Hospital Safe Mobility and Fall Prevention Procedure

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Hospital Safe Mobility and Fall Prevention Procedure

Purpose

This procedure describes the standardised, patient centred approach to hospital safe mobility, fall prevention and management across Waitaha Canterbury hospital inpatient and outpatient services.

Applicability

Includes all hospital staff/ personnel, contractors and access agreement holders. Students under direction of clinical staff.

Excludes Community and Aged Care facilities. The Age-Related Residential Care (ARC) Safe Mobility and Fall Prevention Procedure (2409023) is to be used for aged residential care residents.

Definitions

Patient fall: Any unintentional change in position where the person ends up on the floor, ground, or other lower level; includes falls that occur while being assisted by others.[1]

Developmental fall: Involve young children 3yrs old or younger that have the Safety 1st contributing factor of 'Patient-Developmental Stage'.

Prerequisites

Education and training: All staff involved in patient contact, must complete the appropriate education and training: fall prevention during orientation.

As a minimum the related areas of education considered for safe mobility are deteriorating patient, safe handling, dementia/delirium, malnutrition in hospital, informed consent, privacy, clinical record keeping.

Clinical Governance: All teams have clinical governance processes which include person-centred care, patient safety, harm reduction, systems improvement, education and training.

All clinical area managers monitor and ensure new staff complete pre-requisite education.

Outpatient Departments / Day Patients

Identified risk factors that may impact safe mobility are considered as part of any consult**.**

Identified risk factors relating to mobilising are communicated to the patient's GP and community providers for follow up if agreed in partnership with patient.

Safe Mobility/ falls prevention key messages are well communicated to staff, to maintain sustained awareness of effective health promotion and resources available to patients and whānau.

[1] Definition from operational definition used in InterRAI Assessment Tools. This definition is referenced by the Health Quality & Safety Commission in Topic 5: After a fall What should happen?

Inpatient Areas/ Emergency Department

Assessment, Planning and Care Evaluation

All inpatients are considered to **have at least a 'low risk' of falling** in hospital as they are in an unfamiliar environment and their condition and presenting problems are serious enough to require acute hospital level care.

Assess and partner with all newly presenting and transferring patients, or those who experience a change in condition, to identify risk factors that may impact safe mobility and pose risk of falling as soon as possible (max 6 hours). **Ensure** the **patient's history**, **condition and presenting problems** are considered as part of this risk assessment process.

Pay particular attention to patients with a history of falling, medical conditions that affect safe mobility, postural hypotension, syncope, postural reflexes, strength and balance issues, functional decline, communication impairment, impaired cognition, impulsivity/ risk taking behaviours, toileting and continence support, nutrition and medicines (including timeframes for administering) that can effect safe mobility and informed decision-making as per *Hospital Falls Prevention Care Planning Cycle* staff resource.

Following surgery and **procedures** be aware and mitigate risk from changing levels of consciousness, balance and limb strength as well as sedation and anaesthesia, including epidurals and spinals.

For babies ensure education is provided to whānau relating to safe handling and safe sleeping for babies – *https://www.healthinfo.org.nz/index.htm?* The following resource is available for babies using a Pepi Pod - *Safety Checklist for use of First Day Pepi Pods Sleep Safe.*

Provide education to whānau about keeping their baby/infant safe while in hospital by ensuring cot sides are up, and babies/infants are not left unsupervised on a surface which could result in a fall if unattended.

Bedrail use can make it difficult for patients to mobilise in and out of bed safely and potentially increase the risk of injury including from falls. Bedrails are classed as restrictive equipment and may therefore become a physical restraint that needs to be reported accordingly – refer to the Restrictive Equipment Safe and Appropriate Use (incl bedrails) procedure which includes the 'Decision Matrix – How to Use Bedrails Safety?'.

Be proactive, anticipating patients' needs. **Plan** and **identify** prevention interventions and level of observation required to mitigate risk factors **with** the patient and family/whānau. Follow informed consent processes.

Record interventions in the care plan and response in the progress notes.

Apply the relevant **visual cues** indicating level of support required and **keep up to date**:

- Mobility bracelets.
- Mobility equipment tags for individual dedicated walking aids.
- Bedside boards - safe mobility plan components.
- Fall risk magnet/symbol for Ward Information boards/Floview.
- Post Fall magnet/symbol for Ward Information boards/Floview.

