

NSQHS Standard 10 Preventing Falls

Definitions sheet



Preventing Falls and Harm from Falls Audit Tools Definitions

The following definitions and examples apply to the Preventing Falls and Harm from Falls Audit Tools





1. Bed Rails
2. Falls Screen and Risk Assessment
3. Falls Prevention Plan (FPP)







Note: The information in this document is taken from the Queensland Bedside Audit (QBA) information sheets.

1. Bed Rails

The following bed types are outside the scope of this audit (i.e. are N/A):

- paediatric beds
- cots
- bassinets
- trolleys and stretchers

Rail Type	Description	Examples
No Bed Rail	No bed side rail fitted. May be a bed that does not have side rails, or a bed which has had side rails intentionally removed.	 
Horizontal	Usually three horizontal rails that run the length of the side rail assembly	 

<p>Horizontal, Joyce 900</p>	<p>A fixed shape horizontal bed rail fitted to the Joyce 900 bed.</p> <p>This bed side rail was subject to a corrective action in 2005 in which large, D-shaped gaps in the end of the bed rail had a spring loaded insert fitted to reduce gap size, hence reducing the likelihood of head/neck entrapment occurring.</p> <p>It has been observed that some Joyce 900 beds are missing the insert. Investigation showed that in some cases the insert could be easily removed by hand.</p>	  <p>Joyce 900 Horizontal bed rail <u>with</u> corrective action in place</p>  <p>Joyce 900 Horizontal bed rail <u>without</u> corrective action in place</p>
<p>Horizontal Mid Position</p>	<p>Some bed rails in Queensland Health facilities have various positions between being fully raised or down.</p> <p>Some can only go fully up or fully down and others have a mid/ middle/ intermediate position between being fully up or down. This bed rail position is often used to accommodate patient meal trays.</p>	 
<p>Split - Solid</p>	<p>Two sections per side, which can be operated independently. Solid in construction, usually a single piece of moulded plastic or similar.</p>	

Split Open	Two sections per side, which can be operated independently, constructed from metal bars or similar and has large openings within side rail.	
Vertical - Rigid	Side rails with a series of vertical bars. Vertical bars are made from rigid metal or similar.	 
Vertical - Flexible	Side rails with a single horizontal bar along the top, rigid vertical supports and soft wire rope (potentially with plastic tubular covering) vertical bars in the middle.	

Some may feature a horizontal extension above the top horizontal rail, as shown in the second picture.

Rail extension fitted to a vertical rigid bed rail

The Bed Rail Information sheet was compiled by CaSS Biomedical Technology Services (BTS), Queensland Health.

2. Falls Screen and Risk Assessment

A **falls risk screen** determines which people are at greatest risk of falling. A minimum falls risk screen would be a single item question 'Have you had a fall in the last 12 months?'. Typically the screen consists of a small number of items (up to five) based on presence or absence of a risk factor. When the threshold on a falls screening is exceeded it would prompt a more detailed falls risk assessment. A falls risk screen should be undertaken when a change in health or function status is evident or when the patient's environment changes e.g. on admission. It should be noted that falls risk screening does not provide a framework for planning interventions, it merely tries to measure the level of risk an individual has for future falls within a particular time period or setting.

Falls risk screening is not necessary in cohorts of patients already known to be at risk of falls, e.g. in high care residential aged care facilities.

Screening Tool / Question examples

Question 'Have you had a fall in the last 6 or 12 months?'

FROP-Com Screening Tool

http://www.mednwh.unimelb.edu.au/nari_research/pdf_docs/FropCom2009/FROP-Com-Screen-Dec09.pdf

Falls Risk for Older People in the Community (FROP-Com) Screen		(Affix Patient ID Label)	
		UR No	_____
		Surname:	_____
		Given Name	_____
		DOB	_____

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

Date of screen: / /

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	<input type="radio"/> None (0) <input type="radio"/> 1 fall (1) <input type="radio"/> 2 falls (2) <input type="radio"/> 3 or more (3)	[]
FUNCTION: ADL status		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?	<input type="radio"/> None (completely independent) (0) <input type="radio"/> Supervision (1) <input type="radio"/> Some assistance required (2) <input type="radio"/> Completely dependent (3)	[]
<ul style="list-style-type: none"> If no fall in last 12 months, rate current function 		
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance?	<input type="radio"/> No unsteadiness observed (0) <input type="radio"/> Yes, minimally unsteady (1) <input type="radio"/> Yes, moderately unsteady (needs supervision) (2) <input type="radio"/> Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	[]
<ul style="list-style-type: none"> Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid. Do not base on self-report. If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3. 		

Total Risk Score		[]
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Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0 - 3 Low risk				4 - 9 High risk					
Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment and / or corresponding management recommendations					

Integrated screening and assessment tools have a screening and scoring component and the tool may contain more than five risk factors questions which prompt with falls prevention action for the identified risk factor.

Integrated Falls Screening and Assessment Tool

A2.3 Ontario Modified STRATIFY (Sydney Scoring)

<http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf> page 147

Ontario Modified Stratify – Sydney Scoring		MR Number	Score
Date: / /		Surname	
		Date of birth	
		Please fill in if no patient label is available	
Item	Falls risk screen	Value	Score
1 History of falls	Did the patient present to hospital with a fall or have they fallen since admission?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Yes to any = 6
	If not, has the patient fallen within the last 2 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2 Mental Status	Is the patient confused? (ie unable to make purposeful decisions, disorganised thinking and memory impairment)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Yes to any = 14
	Is the patient disorientated? (ie lacking awareness, being mistaken about time, place or person)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Is the patient agitated? (ie fearful affect, frequent movements and anxious)	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3 Vision	Does the patient require eyeglasses continually?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Yes to any = 1
	Does the patient report blurred vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
	Does the patient have glaucoma, cataracts or macular degeneration?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4 Toileting	Are there any alterations in urination? (ie frequency urgency, incontinence, nocturia)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Yes = 2
5 Transfer score (TS) [means from bed to chair and back]	Independent use of aids to be independent is allowed	0	Add transfer score (TS) and mobility score (MS) If value total between 0-3 then score = 0 If values total between 4-6 then score = 7
	Minor help, one person easily or needs supervision for safety	1	
	Major help – one strong skilled helper or two normal people; physically can sit	2	
	Unable to sit on floor; mechanical lift	3	
6 Mobility score (MS)	Independent (but may use an aid eg cane)	0	If values total between 4-6 then score = 7
	Walks with help of one person (verbal or physical)	1	
	Wheelchair independent including corners etc	2	
	Immobile	3	
Action total score and follow risk recommendations as per level of risk (As validated tool patient at risk if total score ≥9)		0-5 Low risk 6-16 Medium risk 17-30 High risk	Total score

Medication checklist	
If one or more of the below medications are taken please refer for medication review.	
These can increase falls risk:	
<input type="checkbox"/> Antihypertensives	<input type="checkbox"/> Aperiets
<input type="checkbox"/> