HSE MID WEST
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Guideline for the Prevention and Management of Falls & Harmful Falls in Inpatient & Residential Services

Older Persons & Mental Health Services

HSE Mid West Community Healthcare

2022

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Guideline for the Prevention and Management of Falls and Harmful Falls in HSE Inpatient and Residential Services (Older Persons and Mental Health Services) HSE Mid West Community Healthcare

Is this document a:

Policy [ ] Procedure [ ] Protocol [ ] Guideline [x]

Mid West Community Healthcare, Older Persons and Mental Health Division

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Title of PPPG: Guideline for the Prevention and Management of Falls and Harmful Falls in HSE Inpatient and Residential Services (Older Persons and Mental Health Services), HSE Mid West Community Healthcare

PART A: Steps of the PPPG

1.1 Purpose

1.1.1 To review the current 'Guideline for Falls Risk Assessment, Falls management and Post Falls Action Plan for Older Persons in HSE Inpatient Services (Older Persons and Mental Health Services) CHO3' (2015).

1.1.2 To ensure a standard approach to the assessment of falls risk, interventions to address the identified risk factors and post-fall management in relation to residents/inpatients in Older Persons and Mental Health services HSE Mid West, ensuring compliance with National standards and best international evidenced practice.

1.1.3 The purpose of this guideline is to define the processes to reduce the risk of harm resulting from falls and to give guidance on the appropriate steps to take when a fall occurs. This includes:

1.1.3.1 A process for assessing all residents/patients whose condition, diagnosis, situation, or location identifies them as at risk of a harmful fall.

1.1.3.2 A process for the initial and ongoing assessment, reassessment and intervention of residents/patients identified as at risk of a harmful fall based on documented criteria.

1.1.3.3 Actions/interventions to be implemented to reduce harmful falls risk for those identified residents/patients, situations, and locations assessed to be at risk.

1.1.4 HSE Mid West Community Healthcare (MWCH) recognises the significant impact that falls and harmful falls have on the resident/patient (and family members), the staff member and the organisation as a whole. For the resident/patient, falling can result in a physical or non-physical injury, such as fracture or fear of falling, and can significantly impact on their quality of life as a result. For the staff member, their primary goal is to improve patient outcomes and maintain patient safety. Falls and harmful falls detract from that. A fall and harmful fall can have a significant impact on the emotional wellbeing of a member of staff caring for a patient. For the organisation, falls and harmful falls contribute to increased cost, which ultimately, affects patient care. MWCH is committed to reducing the risk of falls and harmful falls across the service.

1.1.5 The goal of HSE MWCH is to reduce the risk of harm resulting from falls; while promoting recovery, rehabilitation and independence. Identifying and addressing risk factors for falls and harmful falls is a realistic organisational approach to reducing the risk of harmful falls. However, the risk cannot be completely eliminated.

1.1.6 The staff of HSE MWCH aim to provide care for residents/patients in a safe environment, where the risk of falls is minimised. All residents/patients shall be assessed for their risk of falls upon admission and on an on-going basis. All residents/patients shall be provided with information, advice and intervention to reduce the risk of falls, based on their assessed risk. Residents/patients will receive appropriate management in the event of a fall.

1.2 Scope

1.2.1 This guideline applies to all employees working in the HSE Mid West Community Healthcare Area in HSE Inpatient and Residential Services (Older Persons and Mental Health) including temporary employees, agency employees, students, contractors and any employee contracted to provide clinical support in HSE Inpatient and Residential Services (Older Persons and Mental Health services) for the HSE.

1.2.2 The population to whom it applies are residents/patients living in residential care (Older Persons and Mental Health Services) on a long-term basis and also people staying on a short-term basis including respite and rehabilitation services.

1.3 Glossary of Terms and Abbreviations

Care plan	A written means of communication that ensures continuity of care between all members of the team in order to achieve the best possible health outcomes for the resident/patient.
Fall	A fall is defined as 'an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level' (NICE 2015). This includes slips/trips, being lowered, loss of balance and/or legs giving way.
Multifactorial Falls Risk Assessment	An assessment with multiple components that aims to identify a person's risk factors for falling (NICE, 2013).
Multifactorial intervention	An intervention with multiple components that aims to address the risk factors for falling that are identified in a person's multifactorial assessment (NICE, 2013).
Older Person	A person with a chronological age of 65 years or more (WHO, 2002).
Resident/Patient	People living in residential care on a long-term basis and also people staying on a short-term basis for respite care or rehabilitation.
HSE	Health Service Executive
MWCH	HSE Mid West Community Healthcare
CHO3	Community Healthcare Organisation 3
Focal neurological deficit	Problems restricted to a particular part of the body or a particular activity, for example, difficulties with understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking.

1.4 Procedures and Guidelines

1.4.1 Prevention of Falls and Harmful Falls

1.4.1.1 As we get older, we often accept that falls are unavoidable. However, this is not the case. Most people over 65 do not fall each year. Falls are not an inevitable part of ageing. A fall is always due to the presence of one or more 'risk factors'.

1.4.2 Falls Risk Assessment

1.4.2.1 Falls Risk Screen (Identifying those at risk of falling)

MWCH have adopted the NICE Falls Prevention Guidelines (2013), the first clinical guidelines that specifically address falling of older adults in the hospital setting. NICE state that hospitals must not use falls risk prediction tools. The following groups of inpatients should be assumed to be at risk of falling:

1.4.2.1.1 All residents/patients aged 65 years or older.

1.4.2.1.2 Residents/patients aged 50 to 64 years who also have at least one of the following: a history of falling; gait, balance, and/or transfer impairments; fear of falling; presence of an underlying health condition that would increase their falls risk.

1.4.2.1.3 Residents/patients under 50 with a history of falling. In addition, this may also include those who are judged by a clinician to be at higher risk of falling because of an underlying condition.

1.4.2.2 Multifactorial Assessment (Identifying individual risk factors for falling)

1.4.2.2.1 Residents/Patients at risk of falling should have their individual falls risk factors identified which can be treated, improved or managed during their expected stay.

1.4.2.2.2 A multifactorial falls risk assessment (MFRA) (Appendix I) must be carried out by a nurse on all residents/patients aged 65 years or over:

- Within 24 hours of admission to ward/unit.
- In the event of a fall.
- At 4 monthly intervals if the resident is long stay.
- If there is a significant change in condition.

1.4.2.2.3 Residents/patients 50-64 years (and those under 50 years where clinically indicated) who have had one of the following should also have a multifactorial falls risk assessment:

- A fall in the last year or admitted with a fall.
- Difficulties with gait or balance.
- Fear of falling.
- Any clinical condition that increases the risk of falling.

1.4.2.2.4 Risk factors to be considered for identification should include:

- Poor Gait, Strength or Balance
- Impaired transfers / Impaired ADLs
- Inappropriate Footwear / Foot Disorder
- Pain
- Poor Vision
- High Falls Risk Medications
- Urinary Incontinence
- Postural Hypotension
- Dizzy / Lightheaded
- Fear of Falling
- Depression / Low Mood
- Cognitive Impairment / Delirium / Dementia

1.4.2.2.5 It should be noted that not all risk factors are equally associated with a fall - some are more predictive of falls than others. In order to ensure that a falls prevention program is both effective and efficient in the reduction of a patient's risk of harmful falls it is necessary to identify those risk factors which are most predictive of future falls; such as lower extremity muscle weakness; gait and balance deficits; and history of falling. In addition, in a typical general hospital at any one time, there are up to 25% of patients with dementia and 20% of patients with delirium. As a consequence, cognitive capacity should always be a consideration for healthcare professionals in the provision of falls and harmful falls interventions.

1.4.2.2.6 For each measure, the MFRA must indicate if the risk factor is present.

1.4.3 Strategies to Reduce the Risk of Falling

1.4.3.1 Orientation to the Ward:

1.4.3.1.1 On admission, the nurse will provide the resident/patient with an orientation to the room, the call bell and light, and nearest toilet. The nurse should inform the resident/patient of the universal falls prevention precautions (See 1.4.3.3).

1.4.3.2 Multifactorial Falls Intervention (Intervening on Individual Risk Factors for Falling):

1.4.3.2.1 All residents/patients at risk of falling should have their falls risk factors identified and intervened upon.

1.4.3.2.2 Multifactorial interventions should be individual to the resident/patient, prompt and take into account whether the identified risk factors can reasonably be treated, improved or managed during the resident/patient's expected stay.

1.4.3.2.3 Do not offer falls prevention interventions that are not tailored to address the resident/patient's risk factors for falling.

1.4.3.2.4 The outcome of the MFRA identifies:

1.4.3.2.4.1 **Interventions to be put in place** by the staff team. Any

identified area of need or support must be addressed in the individual resident/patient's care plan.

1.4.3.2.4.2 **Any additional or more comprehensive risk assessments required** e.g. manual handling risk assessment, assessment of aids, assistive technology and equipment, specialist seating.

1.4.3.2.4.3 **Referrals required** to medical, nursing and other health and social care professionals (e.g. pharmacy, physiotherapy, occupational therapy, speech and language therapy, dietetics).

1.4.3.2.5 All referrals are documented in the resident/patient's file/care plan.

1.4.3.2.6 All falls prevention measures/interventions to address the identified risk factors should be documented in the resident/patient's care plan. The measures/interventions are dependent on competing clinical priorities, resident/patient type, time, and staffing.

1.4.3.3 Universal Falls Prevention Precautions:

1.4.3.3.1 Universal falls prevention measures are put in place for all residents/patients at all times (Appendix V):

- Familiarise the resident/patient to the environment i.e. bed area, toilet facilities and ward.
- Demonstrate the use of the call bell to resident/patient and ensure it is within reach of the resident/patient.
- Keep frequently used items (including mobility aids) within easy reach of the resident/patient.
- Provide appropriate mobility assistance.
- Ensure the bed and chair are at appropriate height for the resident/patient.
- Ensure footwear is well fitted and non-slip.
- Keep wheeled item's brakes locked e.g. bed, wheelchair, locker
- Keep floor clean and dry; clear spills promptly
- Ensure adequate lighting in room and ward area including night lights.
- Keep patient areas uncluttered.
- Comfort rounds take place every hour during daytime shifts to address all of the resident/patient's needs. The resident/patient is checked to see that their needs are met (e.g. toileting, pain, positioning, social stimulation and the environment).

1.4.3.3.2 All residents/patients should be informed of the Universal Falls Prevention Precautions (AVOID FALLS) (Appendix V).

1.4.3.3.3 AVOID FALLS (Br**A**kes, Le**V**el, Fl**O**or, LI**L**ighting, Be**D**space, **F**ootwear, c**A**ll bell, g**L**asses, toi**L**eting, and walking aid**S**) is a falls prevention mnemonic for residents/patients (and their family members) at risk of falling and all staff providing care to residents/patients.

(Appendix V) The specific message can be modified to suit the needs of any resident/patient type or clinical area. Staff should follow up in any component where there is an identified need, as far as practicable. For example, contact Maintenance to repair a non-functioning call bell.

1.4.4 Individualised Care Plan

1.4.4.1 All residents/patients at risk of falling should have a Care Plan(s) completed based on the findings of the multi-factorial risk assessment.

1.4.4.2 The individualised Care Plan(s) identifies the individual action(s) for each risk factor identified when completing the MFRA. For example, vision has been identified as a risk factor and the resident/patient wears glasses – the appropriate action may be to ensure a yearly review by an optician.

1.4.4.3 A separate 'falls care plan' is not recommended as it might miss the relationship between the risk of falls and other care issues e.g. incontinence, malnutrition and medication.

1.4.4.4 The nursing care plan will be developed by the nurse in consultation with the individual resident/patient and/or his/her nominated representative in accordance with the resident/patient's wishes.

1.4.5 High Falls Risk Medications

1.4.5.1 All residents/patients at risk of falling should have their high falls risk medications identified and medication rationalisation should be considered.

1.4.6 General Patient Safety

1.4.6.1 All staff should observe safe systems of work, including using correct people moving and handling techniques.

1.4.6.2 All staff should ensure that wheelchairs, commodes, patient lifting equipment or other equipment used by a resident/patient is fit for purpose and in good working order.

1.4.7 Environmental Review

1.4.7.1 Aspects of the inpatient environment (including flooring, lighting, furniture, and fittings such as hand holds) that could affect residents'/patients' risk of falling must be systematically identified and addressed as part of the healthcare facility's health and safety plan and facility specific risk assessments.

1.4.7.2 Staff should inform Maintenance/Cleaners of broken equipment or any issue that could be deemed a hazard to residents/patients such as broken lighting, broken call bells and/or wet floor.

1.4.7.3 The 'Resident Environment and Orientation Tool' can be used as an aid by staff when identifying a resident/patient's risk factors because of their interaction with the environment, as part of the multifactorial falls risk assessment. (Appendix II)

1.4.7.4 Refer to Appendix VII for further tips for ensuring a safe environment

1.4.8 Management of Falls and Harmful Falls

1.4.8.1 The assessment in the immediate post-fall period is very important. Common gaps in the care of patient after a fall include delayed diagnosis of fractures; neurological observations recorded at infrequent intervals, or not at all, resulting in delayed diagnosis of intracranial bleeding; sling hoists used to move patients despite signs and symptoms of limb fracture or spinal injury; and delays in access to urgent investigations or surgery are common gaps in care of patients after a fall. This section will guide all staff in what to do in the immediate post-fall period.

1.4.8.2 Responses made should be in keeping with a resident/patient's Anticipatory Care Plan and Do Not Attempt Resuscitation decision recording and guidance.

1.4.8.3 The immediate post-fall assessment has five main goals:

- **Assessment:** Identify a suspected injury before moving the resident/patient.
- **Injury Management:** Management of suspected injury.
- **Recovery From Floor:** Safe return of resident/patient to bed or chair without causing (further) harm.
- **Communication:** Report, documenting and following up on the incident, as appropriate.
- **Falls Reassessment:** Reassess to prevent further falls and harmful falls.

1.4.8.4 Management of a Resident/Patient Who Falls in HSE Inpatient and Residential Services (Older Persons and Mental Health Services) in MWCH

1.4.8.4.1 An initial nursing assessment, including secondary survey of resident/patient who has fallen is undertaken by a registered general nurse as per Table 1 below and the falls algorithm (Appendix IV):

Table 1: Management of a Resident/Patient who has fallen

On Finding (Or Witnessing) A Resident/Patient Who Has Fallen	
○ **Do not move the resident/patient** ○ Call for help ○ Ensure safety at the scene ○ Follow all Basic Life Support (BLS) guidelines in the first instance – if acute life threatening medical emergency activate the emergency response system 999/112 ○ Reassure the resident/patient	
Before Moving the Resident/Patient	
Brief History	○ How did you fall? ○ Did you hit your hip / hit your head / blackout? ○ Do you have any pain / soreness? If yes, where?
Secondary Survey	○ Complete head-to-toe assessment (Assess, Look, Feel) (Further guidance in Appendix VIII)

	○ Observe for confusion, lacerations, joint deformity, loss of range of motion ○ Feel for pain / soreness / swelling
Secondary Assessment	○ Complete a set of observations (General or Neurological)
	○ Resident/patient on anticoagulants/antiplatelets and/or witnessed fall – hit head, unwitnessed fall – complete neurological observations ○ The 15-point GCS should be used. ○ If GCS <15 (or baseline) then complete neurological observations every 30 minutes until return to 15/15 (or baseline) ○ If GCS =15 (or baseline) then complete neurological observations every 30 minutes for 2 hours, then 1 hourly for 4 hours thereafter, then 2 hours thereafter. *(Frequency and recording of observation is determined by the resident/patient's condition and instruction from the medical practitioner)* ○ Refer to Appendix VI for further information
Identify a suspected injury before moving the resident/patient	○ Suspected head injury ○ Suspected (near) loss of consciousness ○ Suspected hip fracture ○ Suspected other fracture ○ Suspected sprain / strain ○ Minor injury, such as laceration, bruise or abrasion ○ No Injury ○ **If a serious injury is suspected/noted, contact the Medical Officer/General practitioner or emergency services as clinically indicated (Refer to Appendix IV – Falls Algorithm).** ○ **If in doubt, do not move the resident/patient (unless in a life threatening situation) until a doctor or emergency services reviews the person.** ○ **Following initial assessment, if at any point there is a change in the resident/patient's condition that causes concern, seek medical advice from the Medical Officer/G.P., Out-of-hours GP service or emergency services.**
RETURN THE PATIENT TO BED/CHAIR	
Identify safe method to return the resident/patient safely to the bed or chair if appropriate (dependent on presence/type of injury)	○ For residents/patients with signs or symptoms of hip fracture or potential for spinal injury, **Do not move** – residents/patients require to be flat-lifted – collaborate with emergency services. For minor/no injury: ○ Supervision Only. ○ Verbal instruction / Manual Assist by Staff. ○ Mobile hoist and sling.
	○ Staff must observe safe manual handling procedures. ○ Staff should not lift the resident/patient.

	○ Staff should be up-to-date with their manual handling training.
REPORT THE INCIDENT	
Nursing	○ Ensure the incident is documented in the healthcare record. Complete the Nursing Post-Fall Checklist (Appendix III) and file in healthcare record. Attach a copy to the completed incident report form.
Nurse-in-Charge, CNMI or CNMII, CNMIII or ADON, or HOD	○ A senior member of staff should be promptly informed about the incident to ensure resident/patient safety and give advice as appropriate.
Medical Team	○ All residents/patients who fall in a residential unit, a request for review by a member of the medical staff or GP (or Out-of-hours GP service) within 24 hours (when no suspected injury) or within 30 minutes in the case of a suspected injury (Medical staff or GP on-site, Out-of-hours GP service or emergency services, as clinically indicated).
Family Member	○ The resident/patient's family member should only be informed of the fall with the resident/patient's consent. ○ The resident/patient should be encouraged to allow the service to inform their family that the resident/patient has had a fall as important aspects from a collateral history, or bringing footwear, glasses or walking aids into the resident/patient, may help prevent the occurrence of another fall. ○ With the resident/patient's consent, staff should use their clinical judgement as to when to contact the family member. The below are suggestions for when to contact the family: - For all falls, staff may contact the family without the doctor having seen the resident/patient to inform the family of the fall. Staff can inform the family that you will contact them again after the doctor has reviewed the resident/patient with an update of their plan of care. - For a fall with no / minor injury, the family should be informed during 08:00 – 22:00. If the resident/patient falls during the night, they should be contacted the next morning in consultation with the ADON/Nurse-in-charge. - Where there is no close relative, staff should use their judgement, considering the closeness of the relationship between the resident/patient and their most significant relative/friend. - If the resident/patient experiences frequent falls, consider discussing the family members' preference about when to be contacted. - When a resident/patient falls and is diagnosed with a significant injury (e.g. fracture) the family should be contacted as soon as possible.
Adverse Incident	○ Complete and forward the incident form to Quality, Safety and Service Improvement Department within 24-48 hours.

	○ Harm from a fall may not be identified at the time of fall and may become apparent in the days after the fall e.g. fracture. The CNM/Nurse-in-charge should report resultant harm to the Quality, Risk and Patient Safety Department even if the adverse incident form has already been sent.
REASSESS TO PREVENT FURTHER FALLS	
○ All residents/patients who fall are, by definition, at risk of falling. ○ A review of what happened and evaluation of the interventions in place should commence. ○ All residents/patients who fall should be reassessed as per procedures and guidelines in 1.4.2. ○ Subsequent to MFRA and review of the fall, the resident/patient's care plan should be reviewed and updated, if applicable, to reflect any changes or additional supports required.	

1.4.8.4.2 **On Discharge/Transfer from Hospital:** On discharge/transfer, the service should share relevant information across services for any resident/patient who has had a fall during their episode of care in hospital. This may include liaising with the Primary Care Team, and/or Acute Care, and/or other Residential Facilities to recommend further assessment and intervention to reduce the risk of harmful falls.

1.4.9 Education

1.4.9.1 Staff Education

1.4.9.1.1 All staff will receive general education on this guideline.

1.4.9.1.2 All staff providing direct care to residents/patients will receive education specific to their role.

1.4.9.1.3 All staff should be up-to-date on their manual handling training.

1.4.9.1.4 All frontline managers and heads of department will receive falls-related data on a regular basis for their areas. They are responsible for disseminating this data to their staff.

1.4.9.2 Resident/Patient (and Family) Education

1.4.9.2.1 Resident/Patient Education is an important component of a successful Falls and Fracture Prevention Programme. Healthcare professionals should ensure that they provide the necessary advice and education to residents/patients, and their family members, which allows the resident/patient to be active participants in their own healthcare and safety.

1.4.9.2.2 Residents/Patients and their families should be educated by a variety of methods.

1.4.9.2.3 Falls Prevention information: should be available on each ward and / or waiting areas.

1.4.9.2.4 Shared Decision Making: the individualised Care Plan(s) gives staff members and residents/patients a template to discuss the

residents/patients care needs to reduce their risk of harmful falls. This may include, for example, participating in an exercise programme prescribed by the physiotherapist, or bringing in footwear, glasses and walking aid, if applicable.

1.4.10 Incident Management

1.4.10.1 Falls and fall-related injuries are the most common reported incident in the HSE.

1.4.10.2 It is policy that all incidents are identified, managed, disclosed, reported, investigated and steps are put in place, where possible, to prevent a recurrence. For further detail refer to HSE MW Incident Management Procedure (2018), HSE Incident Management Framework (2020) and Service User Falls: A Practical Guide for Review (2018).

1.4.10.3 All falls should be reported on the incident report form within 24 hours by the witness to the occurrence or the person first on the scene. Serious falls resulting in death or permanent disability; hip fractures; pelvic fractures; traumatic brain injuries leading to transient or permanent functional or cognitive decline/deterioration are Category 1 incidents and classified as Serious Reportable Events – these are reported accordingly.

1.4.10.4 All patient safety incidents (i.e. falls) must be factually documented in the resident/patient's healthcare record, including details of care provided and the salient points of open disclosure.

1.4.10.5 As soon as possible after the event, the resident/patient and, with the resident/patient's consent as appropriate, their family/significant other are informed of what is known about the event and what actions have been taken to immediately mitigate or remediate the harm to the resident/patient. An expression of apology or regret can be extended at that time. The salient points of open disclosure will be documented in the service user's healthcare record. Refer to HSE policy and guidelines on Open Disclosure (2019) for further guidance.

1.4.10.6 It is the responsibility of managers to review incident report forms and ensure that all elements of the incident management framework are followed including:

1.4.10.6.1 Ensuring the completion of all mandatory fields.

1.4.10.6.2 Appropriate communication of Category 1 and 2 incidents (including Serious Reportable Events).

1.4.10.6.3 For Category 1 and 2 incidents, initiate and complete the falls incident specific Preliminary Assessment Part A in conjunction with the Quality, Risk and Patient Safety Advisor https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/incident-management.html

1.4.10.6.4 Reporting to external agencies as required.

1.4.10.6.5 Each service user fall (including no harm/low harm incidents)

presents an opportunity to minimise the risk of or prevent future falls, particularly for residents/patients who experience a fall for the first time.

1.4.10.6.6 The purpose of review is to find out what happened, why it happened (i.e. the cause and the factors that contributed to the fall) and what learning can be gained in order to minimise the risk of or prevent a similar fall occurring in the future.

1.4.10.6.7 The falls specific Preliminary Assessment is a useful tool in assisting multidisciplinary teams to review Category 3 incidents at local level.

1.5 Roles and Responsibilities

1.5.11 Older Persons and Mental Health Division Management Teams are responsible for ensuring the provision of adequate managerial, educational and clinical resources to enable implementation of this guideline.

1.5.12 Heads of Department are responsible for ensuring that they, and their staff, are aware of, and adhere to, this guideline.

1.5.13 All staff are responsible for ensuring that they are aware of, and adhere to, this guideline.

1.5.14 All staff are responsible for promoting a safe environment for residents/patients by carrying out hazard identification and prompt reporting and management of risks identified.

1.5.15 It is the responsibility of the multidisciplinary team to investigate the cause of resident/patient falls.

1.5.16 Where a resident/patient presents with a falls risk, the responsibility rests with the multidisciplinary team to set out a plan of care that meets the resident's/patient's needs.

1.5.17 Healthcare Professionals

The role of each healthcare professional, where available, in the prevention and management of falls and harmful falls is below:

1.5.17.1 Estates/Facilities (such as Maintenance Dept and cleaning staff): To provide a safe physical environment for patients to reduce the risk of harm from falls.