If the patient has a fall, use the Canterbury Post Fall Clinical Pathway to support a thorough review of the patient's condition and the ongoing post fall care.

At the time of the fall:

- the relevant content of the **bedside board just prior to the fall is to be recorded** in the clinical record.
- the **bedside board must be updated in line with the reviewed care plan**.
- the **clinical record** must be updated to support continuity of care.
- a **Safety 1st fall event** form must be completed to assist with the incident investigation process (not required for developmental falls).

Complete an ACC 45 if there is significant injury.

Partnering with the patients and whānau/family.

- Ensure the patient and whānau 1) **knows** enough, 2) **can think through** (understanding and reasoning) and **is** 3) **free** to participate and carry out the **agreed** safe mobility and fall prevention interventions throughout their care. When the patient is **less able** to partner in care, it's even more important to involve whānau/ family/ friends.
- Ensure the patient and whānau is **orientated to the physical environment, equipment, staff call method, and daily routine, including when changing the patient's environment i.e. lounge, bathroom**.
- Ensure staff call / **call bell is in reach** and patient is able to use.
- **Be proactive** in meeting patient's needs such as regular toileting, pain relief, nutrition, and the utilisation of hearing and visual aids as appropriate.
- Ensure the patient's and whānau **cultural needs are being met** as part of their care plan.
- **Assess** the **patient's and whānau knowledge, confidence and concerns** about, how to support **safe mobility**. **Tailor education** to meet their learning requirements for safe mobility and fall prevention in a context that they can relate to (considering their values, beliefs and perceptions of their fall risk). Include education on how to use the brakes on the bedside tables and encourage patients to sit in their chair for meals where possible. **Reinforce knowledge during care and have them** teach back **to assess their learning. Record care.**
- **If a patient** declines **care,** escalate **to the nurse in charge and follow** the Informed Consent Policy**. Ensure acceptable alternatives are in place so that the required standard of care is delivered.** Refer to Informed Consent Policy PPID 2400626 for how to manage and what to record in the clinical record.
- Regularly **discuss** with the patient and whanau their safe mobility plan and **remind** them of why the interventions are required. Record care.
- **Provide** the appropriate educational **written material** to the patient and their family/whānau and evaluate learning e.g. have them teach back.
- **Evaluate** effectiveness of interventions that promote safer mobility and patient risk factors **each shift,** and **record** in the progress notes. Ensure the rationale for any changes made to interventions is recorded and care plan is updated.

All patient **safe mobility plans** are to be **evaluated** and updated as part of the **bedside handover/handover** process with the patient/whānau.

Prior to mobilising:

- Ensure the patient has had their **safe mobility plan discussed with them** and their whānau and have understood and agree with the plan.
- **Fit appropriate footwear** to assist with safe mobilising, as per *Hospital guidelines for the use of appropriate footwear to promote safe mobility and functional recovery.* For patients without appropriate footwear staff must ensure a request is made to family/whānau/carer as soon as possible for this to be brought in.

  Note: Consider fitness of footwear in relation to risk of pressure injury.
- Patients wishing to wear **socks** or who are required to wear **stockings** such as graduated compression stockings must **wear appropriate footwear** or have their **feet bare** when walking.
- **Encourage** patients **to have their own mobility aid brought into** hospital. **Complete a safety check** on the mobility aid. Record in the clinical record that this has been completed and the outcome of the safety check. (Refer to *Mobility Aid Safety Guidance* staff resource)
- Where possible, ensure that patient's requiring a **walking aid** to move around safely have these **within reach**.

Transfer between Te Whatu Ora Waitaha facilities

Include the patient's safe mobility status, cognition and interventions in any handover (including e-Handover) and transfer of care records. Include any information on barriers to safe mobility and risk mitigation interventions in use.

Ensure the patient's current mobility and cognitive status is communicated to the receiving facility so they can ensure the new location is appropriate and reassess in the new environment. **Check this has also been recorded in TrendCare.**

On arrival assess and check the transfer documents and complete the **Bedside Board Safe Mobility Plan.**

Discharge

Include in the patient's discharge summary and transfer of care documents, a record of the mobility status and any falls while in hospital. **Communicate** any ongoing issues for mobilising to the patient's GP and community providers. This includes patients discharging to Aged Residential Care, include safe mobility interventions utilised.

