Falls in Adults

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1. Purpose of policy

The purpose of this policy is to ensure that all patients in the care of Auckland District Health Board (Auckland DHB) are assessed for risk of falls on admission, to outline the appropriate actions to be taken to minimise the risk of falling, and the activities required following a fall.

2. Policy statements

It is the policy of Auckland DHB to ensure that clinicians identify the risk of falls and put processes in place that minimise the number of falls, thereby ensuring patient safety.

Auckland DHB is committed to providing a safe and therapeutic environment for patients.

3. Definitions

The following terms are used within this document.

Term	Definition
Fall	Inadvertently coming to rest on the ground, floor or other lower level, assisted or otherwise, excluding intentional change in position to rest on furniture, against the wall or other objects
Fall with harm	Where a patient has suffered physical injury as a result of the event
Harm	Where a patient has suffered an injury, whether it needs to be treated or not, e.g. bruise, laceration or bone fracture
Major harm	Any injury that is classified as a SAC 1 or SAC 2 when using the Severity Assessment Code Rating and Triage Tool for Adverse Event Reporting and includes patients who fall and suffer a fracture
SAC	Severity Assessment Code

4. Assessment and evaluation

While any patient can suffer a fall, certain patients present with risk factors that predispose them to falling. Identifying patients' fall risk factors and adjusting care and environmental factors accordingly aims to reduce the probability of a fall.

4.1 Risk factors

- History of falls
- Impaired mobility, e.g. unsteady gait, use of a walking aid
- Medications, e.g. polypharmacy, anticoagulants; antihypertensives
- Consider need for medicines reconciliation
- Cognitive impairment or delirium
- Assisted toileting, incontinence or frequency
- Impaired vision
- Frailty
- Medical problems, e.g. syncope
- Postural instability

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- Age
- Inappropriate footwear
- Impaired communication
- Attachments that are at risk of tethering or impeding mobility, e.g. IV line, IDC, pneumatic compression device.

4.2 Assessment

Assessments must be carried out on every adult patient:

- Within 6 hours of admission to hospital
- When the patient's room or bed space allocation changes
- When the patient's health or functional capability changes
- After a fall or near miss.

4.3 Assessment and care planning

All patients are to have an assessment using the Falls Needs Assessment and Care Plan (Adult Inpatient) CR4562 (see clinical forms). The 'Ask' questions on the first page are to be completed, along with the 'Core Interventions for all patients'.

If 'yes' is answered to any of the five 'Ask' questions, the 'Assess need' and 'Act' sections on the inside of the chart also need to be completed. This allows for an individualised care plan to keep the patient as safe as possible in the hospital environment.

The falls assessment complements the clinical judgement of the staff member completing the assessment and does not replace it. Additional interventions can be added to the care plan if required for the individual.

- Date, time and staff signatures are required for all assessments.
- Where possible, the patient and/or family/whānau should be involved with completion of the assessment and plan.
- Falls prevention must not be at the expense of patient autonomy, rehabilitation and/or need.
- Patient needs are to be re-assessed by completing all relevant sections of the form when:
    - The patient's room/beds pace or ward/unit changes
    - The patient's health status changes
    - The patient's mobility status changes
    - After a fall or near miss

4.4 Physiotherapy Falls Prevention Team

For patients who have had an inpatient fall, are admitted with a fall and/or a history of falls, or are judged by clinician as at risk of an in-patient fall, consider referral to the Physiotherapy Falls Prevention Team via the ward Physiotherapist, or by telephoning the Physiotherapy Falls Prevention Team.

4.5 Bed rails

Within Auckland DHB, there have been adverse events involving bed rails that have led to major harm. Bed rails must only be used in specific circumstances, after a full assessment, and as an enabler to care, with documented consent, as defined in the Restraint Minimisation and Safe Practice for Patients policy. Bed rails must not be used as a restraint. There is a decision guide available to provide guidance about the use of bedrails (see associated documents). Refer to the

restraint minimisation policies for additional information on restraints (see associated documents).

Patients or family/ whānau members requesting bed rails to prevent a fall need to be provided with information about the risks associated with bed rails. The decision guide can be used to support these conversations. Documentation in the clinical record of the conversation must occur.