1.5.17.2 Dietician: On initial assessment, to identify and intervene on falls risk factors, in particular nutritional needs. On falling, to reassess risk factors for falling and intervene as appropriate.

1.5.17.3 HCA/MTA: To promote a safe environment, identify hazards and intervene as appropriate to prevent falls; implement the measures specified in the resident/patient's care plan and report any changes/or concerns; on finding a fallen resident/patient, to reassure the resident/patient and inform nursing staff immediately.

1.5.17.4 Medical: On admission, to identify and intervene on falls risk factors (where appropriate), in particular high falls risk medications. On falling, to identify and manage injuries and prevent further falls.

1.5.17.5 Nursing: On admission and at review, to identify risk of falling, and

identify and intervene on falls risk factors, ensuring an individualised care plan is in place. On falling, to identify and manage injuries, to return the resident/patient safely to sitting or lying, and reduce risk of further falls.

1.5.17.6 **Occupational Therapy:** On initial assessment, to identify and intervene on falls risk factors, in particular impaired activities of daily living, cognitive impairment and fear of falling. On falling, to reassess risk factors for falling and intervene as appropriate.

1.5.17.7 **Pharmacy:** On initial assessment, to identify and intervene on falls risk factors, in particular high falls risk medications. On falling, to reassess risk factors for falling and intervene as appropriate.

1.5.17.8 **Physiotherapy:** On initial assessment, to identify and intervene on falls risk factors, in particular gait, strength and balance dysfunction, impaired transfers, fear of falling and impaired activities of daily living. On falling, to reassess risk factors for falling and intervene as appropriate.

1.5.17.9 **Speech and Language Therapy:** On initial assessment, to identify and intervene on falls risk factors, in particular communication and/or dysphagia assessment. On falling, to reassess risk factors for falling and intervene as appropriate.

1.5.18 All staff must work within their scope of practice.

1.6 Part B

Available on request from Quality, Safety and Service Improvement Department, HSE Mid West Community Healthcare

1.7 Appendices

Appendix I	Multifactorial Falls Risk Assessment
Appendix II	Resident Environment and Orientation Tool
Appendix III	Nursing Post Fall Checklist
Appendix IV	Post Fall Algorithm
Appendix V	AVOID Falls
Appendix VI	Neurological observations and Glasgow Coma Scale
Appendix VII	Tips for maintaining a safe environment
Appendix VIII	Secondary Survey
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Appendix I: Multifactorial Falls Risk Assessment (MFRA)

HSE MID WEST COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
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Attach patient label here

MULTIFACTORIAL FALLS RISK ASSESSMENT

Complete for residents/patients aged 65 years+:	**Complete for residents/patients 50-64 years (under 50 years where appropriate) with one of the following:**
• Within 24 hours of admission to ward/unit • In the event of a fall. • At 4 monthly intervals if the resident is long stay • If there is a significant change in condition	• A fall in the last year or admitted with a fall • Difficulties with gait or balance • Fear of falling • Any clinical condition that increases the risk of falling

	Circle	COMMENTS
Resident/Patient input	Yes / No	
Family input	Yes / No	
Carer/staff/other input	Yes / No	
History of falls		**COMMENTS**
Previous falls	Yes / No	*Frequency of falls?*
Cause of fall(s) *(slip, trip, fall, medical event e.g.blackout, dizziness)*		
Injuries from previous fall(s)	Yes / No	
Fear of falling: Does the patient worry about falling or losing their balance?	Yes / No	
Consider (Refer to workbook for further information): *Frequent falls can indicate health deterioration or Blackouts– consult GP/Medical Officer* *Occupational therapy referral, Physiotherapy referral*		
Mobility		**COMMENTS**
Unstable gait or looks unsafe walking	Yes / No	
Has the gait recently changed?	Yes / No	
Does the patient use mobility aids?	Yes / No	
What mobility aids does the patient use? *How long? Assistance required?*		
Impaired Transfers/Impaired ADL's	Yes / No	
Inappropriate Footwear/Foot Disorder	Yes / No	
Consider (Refer to workbook for further information): *Occupational therapy referral, Physiotherapy referral, Podiatry referral,Medical review, Other*		
Vision, hearing, language		**COMMENTS**
Patient has visual deficit	Yes / No	
Patient wears glasses?	Yes / No	
Consider (Refer to workbook for further information): *Ophthalmology referral*		
Patient has hearing deficit	Yes / No	
Hearing aids are functional	Yes / No	
Consider (Refer to workbook for further information): *Audiology referral*		
Patient speaks and understands English?	Yes / No	
Consider (Refer to workbook for further information): *Use of interpreter*		

Falls risk assessment

Falls Risk Assessment Tool August 2022 Version 3.0
Adapted with permission from Health, Quality & Safety Commission, New Zealand https://www.hqsc.govt.nz/assets/Falls/PR/risk-assessment-tool-Oct-2014.pdf

Cognition		COMMENTS
Patient has communication impairment?	Yes / No	
Patient has confusion/disorientation or altered mental state?	Yes / No	
Patient has memory loss?	Yes / No	
Patient is agitated, impulsive, or unpredictable?	Yes / No	
Patient overestimates/ forgets limitations?	Yes / No	
Consider (Refer to workbook for further information): *Observe, Medical review, Written visual prompts, OT referral*		

Continence		COMMENTS
Patient has frequency, urgency or incontinence?	Yes / No	
Patient has a UTI?	Yes / No	
Consider (Refer to workbook for further information): *Catheter, Commode/urinal by bed, Assessing for appropriateness of incontinence aids, Complete continence assessment*		

Nutrition		COMMENTS
Does the patient have difficulties eating or drinking enough?	Yes / No	
Has the patient experienced recent unexplained weight loss?	Yes / No	
Consider (Refer to workbook for further information): *Referral to dietician, SLT or GP*		

Bone Health & Fracture Risk		COMMENTS
Does the person have contributing factors that place them at risk of bone fracture?	Yes / No	
Consider (Refer to workbook for further information): *Consult with GP/MO if Bone Health Review is needed, is the person on bone protection medication?*		

