in patient days and therefore at higher risk of falling

1.3. Consequences of a fall

For the patient:

- Increased risk of complications e.g. broken bones, cuts, pneumonia or problems with not being able to mobilise
- Decreased confidence
- Increased fear of falling
- Increased risk of having to go into care (especially if frail and older then 80 years)

For the Hospital:

- Longer length of hospital stay
- Additional cost because of x-rays and possible surgery
- Cost of staff if a hospital aid special is required
- Added cost to overall care, e.g. a US study estimated the cost of a fall to be $4,233 ($US)
- A patient is three times more likely to fall within the immediate period following discharge from hospital versus three months post discharge
- Fall related injuries account for 15% of readmissions within the first month post discharge

For these reasons, Falls and Falls Injury Prevention is very important in the hospital setting.

For most patients the hospital stay often focuses more on the medical problems the patient is experiencing and less attention is given to how the patient functions. Often patients are only in hospital for a short period of time so we must make sure that we identify those who are at risk of falling so we can put actions in place to reduce this risk as quickly as possible.

We need to minimise the risk of falls during admission and put into action appropriate plans on discharge to maintain continuous care.

2. Section 2 - Risk Factors

The patient presenting with more risk factors has an increased risk of having a fall examples include:

Patient risks

- Increasing Age
- Physical or mental or visual impairment
- Low Blood Pressure
- Some specific medications or patients that are receiving more than four medications per day
- Activity at time of fall ie walking without a walking frame
- Decreased strength and balance when attempting to stand or when walking
- Depression
- Malnutrition
- History of Falls
- Existing illnesses e.g. arthritis, fainting, Parkinson's disease, stroke
- Confusion/Delirium/Dementia
- Altered Bladder/Bowel Habits
- Changes in mobility
- Diagnosis at the time of admission

Ward / Hospital factors

- Patients in hospital for 19 days or more
- Hazards within the ward / room environment ie clutter at the bedside, uneven flooring
- Most falls occur at the bedside
- Time of day (most occur when there are less staff around e.g. night shift)

In Summary

Older adults (65+ years) are at the highest risk of falling.

Improved observation and knowledge of fall risk are important in the day to day management of older adults in the hospital setting.

Equally important is including actions for preventing falls when the patient is discharged

3. Section 3 – Falls Risk Assessment

3.1. Modified Hendrich II Falls Assessment Scale

(This is the name of the tool used to assess the patients risk of falling)

Within Christchurch Hospital the Modified Hendrich II Falls Risk Assessment Scale is used as a screening tool to determine each patents risk of falling. It is one of the few scales that is recommended for use within the acute hospital environment.

Every patient must be screened using this scale at the time of admission by a nurse. Refer to Appendix 1 (page 18).

After this assessment the nurse will then determine if the patient is a falls risk. If they are at risk of falling a green wrist bracelet is to be placed on the patient, falls risk sign placed above the patents bed, patient status board will have falls magnet present, and falls prevention information brochure given to patients and family/whanau.

The nurse has to complete the Risk Assessment and consider every patient's falls risk daily and document this in the care plan. All patients are reassessed for risk of falling should their health condition change or if they have a fall.

3.2. Previous Slip/Trip/Fall

3.2.1. Suitable for Falls Prevention Programme

Using the flowchart Appendix 2 (page 22), the nurse assesses the patient to see if they would benefit from one of the community programmes. This is often useful to do in discussion with the hospital aides, physiotherapist, the patient and their family.

3.2.2. Visual Issues

Assessing a patient's sight is important, because if a person's vision is poor then they are at greater risk of a fall. If, when observing a patient, you notice behaviour such as the patient not being able to see the details of objects, not wanting to /or unable to read a book or watch television, spilling drinks and bumping into objects, then please share this with the nursing staff. It is also important to ensure the patient is wearing their normal glasses/contact lenses at the appropriate time.

It is vital to ensure **all** patients including patients with visual impairment:

- know how to call for help
- have a clutter free bed space
- have footwear that is easy to locate or have non slip socks on
- be orientated to the ward environment
- be placed close to toilet facilities if possible
- have any visual or walking aides within reach at all times

With the patients permission it is a good idea to have a sign by the patient's bedside to alert everyone so help can be provided when required

3.2.3. Hearing Issues

If a patient appears to lean forward when listening to conversation, asks to have words or sentences repeated, speaks louder then usual or has the radio or television volume up loud, this may indicate hearing problems. Ensure that their hearing aides are working properly and being used, with the patient's permission place a sign above the bed to indicate the patient has a hearing problem.

3.3. Unable to "Get up and go"

3.3.1. Recent Decrease/Change in Mobility

If the patient has been admitted to the ward with a specific medical condition, such as a stroke or broken limb, it is reasonable to immediately identify them a falls risk.

Some patients suffer from life changing diseases that become worse over time (e.g. cancer or heart failure) and they may have a reduced level of ability to look after themselves due to tiredness.

Watch the patient attempting to transfer/mobilise with their normal walking aids and provide assistance as required. If they are unable to transfer, appear unsteady, are reaching out for objects or overbalance while attempting to stand and mobilise – inform the nurse caring for the patient as the patient may need physiotherapy input.

If a patient is having difficulty managing their normal activities of daily living while on the ward (e.g. showering, dressing etc) let the nurse know as they may consider occupational therapy input.

Remember it is important to supervise/assist patients as required and ensure the patient is aware that this is to help to keep them safe during their stay in hospital.

If walking aids are used, it is also important to ensure that these are within reach and used safely.

3.3.2. Footwear and Non Slip Socks

If a patient appears to be limping, or has poorly fitting footwear, then the risk of falling is heightened. Inappropriate footwear is usually:

- Loose fitting
- Open backed
- Has worn soles, or heels
- Has poor or no fastenings
- High heels
- Ill-fitting Slippers

If you notice poor foot condition ensure you bring this to the attention of the nurse who can then follow this up with either an onsite podiatrist at the diabetes centre or suggest the patient makes an appointment with a community podiatrist.

If the patient has unsafe footwear, it is important to contact the family/whanau or carer to request more suitable footwear is bought in – explaining the rationale clearly. All wards within the medical surgical division have a supply of non slip socks available.