4.6 Discharge planning and education

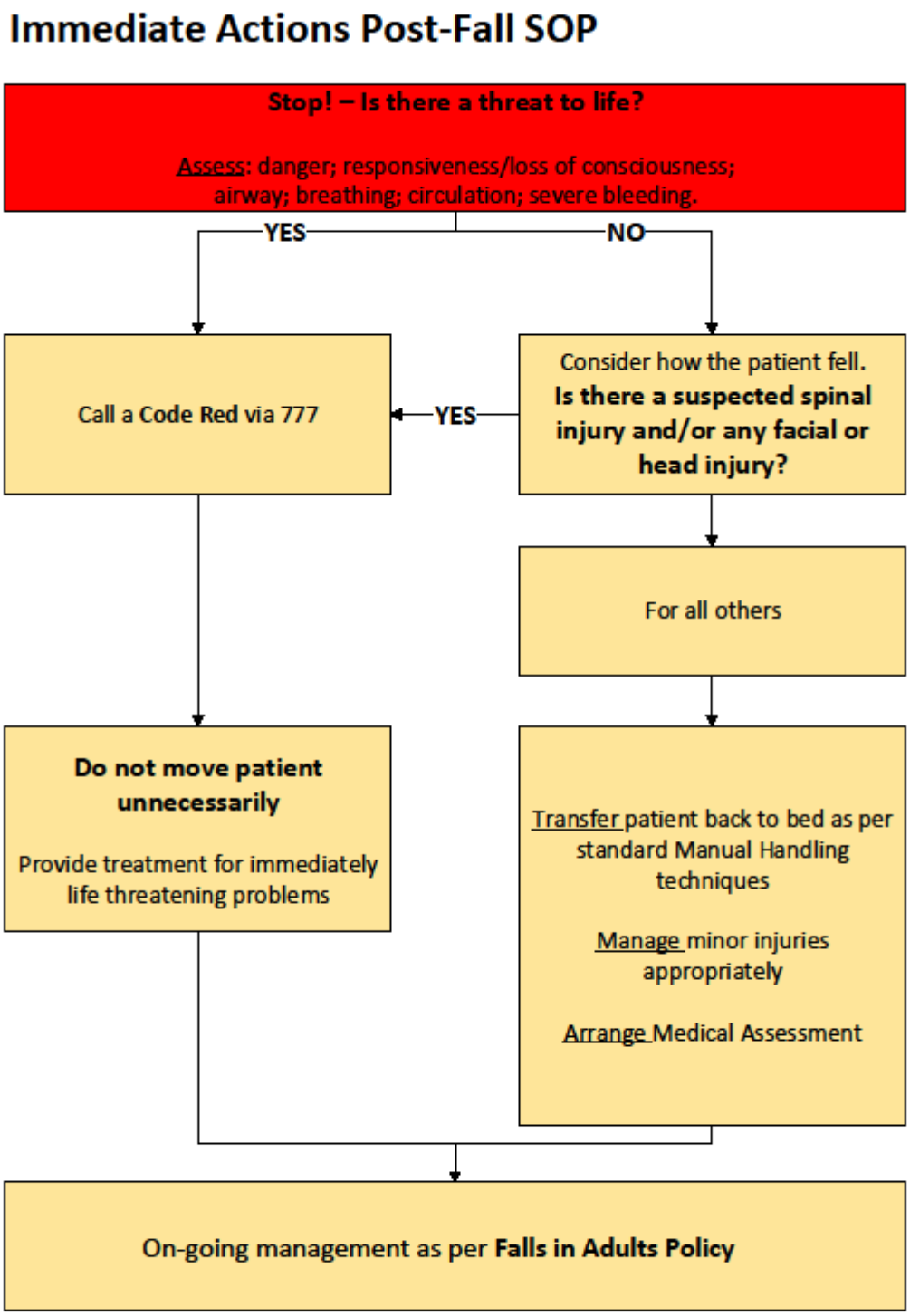
Consider the following before discharging the patient:

- A patient returning home with the potential for a fall or who has had a fall may be provided with a copy of the ACC Home Safety Checklist and/or Love Your Independence booklet. The content of the booklet must be discussed with the patient and/or family/whānau. These resources can be downloaded or ordered from the ACC-sponsored Live Stronger for Longer web site (see associated documents).
- Referral to the Fracture Liaison Service for the patient who has sustained a fracture as result of their fall.