Medications		COMMENTS
Patient takes four or more drugs/day?	Yes / No	

High Falls Risk Medications *(Tick drug class below)*

❑ Anticholinergics	❑ Anti-Emitics	❑ Anti-Hypertensives	❑ Diuretics	❑ Drugs with sedative effect	❑ Hypnotics/ Anxiolytics	❑ Laxatives	❑ Opioid Analgesics

Consider (Refer to workbook for further information):
Pharmacy/Medication review, Monitoring lying and standing BP, Assistance with mobilisation

Environmental Hazards		COMMENTS
Are there environmental hazards (personal or structural)? **(Use Environment & Orientation Check)**	Yes / No	
Consider: *Footwear & clothing, flooring, lighting & contrast,bed,bathroom, hallways, furniture & eating, walking aid & wheelchair* **(Refer to Environment & Orientation Check and workbook)**		

Other risks		COMMENTS
Other Health Conditions eg stroke, frailty, infection, delirium	Yes / No	
Does the patient have any other risk factors?	Yes / No	

Further comments and observations:

Name of healthcare professional who completed this falls risk assessment:

Name	Signature	Date

Falls Risk Assessment Tool August 2022 Version 3.0
Adapted with permission from Health, Quality & Safety Commission, New Zealand https://www.hqsc.govt.nz/assets/Falls/PR/risk-assessment-tool-Oct-2014.pdf

Falls risk assessment

Appendix II: Resident environment and orientation tool

MWCH Version 1, February 2022

Resident environment and orientation tool

Footwear and clothing	Is footwear lightweight, non-slip and the correct size? Are clothes non-slip and correct length?	Consider: Residents should wear slippers and shoes with low heels and non-slip soles. Liaise with relatives and discuss with resident the importance of suitable footwear and clothing. Check footwear monthly. Ensure personal aids, for example long-handled shoe horn, are provided if required. Podiatry/Orthotics.
Flooring	Is flooring unworn/non-slip? Are all thresholds flush? Adequate space, free from clutter?	Consider: Observe residents going from one area to another and look for risks. Report any problems to manager and arrange repair. Rearrange furniture if required. Encourage good housekeeping. Avoid having highly patterned and shiny flooring. Rugs and pressure mats can be a trip hazard.
Lighting and contrast	Is the lighting suitable for the resident's needs?	Consider: Is the resident's vision affected by glare or dull lighting. Night light. Bedside light. Is light switch accessible to resident. Additional lighting. Timer and/or sensor lighting. Contrast colours on toilets, seating, beds. Dementia friendly environments.
Bed	Is the bed suitable for the resident's needs?	Consider: Observe resident in/out of bed – can they get in/out easily and safely? Bed height/adjustable. Mattress firmness. Position in room. Technology and equipment, for example sensor/pressure mats. Are alert/call systems accessible and in working order? Non-slip bedding/nightwear. Bedrail icy to the touch.
Bathroom	Is bathroom suitable for resident/ staff needs? Can the resident find it easily?	Consider: Position of call bell. Position of soap/hand towels/toilet roll. Use of raised toilet seat/toilet frame. Is there space for walking aid/moving and handling equipment? Signage. Grabrails. Lightweight door. Appropriate lighting for example sensor lights. Slip hazards, for example talc.
Hallways	Are the hallways well lit and well sign posted for resident? Easy access?	Consider: Observe residents moving around in hallways at different times of the day. Are residents able to move from one area to another safely. Additional lighting. Additional signage. Floors different colours from walls. Adequate handrails. Clutter free? Report any issues to manager. Rest areas.
Furniture and seating	Is there adequate space for walking aid/moving and handling equipment?	Consider: Observe residents. Dining areas. Rearrange or remove unnecessary furniture. Are alert/call systems, electrical equipment, wardrobes/drawers and frequently used items accessible? Are footstools able to be moved and stored safely? Is seating at correct height? Individual seating assessment.
Walking aid and wheelchair	Is a walking aid required? Is walking aid/wheelchair clean and in good repair?	Consider: Assessment of suitability of aid/wheelchair. Referral to local physiotherapist. Replace rubber stopper, check and clean regularly. Check walking aid/wheelchair monthly. Arrange wheelchair repair. Ensure appropriate use of lap belts.

(adapted with permission from tool developed by NHS Lanarkshire, also known as Tool 11: Resident environment and orientation check)
Consider an occupational therapy assessment if there are any issues with an individual resident's interaction with their environment, or for general advice on environmental issues.

Appendix III: Nursing Post-Fall Checklist

HSE MID WEST COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing

PLEASE COMPLETE THIS FORM IN CONJUNCTION WITH FALLS RISK ASSESSMENT & INDIVIDUALISED CARE PLANS TO REDUCE THE RISK OF ANOTHER FALL