Make appropriate referrals for community-based falls prevention in accordance with current Discharge and Follow-up guidelines in the Fall Assessment section in Hospital HealthPathways as necessary.

Clinical Governance

Ward/ Department/ Area Level

- All clinical area managers are to monitor adherence to safe mobility planning at least monthly. Any area with less than 85% achievement in meeting the standards of care must monitor adherence weekly, plan and action improvements so that acceptable results are achieved as soon as possible.
- Interventions that are used to mitigate patient risk factors and methods to enhance safe mobility/ fall prevention used in an area are reviewed for effectiveness on a regular basis, with a report being provided to the relevant Divisional Committee.

- All teams' clinical governance activities include regular review of falls data, prevention care and shared learnings at area and service level meetings.

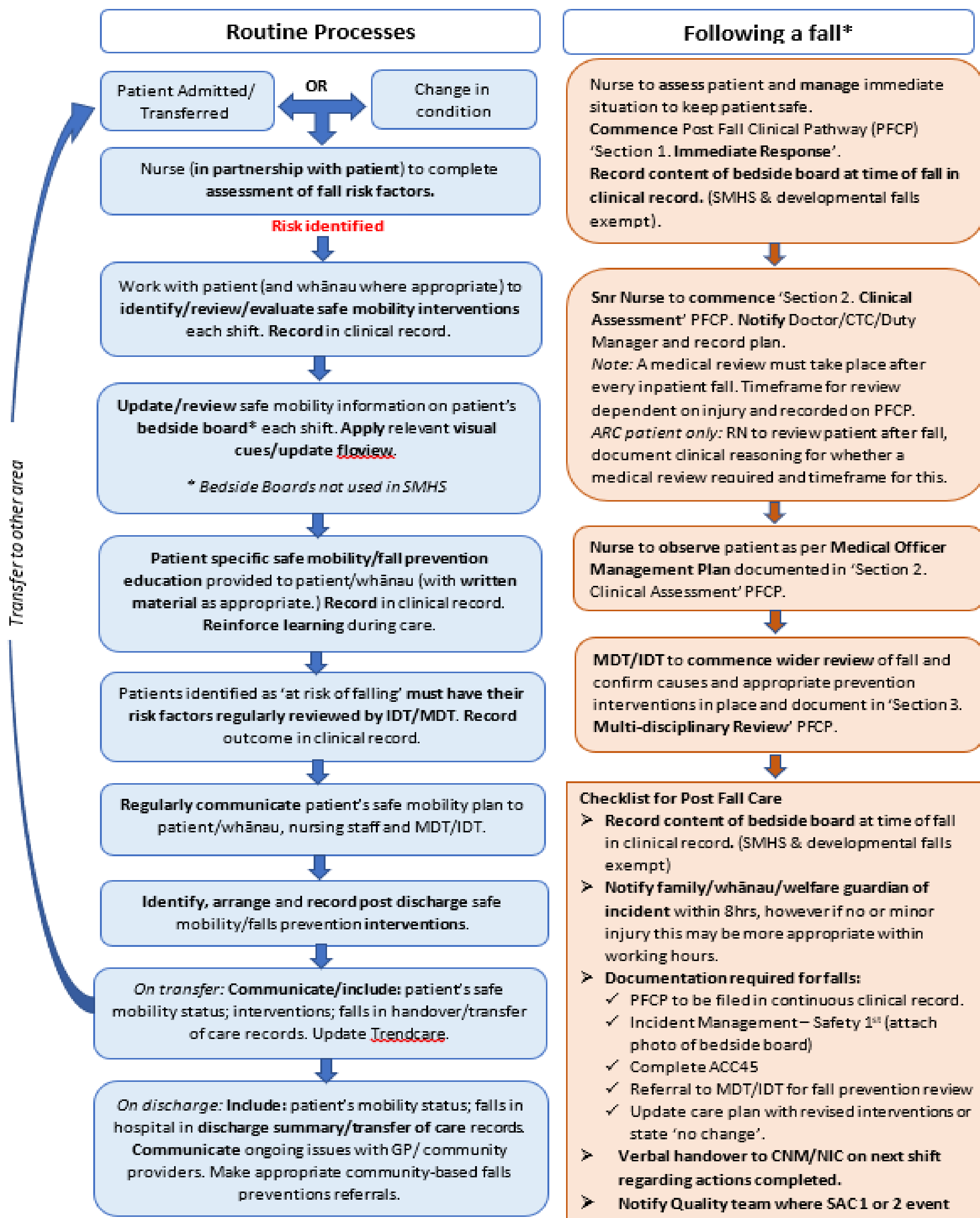
Divisional Level

- Safe Mobility Committees or appropriate divisional delegated group are responsible for:
    - Monitoring local safe mobility/fall prevention audit data and adequacy of improvement plans.
    - Ensuring partnering of care is measured, monitored and results are acted on as needed.
    - Providing direction for local population specific improvement initiatives.
    - Implementing and monitoring hospital-wide initiatives.
    - Providing regular updates to the Steering Group using the standard template.

District Level

- The Waitaha | Canterbury Safe Mobility Steering Group is responsible for providing the direction and oversight for the Hospital Safe Mobility Programme which includes hospital-wide improvement initiatives.

Inpatient Falls Prevention & Management Fundamentals Flowchart



***Definition of a fall:** Any unintentional change in position where the person ends up on the floor, ground, or other lower level, includes fall that occur while being assisted by others.*

Key Performance Indicators

Outcome Measures: The key outcome measures for safe mobility are hospital inpatients falls (Total Falls, Inpatient Falls, Falls resulting in injury and SAC 1 & 2 Falls) which are monitored by the Safe Mobility Steering Group and by divisional safe mobility committees, Clinical Governance Committees or equivalent and management teams on an ongoing basis.