The guidelines for non slip sock use and management are located alongside the sock supply on each ward and also in Appendix 5 (pg 26). If you think a patient would benefit from wearing non slip socks please discuss this with the nurse responsible for the patient care.

If a patient has no appropriate footwear at home replacement footwear may need to be purchased and information on where to purchase speciality footwear can be found in Patient Falls Information brochures. It is useful to also give this information to the patient and their family.

3.3.3. Weight Loss/Malnutrition

Malnutrition is a serious health problem affecting 15-40% of patients admitted to hospital. It is associated with poorer clinical outcomes such as delayed recovery from surgery/illness, longer length of hospital stay, increased readmissions, poor wound healing, increased risk of falling and reduced quality of life. It is a serious issue among acute care patients on admission and frequently worsens during the hospital stay. Groups at risk of malnutrition include patients with chronic diseases i.e. diabetes, the elderly, those recently discharged from hospital and those who have limited financial income or are socially isolated. The nurse is able to refer the patient to a dietician if required. The dietician may request a food and fluid chart to collect information about the quantity of food and fluids the patient is consuming. As a H/A you often assist these patients with their food and fluid intake so it is important you pass this information onto the nurse caring for the patient.

Patients who are malnourished and referred to a dietician will be placed on a high protein/energy diet. Patients who are not malnourished or at risk of malnutrition will receive a ‘normal diet’. The catering to you associate will discuss menu options with the patient including any cultural requirements and standard dietary modifications e.g. vegetarian, gluten free. Family members and friends are welcome to bring in additional foods for the patient

If you notice the patient is having swallowing difficulties inform the nurse immediately. The nurse may request speech language therapy input, and this may result in the patient having a modified diet. If the patient is having difficulty with loose fitting dentures, ascertain if they use a denture adhesive and either ask family to bring it in or obtain ‘polygrip’ from a pharmacy.

It is important to remember to leave patient sufficient time to eat their meals, as meal times are a very social occasion, and within the hospital environment mealtimes are a significant event in what is often a long day.

3.4. Risk Taking Behaviour

The patient may not understand what they can do to keep themselves safe. The first step is to consider the actual environment the patient is in. Is there clutter which may increase the patient’s risk? Is a walking aide in reach and in sight? Are they using the walking aide safely?

Fatigue from chronic disease (e.g. cancer or heart disease) may increase the patient's risk of falling as they want to maintain independence. It is worth taking time to discuss with family members and friends of the patient if this is usual for the patient, and is there anything we can do that would assist in maintaining safety.

Frequent reminders to ask for assistance before mobilising can help and writing this on a whiteboard may be useful. If patients know that you have time to help them they will be more likely to ask for assistance. Moving the patient to an area of high visibility – such as close to the nursing / staff base can assist other staff to be aware of the patient, and the patient may be able to more easily ask for assistance. Always check the patient has a call bell and knows how to use it before you leave them. The use of a sensor system may also be appropriate for some of these patients let the patients nurse know if you think this may be helpful – (See sensor system information pg 14).

Performing regular toileting is important as a lot of falls occur when the patient is attempting to go to the toilet. Checking on the patient regularly helps build a trusting relationship between patient and staff and by doing this you are likely to see them if they are attempting risk taking behaviour. If a safety risk remains the patient may require an H/A special, the nurse caring for the patient can request this once all other options have been tried. If there are family members who are willing to come and spend time with the patient, then this is preferable, as it may reduce problems having someone familiar present.

Some of the wards at Christchurch Hospital use a nursing framework whereby one nurse is allocated to care for one room of patients. This ensures that the nurse is able to visualise the patient much more frequently and when they are required to leave the room for such things as medication administration they may ask you as a team member to stay in the room and monitor their patients.

3.5. Medications

Certain medications and being on more than four medications increases a person's risk of falling. Within the acute hospital environment it is common for patients to be on a number of medications.

Occasionally new symptoms such as dizziness or drowsiness may occur soon after a new medication is started. If a patient tells you they are experiencing any new symptoms report to the nursing staff immediately.

If a patient is on medication that may make them sleepy, then ensuring their surroundings are safe is important. Ensure clutter is reduced around the bed and the use of night lights. Where possible supervise or assist them mobilising. Another option to consider is the use of a bedside commode to reduce mobilisation during the night. During the day time the commode should be removed and the patient encouraged to mobilise to the toilet.

3.6. Confusion/Disorientation

Changes to a patient's environment can have the effect of disorientating / confusing a patient. This may occur on, or shortly after admission, if there is a room change or a change in the patient's routine.

It is not normal for patient's to be acutely confused and this should be considered as a symptom of a more serious medical problem. If this occurs inform the nursing staff immediately.

Assist the patient to remain orientated by the use of:

- Whiteboards
- Distraction boxes
- The presence of family and friends
- Maintaining the patient's usual routines if possible
- Maintaining consistency of nursing staff if possible
- Use and availability of familiar possessions.
- Minimise shifting the patient from room to room if possible.
- Use the patient's aids such as glasses and hearing aids and ensure that they are in a good working order
- Verbally remind confused patients where they are and the time of day

3.7. Altered Elimination/Continence

Having a toileting programme is a key part of falls prevention management. It has been identified that a large percentage of falls happen when the patient attempts to mobilise to the toilet. Urgency (sudden urge to go) or frequency (wanting to go frequently) can result in risk taking behaviours as a patient tries to get to the toilet in time. Difficultly related to unfamiliar clothing e.g. hospital gowns and the impact of a new health problem also may impact on their mobility and safety. Take into account I.V. fluids or medication that may change their need to go to the toilet

To assist in planning care, ask the patient about their usual toilet routine at home, especially at night, this will help determine if assistance may be required. It is important that you pass the any of the following information onto the nurse:

- Fluid intake
- Bowel and bladder activity
- Offensive smelling, dark urine and or urinary frequency
- Not being able to/or difficultly passing urine or bowel motions
- Loose offensive smelling bowel motions

It is useful to work out a toileting programme that best suits the patient's preferred routine with the nurse responsible for the patents care. You can provide assistance by ensuring the patent is assisted to the toilet at regular intervals e.g. an hour after drinking or before settling for the night. If possible, consider moving the patient to a room closer to toilet facilities. Also ensure the call bell is available and visible for the patient. On a night shift ask if they would prefer to be woken to go to the toilet if they normally need to go overnight, this will help ensure they are not trying to go on their own as a high number of falls occur during the night when patients are attempting to go to the toilet.