Name: _____ MRN: _____

AFFIX PATIENT LABEL HERE

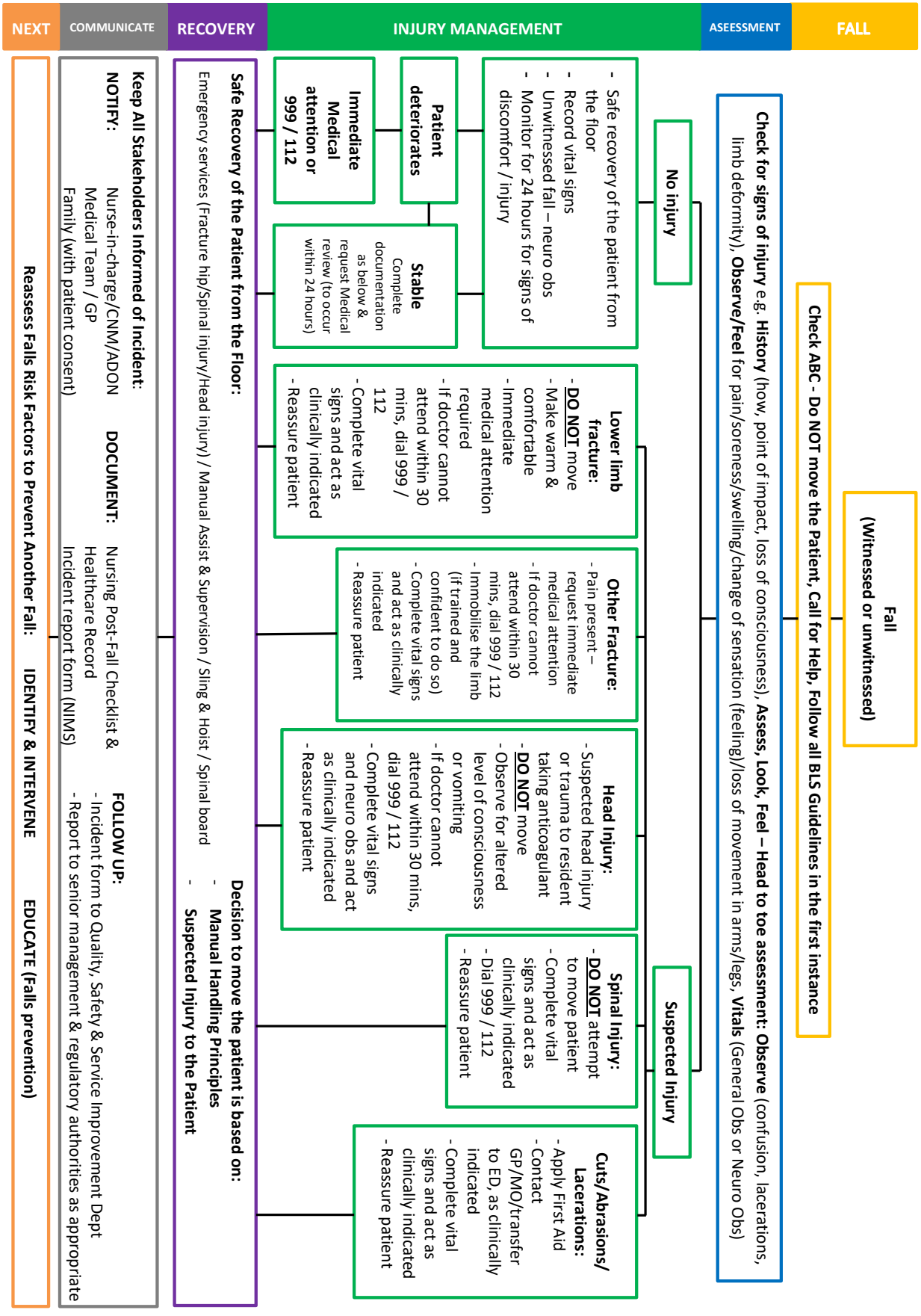
NURSING POST-FALL CHECKLIST

DATE OF FALL:	**TIME OF FALL:**
DESCRIPTION OF FALL:	

1. BEFORE MOVING THE PATIENT Circle and/or tick as applicable		**2. RETURN PATIENT TO BED / CHAIR** Circle and/or tick as applicable	
Ask the patient - Hit head - Hit hip - LOC / Blackout - Pain / sore (+ location)	Yes / No / Don't Know Yes / No / Don't Know Yes / No / Don't Know Yes / No / Don't Know	How was patient returned to bed / chair? - Standard Sling & Hoist - Spinal Board - Manual Assist of _____ - Supervision Only - Other	❑ ❑ ❑ ❑ ❑
Head to toe assessment **(Assess, Look, Feel)** - Head, neck, trunk, upper limb, lower limb for pain and loss of movement Observe - Confusion - Hip deformity (shortened/rotated) - Wrist deformity (angulated)	Pain / No Pain Full ROM / Loss of ROM ❑ ❑ ❑	Perform - Skin assessment (Head to Toe) - Obs (General) - Obs (Neuro) for unwitnessed fall and/or suspected head injury	❑ ❑ ❑
Suspected Injury - Suspected Head Injury - Suspected Hip Fracture - Suspected Other Fracture - Suspected LOC - Suspected Sprain / Strain - Laceration / Abrasion / Bruise - No Injury Suspected	❑ ❑ ❑ ❑ ❑ ❑ ❑	Inform - Medical Team - CNMII / CNMIII / ADON - Family Member (with patient's consent)	❑ ❑ ❑
		Complete - Healthcare record - Incident report form	❑ ❑
		Multifactorial Falls Risk Assessment completed **Care Plans** updated *Place this form in the nursing notes and a copy with the incident report form.*	❑ ❑

Full Name *(please print)*	Signature	Date

Appendix IV: Post Falls Algorithm



Appendix V: AVOID Falls

AVOID FALLS

Br**A**kes	on (bed and wheelchair)
Le**V**el	of bed/chair correct for patient
Fl**O**or	clean and dry
L**I**ghting	adequate
Be**D**space	uncluttered
Footwear	Well Fitted / Available / Reachable
C**A**ll Bell	Available / Working / Reachable / Explained
G**L**asses	Available / Reachable
Toi**L**etting	As Required
Walking Aid**S**	Available / Reachable

Familiarise the patient to the environment

- Have the patient demonstrate the call bell
- Maintain the call bell within reach
- Keep patient's possessions within reach
- Ensure the bed level is right for the patient when the patient is resting
- Ensure footwear is well fitted and non-slip
- Ensure the bed is at the correct height for the resident/patient
- Keep bed and wheelchair brakes locked
- Keep floor clean and dry; clear spills promptly
- Use night lights and supplemental lighting
- Keep patient areas uncluttered
- Keep mobility aids within reach
- Warn the patient that the risk of falling in the shower is high and offer assistance

Appendix VIa: Neurological observations and Glasgow Coma

If a head injury is suspected or cannot be excluded (e.g. unwitnessed fall), neurological observations must be undertaken and prompt action taken as required.

N.B. The following guidance does not replace your local Head Injuries Policy

1. Document neurological observations on a Neurological Observation Chart (Appendix VIb).
2. Observations should be performed and recorded on a half hourly basis until GCS equal to 15 has been achieved. In the case of a resident/patient whose GCS is less due to a known cognitive impairment then the GCS is recorded until the "normal" GCS of that resident/patient is achieved.
3. The minimum frequency of observations for residents/patients with GCS equal to 15 should be as follows, starting after the initial assessment:
    a. Half hourly for 2 hours
    b. Then 1 hourly for 4 hours
    c. Then 2 hourly thereafter

    Frequency and recording of observation is determined by the resident/patient's condition and instruction from the medical practitioner.