It is important to educate the patient's family/whānau about falls prevention by providing the Auckland DHB Falls leaflet (available in each ward) and discussing any concerns they may have. The Falls Needs Assessment and Care Plan form has a 'Discharge plan' section on its front page as a reminder, because patients may have an increased risk of falling in hospital 24-48 hours prior to discharge.

5. Post-fall actions

Follow this flowchart immediately post-fall:



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5.1 When patient is stable following a fall

- Discuss with patient and notify next of kin of fall at an appropriate time, based on the patient's consent and severity of the injury.
- Re-evaluate and update the Falls Needs Assessment and Care Plan (Adult Inpatient) CR4562.
- Record a detailed note in the patient's clinical record.
- Report the fall in Datix.
- Ensure an ACC45 is completed.
- Hand-over to MDT and nursing colleagues about the patient's fall.
- Ensure status boards have been updated, e.g. whiteboard, PSAG/My Care board, toileting attendance chart.
- Refer patient to Physiotherapy: Mon-Fri ward PT; weekend's on-call PT via operator.
- A post-fall huddle and/or alert form is to be completed and actions undertaken as soon as possible after the fall, to assist with identifying the cause of the fall and prevent further falls for the patient.
- Involvement of MDT should occur with interventions suggested by all disciplines where appropriate.
- Review for potential new illness, e.g. sepsis, hypotension, delirium.

A fall with major harm is considered a serious event and the review process for this should be commenced as soon as possible.

Auckland DHB has a zero-tolerance approach for falls involving bed rails. A fall involving bed rails is considered a 'never event'. A case review must occur by the ward/area and be presented to the Falls and Pressure Injury Working Group. See Falls Prevention and Management web page on Hippo intranet for details.

5.2 ACC forms

In the situation where a patient has fallen with harm, an ACC form must be completed:

- ACC45 if the patient has fallen and harm has occurred
- In addition, an ACC2152 to be completed for a fall with harm that occurs as a result of treatment, therapy or intervention.

For more information on the definition of a treatment injury, refer to the ACC Treatment Injury policy (see associated documents). Further information is also available on the ACC intranet page.

6. Supporting evidence

- Cameron, I. D. G. L., Gillespie, L., Robertson, C., Murray, G., Hill, K., Cumming, R., & Kerse, N. (2012). Interventions for preventing falls in older people in care facilities and hospitals. *Cochrane database of systematic reviews*, *12*, CD005465-1.
- Health Quality & Safety Commission New Zealand. (2017). *10 Topics in Reducing Harm from Falls*. Retrieved from https://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/10-topics/

7. Associated documents

Auckland DHB policies and guidelines

- ACC Treatment Injury
- Behaviours of Concern (BOC) - Patient Observation
- Falls in Adults – Allied Health
- Restraint Minimisation and Safe Practice for Patients
- Restraint Minimisation and Safe Practice in Mental Health
- Moving and Handling Policy
- Bed rails use – Decision Guide

Auckland DHB intranet resources

- Falls – Guide to classifying consequence in DATIX System
- Severity Assessment Code Rating and Triage Tool for Adverse Event Reporting

Clinical forms

- CR5826 Adult National EWS Chart
- CR5782A : Adult Observations Axillary Chart – use Neuro Observation section only
- CR4562: Falls Needs Assessment and Care Plan (Adult Inpatient)
- CR6649: Modified Falls Self Efficacy Scale (Allied Health)
- CR6683: Short Falls Efficacy Scale – International (Allied Health)

ACC forms

ACC45: New Injury Claim
ACC2152: Treatment Injury Claim

Patient information

- Falls! – Auckland DHB brochure
- Live Stronger for Longer – Love Your Independence
- Live Stronger for Longer – Home Safety Checklist

8. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

9. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.