- Under direction from the Nurse consider using:
- Bedside commodes
- Urinal bottles
- Smaller pads for urgency

- Larger pads for incontinence

Remembering that the use of pads often serves to increase incontinence problems and reduce mobility

If incontinence is an issue, let the nurse know.

4. Section 4 - Sensor Systems

Within Christchurch Hospital we have two sensor systems available; sensor clips and sensor mats. It is important within your role have an understanding of these devices.

4.1.1. When to use a sensor system

A sensor system can be used on any patient with verbal consent of the patient/family/whanau.

Sensor systems are useful to use in the following situations:

- Patients who are likely to wander from the ward/unit
- When the staff need to be alerted if a patient is leaving isolation
- Patients who have a history of risk taking behaviours i.e. mobilising without recommended walking aids
- Patients who are at risk of falling/rolling/slipping from the bed or chair

4.1.2. When we should not use a sensor system

- The patient **must** be able to carry their own weight and their balance must not be unsteady when standing
- Patients who are at risk of self harm behaviours (suicide)
- Patients who have devices implanted containing magnetic fields i.e. pacemakers
- Patients who are attempting to mobilise frequently as they sensor systems will alarm frequently

4.1.3. Who is responsible for the care of patients on sensor systems

- All staff including hospital aides are responsible for attending to the alarm quickly to maintain patient safety
- For wards that have a patient status boards a magnet needs to be placed on the board so all staff know that the patient is on a sensor system
- The Registered Nurse caring for the patient who has a sensor system in place has the ultimate responsibility for the safety of the patient

Remember it is every staff member's responsibility to respond to a sensor system alarm

5. Section 5 - Christchurch Hospital Falls Data (2010 - 2011)

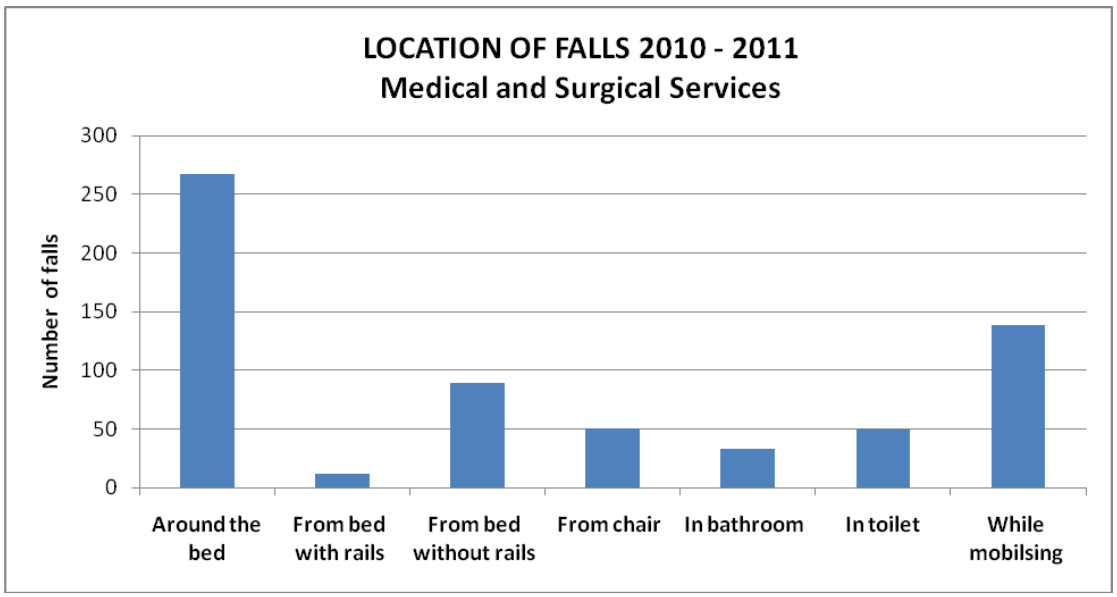
Summary of Reported Patient Falls at Christchurch Hospital:

There was a total of 698 patient falls reported during the 2010 -2011 financial year of these, 2% resulted in moderate or serious harm (i.e. died because of the fall , had a fractured bone or required sutures because of the fall)

This means approximately:

- 58 patients fall each month
- 47% suffered some harm from the fall
- 40% of patients fell during the night shift and the rest were split evenly between the morning and afternoon shift
- 30 % wanted to go to the toilet
- 24% of patients were identified as confused at the time of the fall

Where Patients Fell:



6. Section 6 – Safer Patient Handling

Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast
DISTRICT HEALTH BOARD
TE POARI HAUORA A ROHE O TAI POUTINI

Safer Patient Handling:
Managing the fallen patient

Keeping people safe and well

Health and Safety

'Staff Safety and Safer Handling"

When you are assisting a patient (who is at risk of falling) to mobilise it is important that you stand to the side and behind the patient and support the patient's pelvis. This means that you will be in a safe POSTURE and will BE PREPARED (refer to the 5Ps of Moving Safely) to control the patient's balance and control their descent if there is a need to lower the patient to the floor. This may be done only when the person is falling backwards or directly downwards; they are not resisting; there is sufficient space and that there is no significant height or weight difference between helper and patient.

If the patient is falling away from you or you are some distance from the falling patient then you should allow the patient to fall. Although this presents an ethical dilemma that goes against the fundamentals of your duty of care, catching a falling person or controlling their descent is inherently unsafe[1] for both patient and helper.

Assisting a fallen person from the floor

Use the 5Ps (Plan – Prepare – Posture/Positioning – Performance/technique – Be Prepared) of the safer handling principles.

Check for any injuries before moving the fallen person. Give them time to get calm and recover.