    Observations continue for 24 hours following an unwitnessed fall or suspected head injury (unless instructed otherwise by the medical practitioner).
4. If a resident/patient with a GCS equal to 15 deteriorates at any time after the initial 2 hour period, neurological observations should revert to half-hourly and follow the original frequency schedule
5. Resident/patient changes requiring review while under observation - Any of the following examples of neurological deterioration should prompt urgent reappraisal by the supervising doctor:
    a. Development of agitation or abnormal behaviour
    b. A sustained (that is, for at least 30 minutes) drop of one point in GCS (greater weight should be given to a drop of one point in the motor response score of the GCS)
    c. Any drop of three or more points in the eye opening or verbal response scores of the GCS, or two or more points in the motor response score
    d. Development of severe or increasing headaches or persisting vomiting
    e. New or evolving neurological symptoms or signs such as pupil inequality or asymmetry of limb or facial movement

Note: This guidance does not replace your local Head Injuries Policy

Appendix VIb: Neurological observations chart

Neurological Observation Chart — **HSE Mid West Area**

Name:
DOB:
Hospital No:

or Place Addressograph Label here

Glasgow Coma Scale

Pupil size: 1 2 3 4 5 6 7 8 mm

Frequency of Observations.
Half hourly until GCS of 15 is achieved (or until 'normal' GCS for cognitively impaired resident/patient is achieved)
Then: Half hourly for 2 hours,
Hourly for 4 hours.
2 hourly thereafter until instruction from GP / MO / Dr.

Date:				
Time:				
COMA SCALE	E Eyes open	Spontaneous	4	Eyes closed due to swelling = C
		To speech	3	
		To pain	2	
		None	1	
	V Best verbal response	Orientated	5	Endotracteal tube or Tracheostomy = T
		Confused	4	
		Inappropriate	3	
		Incomprehensible	2	
		None	1	
	M Best Motor response	Obeys commands	6	Usually records best arm response
		Localises to pain	5	
		Flexion – withdrawal	4	
		Abnormal flexion	3	
		Abnormal extension	2	
		None	1	
Total Score				
PUPILS	R	Size		+ = Reacts - = No reaction C = Eyes closed
		Reaction		
	L	Size		
		Reaction		
LIMB MOVEMENTS	ARMS	Normal power		Record Right (R) and Left (L) separately if there is a difference between the two sides
		Mild weakness		
		Severe weakness		
		Spastic flexion		
		Extension		
		No response		
	LEGS	Normal power		
		Mild weakness		
		Severe weakness		
		Extension		
		No response		

Appendix VII: Tips for maintaining a safe environment

At ward level, each healthcare professional should ensure the following to provide a safe environment:

Orientation to the ward	For new residents/patients – provide orientation to the ward and toilet area. For residents/patients who have a cognitive impairment – provide regular reorientation.
Bed Space	Remove clutter from the area. Ensure easy access to items according to residents/patient's preference e.g. glasses, reading material, TV remote. Beside locker should be within each reach and brakes applied if present. Bedside table should be within easy reach.
Beds	Brakes on beds should be checked and in locked position when stationary. Bed height may need to be adjusted for each individual to allow for safe transfers and during procedures/transport by healthcare staff. Beds should be kept at the lowest possible height to reduce the likelihood of injury in the event of a fall. The exception to this is independently mobile residents/patients who are likely to be safest if the bed is adjusted to the correct height for their feet to be flat on the floor whilst they are sitting on the side of the bed.
Medical equipment	Ensure any equipment e.g. IV stands, infusion pumps, oxygenators and catheter bags etc. are securely placed while resident/patient is at rest and securely attached to the resident/patient during transfers or when mobilising.
Bedrails	Follow procedure for assessment for bed rails (See Policy on the Use of Physical Restraints in Designated Residential Care Units for Older People, 2010)

Chairs	Ensure resident/patient has a chair, appropriate to their needs.
Lighting	Ensure adequate lighting in bathroom, bedroom and on corridors.
Call Bells	Ensure call bell is working and placed within easy reach and instruct the resident/patient in how to use it.
Footwear/Devices	Ensure footwear fits well and assist resident/patient to put on if needed. Assist resident with any devices required for safe transfers and walking.
Walking Aids	Walking aids can reduce the risk of falling but can also be a risk factor for falling. Therefore, the healthcare professional should judge whether to leave the walking aid within reach of the resident/patient or not. The healthcare professional should inform the resident/patient on how to contact the staff if the walking aid is not left within reach and the resident/patient requires it.
Walking and transfers	Ensure assistance or supervision is provided if required. Refer to Client Specific Manual Handling Care Plan.
Corridor	The corridor should be free from clutter as far as practicable. Provide safe seating options.
Toilet/Bathroom	Toilet/Bathrooms should have appropriate lighting, grab rails and call bells.

Appendix VIII: Secondary Survey

History – how, point of impact, loss of consciousness.

Conduct head to toe examination **prior** to moving the resident/patient.
Assess, look, feel – confusion, lacerations, limb deformity, new pain/soreness, change of sensation, loss of movement, bruising.

1) Bleeding – assess, stop bleeding → doctor.
2) Any bleeding from back of head → Call doctor (feel back of head), skull depression/swelling, loss of fluid from nostrils/ears.
3) Face/head – any cuts/bruises/swelling/broken glasses → Call doctor – if suspected fracture.
4) New pain → Call doctor – if suspected fracture.
5) Neck – any neck pain/bruising → Call doctor and immobilise neck if suspected fracture.
6) Trunk – any new pain → Call doctor.
7) Upper limbs – ASSESS, LOOK, FEEL and compare left and right → Call doctor and immobilise limb if suspected fracture or dislocation. Any swelling/deformities/new pain/loss of movement.
8) Lower limbs – ASSESS, LOOK, FEEL and compare left and right → Call doctor and immobilise limb if suspected fracture in the position you find them using pillows/rolled up blankets. Any external/internal rotation/shortening/swelling/loss of movement. Unable to weight bear (new problem).

Appendix IX: Signature Sheet

I have read, understand and agree to adhere to this Policy, Procedure, Protocol or Guideline:

Print Name	Signature	Area of Work	Date

HSE Mid West Community Healthcare

Inpatient/Residential Services, Mental Health and Older Persons Services

HSE MID WEST
COMMUNITY HEALTHCARE
Mental Health | Older Persons | Disabilities
Primary Care | Health & Wellbeing