The HQSC Quality and Safety Marker outcome measure continues to be monitored and reported by the HQSC on a quarterly basis.

All SAC 1 & 2 fall events are reported to the HQSC.

***Process Measures**:* The monthly Canterbury hospital-wide Safe Mobility audit tool *(Appendix 1)* is used to measure adherence to the Hospital Safe Mobility and Fall Prevention procedure.

The frequency and ongoing monitoring is the responsibility of the Divisional Safe Mobility Committees or equivalent.

- Waitaha|Canterbury Inpatient Experience Survey results for Bedside Board questions.
- Post Fall Care interventions as per the Post Fall Care Clinical Pathway. Quality of review and compliance data on the use of the Post Fall Clinical Pathway in the electronic incident management system - Safety 1st.
- Staff education on falls prevention.

Monitoring of the HQSC Quality and Safety Process Markers continues at a local level through the monthly Safe Mobility Audit.

Supporting material

Guidelines and pathways

Post Fall Clinical Pathway *Ref 2402024*

Canterbury Hospital Health Pathways (Refer to Falls Assessment under Older Adults' Health)

User Guide: Canterbury Hospitals Visual Cues for Safe Mobility R*ef 2405050*

Guidelines for Use of Appropriate Footwear to Promote Safe Mobility & Functional Recovery *Ref 2404687*

Epidural Analgesia in Labour *(GLM0007) Ref 2400495*

Policy

Incident Management *Ref 2403781*

Clinical Governance Policy *Ref 2403162*

Clinical Record Management *Ref 2400570*

Restraint Elimination and Safe Practice *Ref 2400618*

Inpatient Close Observation – Hospital Aide and Security Officer Policy *Ref 2404611*

Safety Checklist First Day Considerations Pepi Pod Sleep Space *Ref 2311649*

Graduated Compression Stockings (TED's) Policy *Ref 2400656*

Adult Policy for Intermittent Oral Opioid Dosing *Ref 2404315*

Procedures

Bedside Board procedure *Ref 2406251*

Lippincott procedures *(on line)*

Restrictive Equipment Safe and Appropriate Use *(incl bedrails) Ref 2404971*

Use of Floor Bed Procedure *Ref 2408155*

ARC Safe Mobility and Fall Prevention Procedure *Ref 2409023*

Hospital Health Pathways – refer Fall Assessment, Syncope and Presyncope

Staff Resources

Hospitals Falls Prevention Care Planning Cycle *A4 - Ref 2406810/ A3 - Ref 2407170*