Do not attempt to manually lift the person unless there is an emergency or life-threatening situation. This involves a high risk of injury for the helpers.

Remember the person cannot fall any further, so make them comfortable then organise additional help and prepare any equipment required.

In some cases where there is no immediate danger it may be appropriate to leave the person on the floor (for example if the person has intentionally placed themselves on the floor for attention or an epileptic having a seizure) and they can get up when they are ready.

If the person has fallen in an area that is difficult to access they should be moved to an area with sufficient space. Place a slide sheet under the person and use two helpers to slide the person out of the confined area.

There are several options for assisting the fallen person from the floor:

1. **Once recovered the person may be able to get up independently without any additional assistance.**

1

2. **The person may be instructed on getting up by kneeling and using a chair for support. Additional assistance may be given by a helper standing behind and guiding the patient's buttocks onto the chair <u>or</u> bringing another chair in directly behind the patient and using the first chair to lean on.**

The person must have good mobility in their hips and knees along with adequate strength in arms and legs.

This technique may not be suitable for patients with hip joint replacements.

If the person is unable to manage either of the above methods then some mechanical assistance is required.

Helpers must be adequately trained (and supervised if appropriate) in the use of this equipment.

3. **Use a hoist. Insert the sling under by rolling the person onto their side. Use hoist according to manufacturers' instructions.**

6.1. Appendix One: Risk Screening, Strategies & Care Planning Documents

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Christchurch Hospital

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

RISK SCREENING

Commenced for all patients at point of entry (use patient assessment questionnaire as appropriate) and completed within 6 hours

☐ Patient label correct ☐ Patient label not correct → ☐ Update PMS and ☐ Update Admission Form

ADVERSE REACTIONS ☐ **No risk identified**

☐ Medicine (specify)
☐ Food (specify)
☐ Other (specify)

→☐ Alerts completed
→☐ Update diet
For 3 or more food allergies →☐ Dietitian referral

INFECTION PREVENTION AND CONTROL ☐ **No risk identified**

☐ PMS Alert checked for MRSA, ESBL, VRE, MDRO
☐ Recent diarrhoea / vomiting (potentially infectious)
☐ Transmission based isolation precautions required →

☐ MRSA screening swabs taken
☐ Other infectious conditions (specify)
☐ Contact ☐ Droplet ☐ Airborne ☐ Protective

COMMUNICATION/COGNITIVE/MENTAL HEALTH ☐ **No risk identified**

☐ Interpreter required (specify language)
☐ Hearing Impaired ☐ Vision Impaired →
☐ Recent changes in ability to make self understood/express self
☐ Known Communication Barrier (specify)

☐ Customer services contacted for interpreter (ext 80843) or Duty Manager paged A/H
☐ Advised to bring in communication aids if appropriate
☐ Cognitive deficits/previous delirium (specify)
☐ Known behavior that causes safety concerns to staff/patients/visitors (specify)

CONFIDENTIALITY ☐ **No risk identified**

☐ Personal information **not to** be shared with specified person/group (specify)
☐ Patient's name requested to be removed from ward identification boards → ☐ Ward Clerk notified
☐ Notification to the Telephone Office as required → ☐ Alerts completed

PERSONAL PROPERTY ☐ **Not applicable**

Property ☐ With patient ☐ With family **Valuables** ☐ With patient ☐ With family ☐ In Hospital Safe
Meds ☐ With patient → to Ward for pharmacist ☐ At home **Yellow Card** ☐ Yes ☐ No ☐ N/A

PRESSURE INJURY ☐ **No risk identified (19 to 23)**

☐ Current PI on admission (location) → Stage
☐ **Automatically at Very High Risk** → ☐ Document in Care Plan ☐ Incident Form completed
☐ Clinical judgment affects level of risk → ☐ Document in Care Plan

☐ At risk (15 to 18)
☐ Mod risk (13 or 14)
☐ High risk (10 to 12)
☐ Very high risk (9 or below)

FALLS ☐ **No risk identified (no categories selected)**

☐ A. Previous Slip/Trip/Fall/Collapse ☐ B. Unable/Difficulty to Get up and Go ☐ C. Risk Taking Behaviour
☐ D. Complex medications/side effects ☐ E. Confusion/Disorientation/Sensory Deficits ☐ F. Altered Elimination

☐ **1 category selected** **(consider strategies from that category in assessment plan)**
☐ **2+categories selected** **(consider strategies from ALL categories in assessment plan)**

Fall risk identified but patient to be discharged

☐ Patient/family informed of risk and given fall prevention pamphlet.
☐ Occupational therapist and Physiotherapist paged for review
☐ Referral to community programme (C24102A)
☐ Medical Team alerted for GP follow-up

ALCOHOL DEPENDENCE/WITHDRAWAL/ABUSE ☐ **No risk identified**

☐ Alcohol related admission or high alcohol intake → complete CAGE/CRAFFT (<18) screen Score __(if score 1 or above) → ☐ Brief advice given → ☐ Refer to Medical Team and Social Worker
☐ Recreational Drug User (specify) → ☐ Refer to Medical Team and Social Worker

FVSQ ☐ **No risk identified FV -**

☐ FV + or ☐ FV (Signs/symptoms?) → ☐ Preliminary Risk Assessment Form completed → ☐ Refer to social worker
Or ☐ Not asked screening questions → ☐ No staff education

SMOKING ☐ Current smoker ☐ Ex Smoker ☐ Exposed to second hand smoke ☐ **Never smoked - No risk identified**

ALL patients identified as a smoker (smoked at least 1 cigarette in the last month)

☐ Brief advice to quit ☐ Patient advised of CDHB Smokefree policy ☐ Quit pack given or ☐ declined ☐ External referral sent or ☐ declined

Patient discharged →☐ Quit card/NRT/Cessation meds prescribed or ☐ declined
Patient admitted to ward →☐ NRT prescribed for withdrawal/cessation or ☐ declined

DOCUMENTATION RECORD

Full Name	Designation	Signature	Date	Time

RISK SCREENING C24009A

Canterbury
District Health Board
Te Poari Hauora ō Waitaha
Christchurch Hospital

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

INITIAL ASSESSMENT

This plan must be completed within 24 hours of hospital presentation
Please refer to the highlighted sections of the Patient Questionnaire if completed.

