FALLS PREVENTION “101”
In hospital
Outline of Presentation

- Overview of Central Coast Health
- Setting the scene – hospital environment
- EBP & Policy at local and state level
- Identifying patients at risk
- What we can do / what we should do
- & if all else fails
DEMOGRAPHICS

- Gosford & Wyong
  A&E / Acute care / Rehab
  Approx 750 beds

- Woy Woy / Long Jetty
  Subacute care
  Approx 45 beds
IMPACT OF falls

- Every 18 secs, an older adult is treated in an emergency department for a fall.

- Older people have by far the highest rates of fall related hospitalisation.

- In NSW 2007 – 2008, almost 28,379 - 62% of all fall related hospitalisations were in people aged 65yrs and over.

FIGURE 1

PROJECTED UTILISATION OF PUBLIC HOSPITAL BED DAYS RESULTING FROM FALLS, NSW, 1993–2051 USING ABS SERIES POPULATION PROJECTIONS
FIGURE 2
PROJECTED UTILISATION OF NURSING HOME PLACES RESULTING FROM FALLS, NSW, 1993–2051

FIGURE 3
PROJECTED COSTS TO THE HEALTH SYSTEM FROM FALLS, NSW, 1993–2051

NSW Public Health Bulletin
Moller 2009.
Central Coast Projected Falls Rate

Fall related bed days by group

Bed days total

Year


NSW Health 2005
THE HOSPITAL ENVIRONMENT: UNIQUE FEATURES

- Acuity of illness
- Intensity of medication intervention
- Variability among wards
- Complex Physical Environment
  - Restraints: intended & unintended
  - Clutter
  - Suboptimal lighting
  - Inappropriate bed height
- Continence

“Delirium - Strangers - Potential loss of identity”
Take away personal clothing

Remove valuable and personal belongings

Allow visiting on a limited basis

Assign people to rooms with strangers, designate people with numbers

Restrict freedom of movement

Serve limited kinds of food and drinks
3 – 20% of inpatients fall during their hospitalization.

Inouye SK. 2009
MULTIFACTORIAL NATURE OF FALLS

- Safe footwear
- Eyesight review
- Increased surveillance
- Communicate strategies
- Treat incontinence
- Treat postural hypotension
Research Evidence  Policy  Performance  Monitoring
**CHALLENGE FOR CLINICIANS**

19 page document  
NO time to read this ??  

BUT ..........

“… an unintentional even which results in a person coming to rest on the ground or floor or other lower level”.
WHAT CAN WE DO TO PREVENT FALLS?

- Multiple intervention are needed.
  - Patient RISK SCREEN (low, medium, high)
  - Environment assessment
  - Medication review
  - Frequent toileting
  - Reduce use of restraints
  - Reduce bedrail hazards
  - Education of patients, family, carers & visitors

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ON YOUR WAY OUT YOU’LL SLIP ON A NOODLE AND FRACTURE YOUR HIP.

Misfortune Cookie
Patient Risk Assessment

Why?

- Quick, accurate identification of those at increased risk of falls

- Guide for management
  - Grade level of risk – determine extent of interventions
  - Individual risk factors identified should have guidelines for practice to minimise impact of that risk factor
Environment

- Beds in lowest position & brakes on
- Keep floors uncluttered, and remove low objects that could trip a patient
- Shower & Bathroom floors are skidproofed.
- Perform regular preventative maintenance on mobility aides
- Ensure that grab bars and wall rails are properly mounted & accessible
Ensure patients clothing will not cause tripping
Patients wear slip proof socks or shoes
Appropriate time the mopping of high volume areas.
Educating Patients

- Discuss falls risks with patient
  - Explain the specific risk factors
  - Explain alternative options
  - Explain the importance of asking for help

Teach the patient to:
- Use the call button, devices, mobility aides
- Transfer in & out of bed safely
- Avoid falling – or how to fall if unavoidable
- Do not move if a fall occurs
- Document all discussions
Educating family members

- Explain the patient’s risk
- Provide education on use and maintenance of mobility aids etc
- Manage family expectations for safety
  - Express facilities concerns for safety
  - Explain to have the patient maintain as high as level of functioning as possible
- Document all discussions
April Falls Day
Educate Staff
When all else fails – Harm Reduction

Use of suitable equipment

- Other types of protective equipment
- Aids to mobility and daily living
- Alarms and alerting devices

Osteoporosis – bone health

Diet – high protein/energy intake
When all else fails - 
Harm Reduction

- Staffing / allocation / skill mix
- Visibility of patient
When all else fails – Harm Reduction

Risk v’s Benefit

“what are we trying to achieve ?”
POST FALL ASSESSMENT

If the patient falls ...

NSCH Post Fall Assessment Protocol

Unwitnessed Fall
- Do not move initially
- Call for assistance
- Assess potential injuries
- Neurological observation: level of consciousness, pupillary response, neck pain, motor strength, sensory function
- Obtain vital signs: pulse, respirations, blood pressure, temperature
- Document and communicate

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POST FALL ASSESSMENT

If the patient falls ...

If the patient falls ...

POST FALL ASSESSMENT

IF FALL (Circle one) Unwitnessed / Witnessed

Current Room/bed number ____________ Time Found ________ Falls Score ________
Location of Fall: bed area / pts room / shower / toilet / corridor / other _______
Post Fall Obs: Bp _______ pulse _______ O2 _______ Sat's _______ GMR _______
Other Observations as indicated: Neuro (GCS) / ECG / Circ ______
Pain / Injuries: Yes / No Document in progress notes
Relatives notified Yes / No If no why? ______
Time RMO notified & whom ______
Re-assess Falls Score ________ Reassess room / bed allocation ________
Hx of Dementia/Cognitive Impairment: Yes / No Document interventions in progress notes
Delirium present Yes / No
IMR Notification Number ________ Sign: ________ Date: ________

ALERT INHOSPITAL FALL

Witnessed / Unwitnessed (Circle one) *Refer to NSCH Post Fall Assessment Flowchart
Thank you

I think my work here is done.