Mobility Aid Safety Guidance *Ref 2407014*

Bedside Patient Boards Informational video

CDHB Hospital Fall Prevention Staff Education video (refer healthLearn or Safe Mobility Education and Resources Intranet page)

Safe Mobility – Fall Prevention Intranet page

Hospital Safe Mobility Programme Improvement Initiatives intranet page

Medicines and Falls – Managing the Risks (ref 2403363)

HQSC How Medicines Increase Falls Table (Table extracted from Topic 8 of the 10 Topics in reducing harm from falls 10 Topics, published in June 2020. Original at: www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/publications-and-resources/publication/2879/)

Fall Prevention Staff E-learning package RGHS 104 (refer *HealthLearn*)

Malnutrition in hospitals Staff E-Learning package RCL006 (refer *HealthLearn*)

Dementia: supporting people with dementia to live well Self E-Learning package RGOP301 (refer *HealthLearn*)

Delirium Fundamental E-learning course (refer *HealthLearn*)

Patient Information

Safe Mobility; Reducing Your Risk of Falls While in Hospital *Ref 2401936*

Preventing Falls by Managing Medicines *Ref 2401418*

Healthinfo Refer to Falls under Older Persons

References

Health Quality & Safety Commission Reducing Harm from Falls Programme website

New Zealand Ngā Paerewa Health and Disability Services Standard

National Institute for Health and Care Excellence (NICE) Clinical Guideline CG161 Falls in older people: assessing risk and prevention

Appendix 1: List of common Fall Risk Factors

All inpatients are considered to **have at least a 'low risk' of falling** in hospital as they are in an unfamiliar environment and their condition and presenting problems are serious enough to require acute hospital level care.

Patients in hospital who are 65 years of age and over are at risk of falling (NICE Guidance cg161[2]), the age for Māori and Pacific people is lower at 55 years and over.

The focus of care is **taking into account and alleviating or mitigating individual specific risk factors** to support safe mobility and enable self-management.

Examples of Patient Risk Factors

- Cognitive impairment e.g.
    - Brain injury
    - Current delirium
    - Disorientation
    - Impaired decision-making (includes impulsivity)
    - Known dementia
    - New/worsened confusion
    - Short term memory loss
- Continence/toileting issues
- Footwear (or if not available bare feet)
- Medical event (e.g. Seizure/stroke, cardiac event)
- Medications or side effects
- Nutrition
- Postural hypo-tension
- Syncope
- Previous slip/trip/fall/collapse in last 3 months
- Risk taking behaviour
- Sensory impairment e.g.
    - Vision impaired
    - Hearing Impaired
    - Peripheral neuropathy
- Strength and Balance (includes unsteadiness)
- Toileting issues around safe mobility

Examples of Environmental Risk Factors

- Bed/chair height
- Clutter
- Equipment (e.g. wheeled, proximity)
- Lighting
- No staff call system
- Proximity to toilets
- Uneven surfaces
- Unfamiliar environment
- Wet areas e.g. floors

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[2] National Institute for Health and Care Excellence, link to guidance - https://www.nice.org.uk/guidance/cg161/chapter/1-Recommendations#preventing-falls-in-older-people-during-a-hospital-stay-2

Appendix 2: List of commonly Used Safe Mobility Interventions

- Appropriate Footwear
- Approved Enabler in Use (e.g. bed loop)
- Bed in Appropriate Position
- Bed Rails Used in Transit
- Brakes On
- Call Bell (staff call) in Reach
- Caution Signs in Place
- Close Observation
- Crib Side Rails in Use (children only)
- Electronic Sensor Systems
- Floor Clean and Dry
- Intentional Rounding
- Items Within Reach
- Light/Night Light on
- Appropriate Mobility Device and in Use/In Reach
- Mobility Information at Beside Current
- Orientation to Ward
- Patient Area uncluttered.
- Patient Whānau Family Education
- Patient Situated Close to Nurse's Station
- Physio /Occupational Therapy Plan
- Safe Mobility Bracelet/falls risk Band in Place
- Safe Mobility Tag on Walking Aid
- Toileting Plan (includes how patient gets to toilet)

Also refer to **Hospital Safe Mobility and Fall Prevention Care Planning Cycle Staff Resource Ref 2406810 or 2407170** for more information.