☐ **Risk Screening Form has been fully completed**

PAIN/COMFORT/WOUND

☐ **No risk identified, proceed to next section**

☐ Pain score above 3 → ☐ Refer to Medical Team urgent review

☐ Wound on admission → ☐ Wound treatment sheet completed

Referrals sent if required for wound management to

☐ Wound CNC ☐ Vascular Nurse ☐ Infectious Disease Nurse ☐ Diabetes Podiatrist

☐ Lymphoedema Issues? Side R / L (circle) Limb Arm / Leg (circle)

PRESSURE INJURY Refer to Braden Scale

☐ **No risk identified, proceed to next section**

FOR ALL LEVELS OF RISK

☐ Heels protected

☐ Encourage remobilisation

☐ Individualised frequent position changes implemented

☐ Pressure reduction support surface for seating and/or mattress

Manage Moisture

☐ Temperature control implemented

☐ Skin folds separated

☐ Skin protectant moisture barrier applied

☐ Wound exudate control implemented

☐ Cause addressed if possible (incontinence, skin moisture etc)

☐ Skin cleansing regime with pH balanced products implemented

☐ Absorbent pads or diapers that wick and hold moisture used

Manage Nutrition (Complete nutrition section)

Manage Friction & Shear

☐ Elevate foot of the bed 10–20°

☐ Trapeze / monkey bar used when indicated

☐ Elbows and heels exposed to friction are protected

☐ Transfer sheet used to move patient

☐ Position head of bed <30° unless medical condition prevents

MODERATE RISK ADDITIONS

☐ Foam wedges used for 30° lateral positioning

HIGH RISK ADDITIONS

☐ Frequency of turning increased to at least two hourly

VERY HIGH RISK ADDITIONS

☐ Pressure redistributing mattress if required

☐ Pressure redistributing surface if patient has intractable pain or severe pain exacerbated by turning or additional risk factors

FALL RISK ASSESSMENT/MANAGEMENT (categories continues over page)

For 2 or more categories ticked complete/consider all strategies for all categories

☐ Family informed of fall risk (required action)

☐ Fall bracelet applied

☐ Fall prevention information leaflet given to patient/family

☐ Fall sticker in place

☐ Fall risk and strategies discussed with patient/family

☐ Fall sign above bed (with consent)

A. Previous fall/slip/trip/stumble/collapse

☐ Orientate to ward environment

☐ Discuss reasons for previous fall and implement appropriate strategies

☐ Ensure hearing, visual and mobility aids are used

☐ Items that may be required by patient are within easy reach e.g. call bell, urinal, drink

☐ Strategies to reduce risk of collapse/syncope in care plan e.g. lying./standing BP

Documentation Record: Full Name	Designation	Signature	Date	Time

INITIAL ASSESSMENT C240009C

Fall Risk Assessment/Management continued	Patient NHI:

B. Unable/difficulty to get up and go

- ☐ Ensure walking aids are within easy reach
- ☐ Advise to call for assistance prior to mobility
- ☐ Encourage use of safe, well fitting footwear
- ☐ Refer to Physiotherapist/Occupational Therapist for risk A and/or B

C. Risk taking behaviour

- ☐ Review need to move to high visibility area
- ☐ Remove non-essential equipment/furniture
- ☐ Ensure bed is at correct height: low for roll risk
- ☐ Consider sensor system.
- ☐ Inform family of falls risk and ask if able to support patient.
- ☐ For frequent risk and no family support, consult CNM/NIC re Hospital Aide Specialling.
- ☐ Consider hire of low bed

D. Complex Medications/Side effects ☐ Review medications likely to cause falls → ☐ Pharmacy referral

- ☐ Consider calcium and vitamin D supplementation if patient over 65 → ☐ Medical review
- ☐ Commence lying and standing blood pressure monitoring as discussed with medical staff

E. Confusion/Disorientation/Sensory deficits

- ☐ Place in quiet area away from main exit doors but still able to be observed easily.
- ☐ Complete CAM score/MSQ on page 5 and refer to medical team as required.
- ☐ Implement and document delirium strategies. → ☐ Occupational Therapy referral
- ☐ Ensure hearing/visual aids are used and/or within reach → ☐ Use signage (with consent)

F. Altered Elimination ☐ Patient with frequency/urgency shifted to room near toilet

- ☐ Consider commode/urinal within easy reach at all times (reiterate assistance is available)
- ☐ Address hydration issues ☐ 24 hour toileting plan and 2hrly checks in Care Plan

COGNITIVE ASSESSMENT

☐ No risk identified, proceed to next section

- ☐ Altered cognition due to a chronic condition (specify)
- ☐ Hx of delirium or ☐ Hx of dementia → ☐ CAM and MSQ performed
- ☐ Cognitive changes within last few days → ☐ CAM and MSQ performed
- ☐ CAM positive →☐ Medical Team assessment ☐ Delirium management in care plan/family education

MSQ = or below 7 (Score___) → ☐ Medical Team assessment

Patient has behavioral issues? (specify)

☐Agitation ☐ Aggression ☐ Wandering ☐ Vocal

Behavioral Management plan available? ☐ No (question usual carers on management included in care plan)
☐ Yes (use specific care/management plan)

☐ Doll /Distraction Therapy used → ☐ To be used during hospital stay and included in Care plan

MENTAL HEALTH

☐ No risk identified, proceed to next section

- ☐ Patient having suicidal thoughts → ☐ Medical referral for psych consult
- ☐ Kessler screening tool not completed in Patient Questionnaire and patient has history of or appears:
- ☐ Depressed or ☐ Anxious → Ask patient to complete Kessler screening tool if appropriate or medical referral
- ☐ Kessler score in Patient Questionnaire (30 or above or patient has circled a response in a shaded column)

If urgent or staff have concerns → ☐ Medical referral If non urgent ☐ Referral to GP on referral for follow-up

SAFETY ASSESSMENT

☐ No risk identified, proceed to next section

- ☐ Current patient self harm/ violence/ security risk or has a clinical management issue (specify)
- ☐ Visitor/family/whanau risk to patient or staff (specify)
- ☐ Place alert on PMS ☐ Potential weapons removed
- ☐ Consider notifying security ☐ Consider urgent medical team review ☐ Notify Duty Nurse Manager
- ☐ Referral to Social Work for family violence / care and protection issues
- ☐ Documented above risks in Care Plan and identify if patient has:
  ☐ Security Guard ☐ Police Escort ☐ Prison Guard ☐ Psych Nurse ☐ Other (specify)

Documentation Record: Full Name	Designation	Signature	Date	Time

Canterbury District Health Board
Te Poari Hauora ō Waitaha

(Attach Label here or Complete Details)

NAME:_____ NHI:_____

GENDER: ____ DOB:_____ AGE:_____ WARD:_____

Christchurch Hospital

Care Plan – 24 Hour

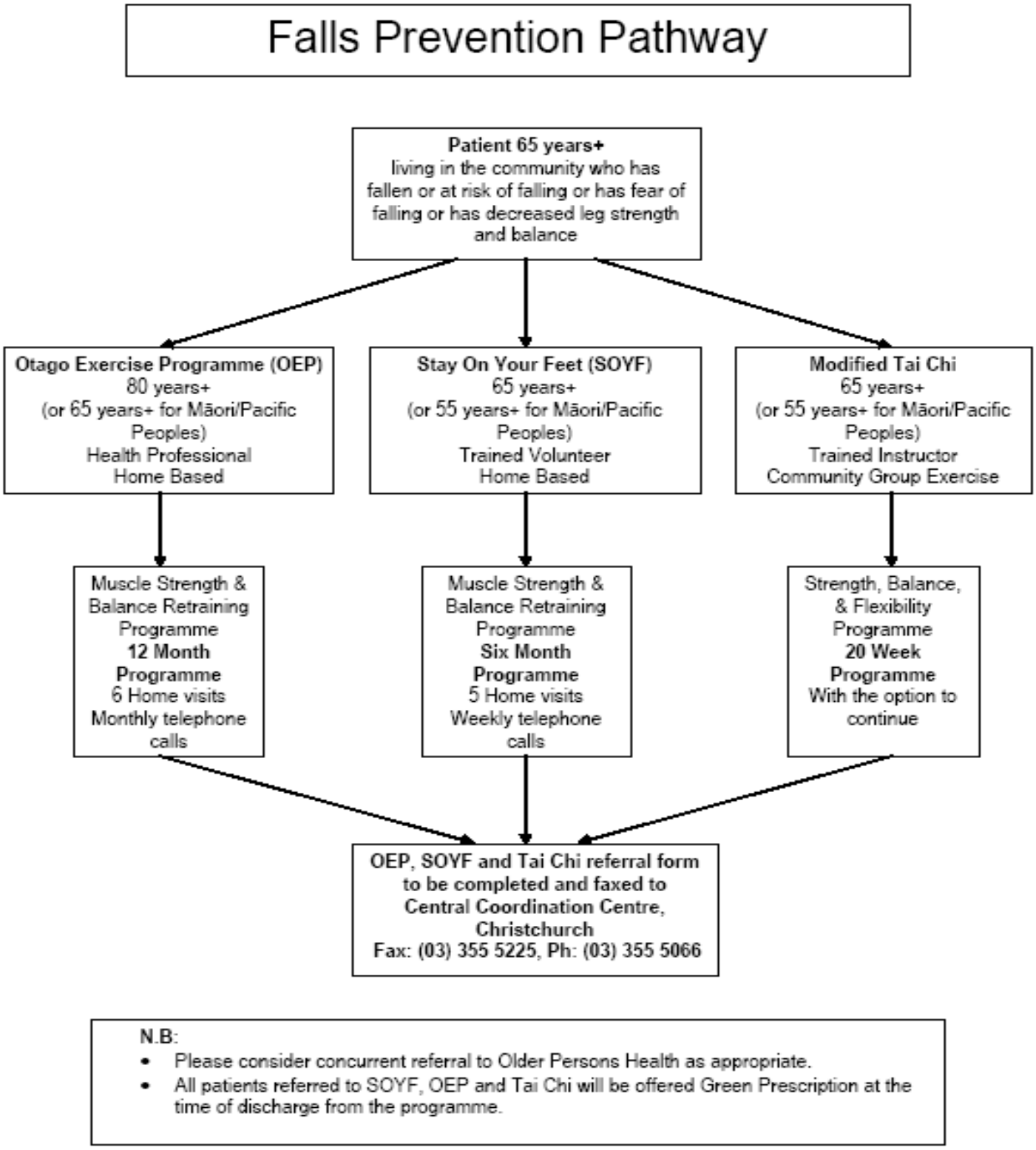
This plan must be updated and reviewed every shift. Identify and document type and frequency of strategies. Use spaces provided to document patient specific strategies or document "NC" if there has been no change from the previous shift's strategies

	MANAGEMENT STRATEGIES	Date: Night / AM / PM	Date: Night / AM / PM	Date: Night / AM / PM
Risk Screening	Falls (circle) A B C D E F or No risk PI Braden score _____ PI Stage (circle) 1 2 3 4 or unstageable or no PI sites PI area (specify) Other (circle) Cognitive, Current smoker, Communication, Restraint, Alcohol			
Airway/Resp	Oxygen requirements Assistive devices Safe swallowing techniques Tracheostomy			
Symptom	Pain relief strategies Nausea relief strategies Medication requirements			
Observation /Monitoring	Vital Observations Fluid balance Weight Neurological Circulation checks BGL			
Fluid & Med	Peripheral cannula change IV tubing change CVAD treatment Dressing PICC– document ext length Plug change Flushes S/C management			

CARE PLAN 24 HOUR

C240076B

6.2. Appendix 2: Fall Prevention Pathway



N.B:

- Please consider concurrent referral to Older Persons Health as appropriate.
- All patients referred to SOYF, OEP and Tai Chi will be offered Green Prescription at the time of discharge from the programme.

November 2007

6.3. Appendix 3: Falls Prevention Programmes in Canterbury

Falls Prevention Programmes in Canterbury

Modified Otago Exercise Programme (MOEP) and Stay On Your Feet (SOYF)

MOEP Eligibility Criteria:

Patients are eligible for MOEP if they have fallen, are frail, fail the strength and balance tests OR possess other risk factors, such as fear of falling or impaired vision. A recent ACC claim is no longer required. If following an assessment the MOEP is not deemed to be the appropriate programme for the patient then they may be referred on to SOYF or Modified Tai Chi.

SOYF Eligibility Criteria:

Patients are eligible for the SOYF programme if they have a fear of falling, have decreased leg strength; decreased balance; or have had a fall in the last 12 months (does not have to be an ACC claim and includes slips and trips that have not resulted in person lying prone on the floor).

These two home based falls prevention programmes BOTH provide points 1 – 5 and the chart below denotes the significant differences:

1. Programmes consist of a set of leg muscle strengthening and balance retraining exercises that progress in difficulty, and also incorporate a walking plan.
2. The exercises are individually tailored and progressed during a series of home visits by a trained instructor.
3. To promote adherence to their individualised programme, participants record on a calendar the days they complete the programme and the instructor telephones them between home visits.
4. The people are living in the community or an independent unit of a retirement village (excludes rest home residents).
5. All patients are routinely offered a Green Prescription (GRx) at completion of OEP or SOYF.
6. These programmes are not suitable for people with significant cognitive impairment.

MOEP	SOYF
Older persons aged 75+ (or 65+ for Māori and Pacific Peoples)	Older persons aged 65+ (or 55+ for Māori and Pacific Peoples)
12 month programme • 6 home visits - 5 home visits in first 6 months, final home visit at 12 months. • Second 6 months – monthly phone calls	6 month programme • 5 home visits • Weekly phone calls
Service delivered by trained physiotherapist or registered nurse	Service delivered by trained volunteers

Modified Tai Chi

The eligibility criteria for the Modified Tai Chi programme is the same as the SOYF programme above.

1. Community based Tai Chi classes using a specific set of Tai Chi exercises which focus on building strength and balance.
2. 16 week introductory course
3. Course consists of 1 class per week over 16 weeks at a number of community venues led by trained Tai Chi Instructors.
4. Maintenance classes are available for participants who have completed the 16 week programme.

Green Prescription (GRx)

1. GRx exercise specialist phones monthly for 4 months to provide ongoing support.
2. GRx also provides guidance on appropriate local community based physical activities.
3. Final discharge report sent to original referrer by GRx.

6.4. Appendix 4: Falls Prevention Referral Form

FALLS PREVENTION REFERRAL FORM

Date of referral		**NHI**	
Patient name	**Address**		**Alternate contact name** **Relationship**
Phone number			**Alternate contact** ☏
Date of Birth	**Ethnicity:**	**Gender M☐ F☐**	**Patient aware of referral Y☐ N ☐**
GP referral Attach medical conditions & medications OR fill in below. **Secondary care referral** Please attach a copy of patient's discharge summary OR fill in below. **Community Referrals** Fill in below as able			
GP details (name, practice, phone and fax numbers) **phone number** **fax number**		**Non GP referrer's details** (name, position, workplace) **phone number** **fax number** **I have informed the GP YES ☐ NO ☐**	
HISTORY SECTION:			
Full medical conditions, including those effecting mobility and cognition History of falls (if any)		**Medications (if not attached)**	
Other relevant information (including any social circumstances)			

Please tick the appropriate programme for your patient
NB Refer to flow chart on health pathways or PTO

Modified **OEP** ☐

75+ (65+ Māori/Pacific)
·Registered Health Professional
·Frail & failed falls risk assessment

SOYF ☐

65+ (55+ Māori/Pacific)
·Trained Volunteer
·Frail; mobile in the community

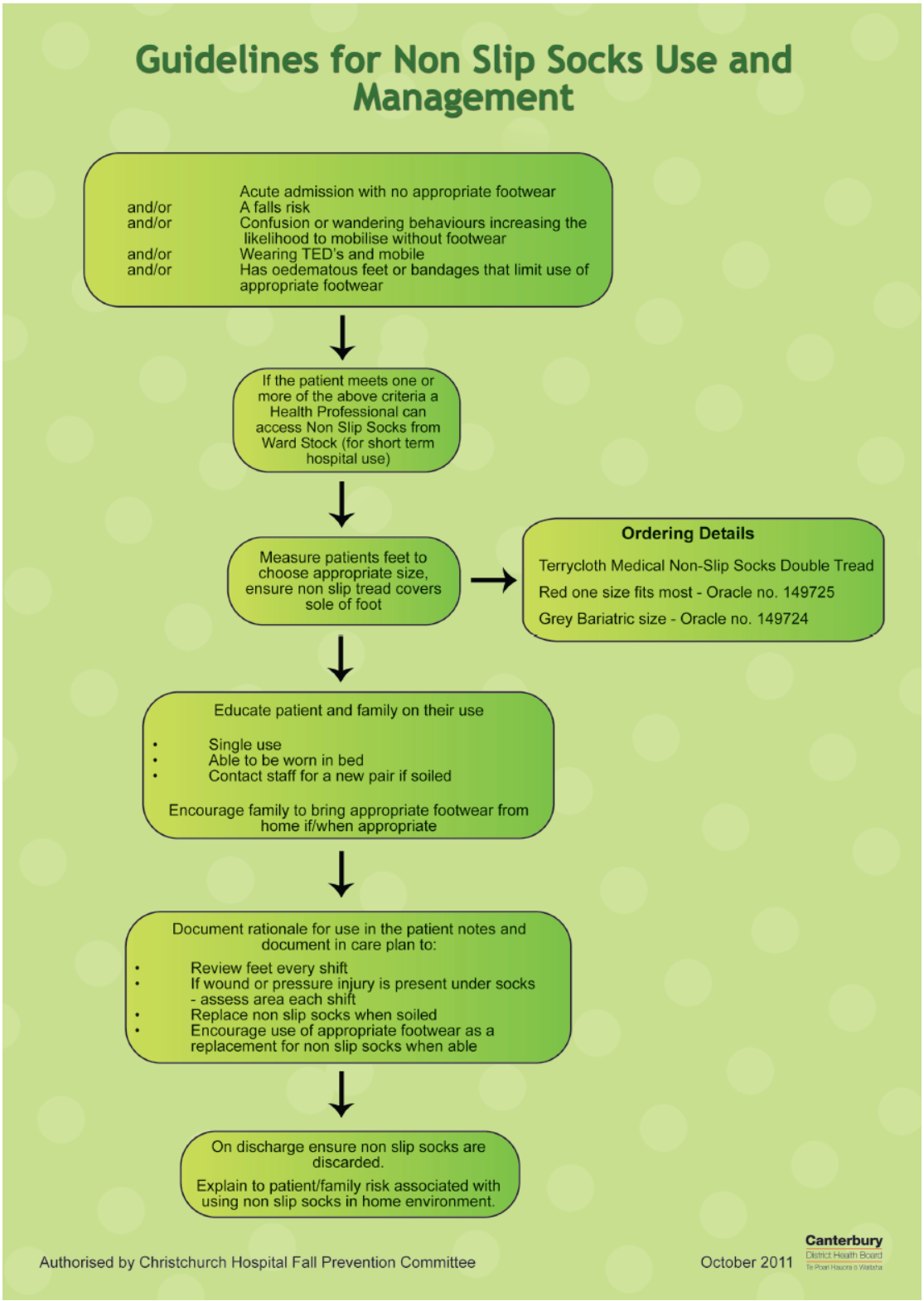
Modified **Tai Chi** ☐

65+ (55+ Māori/Pacific)
·Trained tutor
·Independently living; mobile

Please return this form to Central Coordination Centre CHCH
Fax: (03) 355 5225 **Ph:** (03) 355 5066 or 0800 733 379
Email: referral@coordination.org.nz

February 2012

6.5. Appendix 5: Guidelines for Non Slip Socks Use and Management



6.6. Multi-Choice Test: Hospital Aide

☐ I have read and understand the Falls Prevention Management Policy in Volume A. Policies and Procedures.

Name & Designation Date

Signature Work Area

Please circle the most appropriate answer

1. **Which of the following statements is correct?**
    a. 1 in every 3 patients over 65 will fall in any given year
    b. 1 in 2 patients over 80 years of age fall
    c. Only 50% of these patients will regain their pre fall level of functioning
    d. All of the above

2. **The Modified Hendrich II Falls Risk Assessment Scale is the name of the tool nurses use to assess the patients risk of falling**
    a. True
    b. False

3. **If a patient has been determined as a falls risk by the nursing staff they will:**
    a. Be wearing a green wrist bracelet and have a falls risk sign above the bed
    b. A falls magnet will be placed on the patient status board (if present in area)
    c. Both A & B
    d. None of the above

4. **As a hospital Aide what could you do to avoid and patient falling?**
    a. Ensure the area is free of clutter
    b. Ensure mobility aides are within easy reach of the patient
    c. Increase visual checks of the patient as requested by the Registered Nurse
    d. All of the above

5. **Unsuitable footwear for patient at risk of falls in the hospital environment can be considered to be:**
    a. Socks
    b. TED surgical stockings
    c. Sandals
    d. Many brands of slippers
    e. All of the above

6. **If a patient does not have suitable footwear, then:**
    a. The patient's family should be asked to bring in safe footwear
    b. Consider the use of non slip socks in conjunction with the nurse
    c. The patient should remain on bed rest
    d. 1 and 2

7. **What can you do to help with risk taking behaviour?**
    a. Regular toileting and increasing visual checks on the patient
    b. Remind the patient to ring the call bell prior to attempting to mobilise
    c. Support the patient as they get out of bed
    d. Remind them to use their walking aides
    e. All of the above

8. **If a patient tells you that they are having problems with feeling dizzy since starting on a new medication you would notify nursing staff immediately?**
    a. False
    b. True

9. **Patients who are disoriented/confused are at increased risk of falling. Which following action may help the patient remain orientated?**
    a. Have familiar possessions with the patient and use if possible
    b. Moving the patient regularly from room to room
    c. Ensuring the patient follows strict hospital routines
    d. Recommending family and friends don't visit the patient

10. **Having a toileting programme is NOT a key part of falls prevention management as patients DON'T often fall when attempting to go to the toilet**
    a. True
    b. False

11. **What patients should we NOT use a sensor system on?**
    a. Patients who are likely to attempt to wander from the ward/unit
    b. Patients who are at risk of falling/rolling/slipping from the bed or chair
    c. Patients that cannot support their own weight and have unsteady balance when standing
    d. Patients who are likely to attempt to walk without using there walking aides

12. **At Christchurch Hospital in the year 2010-2011 approximately how many patients fell each month?**
    a. 48
    b. 58
    c. 18
    d. 78

13. **What percentage of the patients that fell in this period wanted to go to the toilet?**
    a. 30%
    b. 20%
    c. 10%
    d. 50%

14. **The majority of patient falls occurred in what area?**
    a. In the bathroom
    b. In the toilet
    c. From a bed with rails up
    d. Around the bed

15. **When assisting a patient to mobilise who is at risk of falling you should stand to the side and behind the patient and support the patient's pelvis**
    a. True
    b. False

16. **Before attempting to move a fallen person in hospital , it is important that the nurse checks for injuries?**
    a. False
    b. True

When completed, please return this test along with the evaluation form to your Nurse Educator, Clinical Nurse Specialist or CNM for marking. (For hospital aides working on pool this will go to Liz Henderson

Thank you

Marked by:

Name **Date**

Signature **Designation**

6.7. Reference List

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6.8. Evaluation Form

(Optional) Name: Work area:

Please complete this evaluation form and send back to your NE, CNS or CNM with the multi choice test.

The content of this self learning package:	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
Increased my awareness in relation to the importance of falls prevention during and after hospitalisation					
Has enabled me to identity and minimise the risk factors related to falls in the acute hospital environment					

Do you have any other comments /recommendations in relation to the Falls Prevention Self Learning Package?

Thank you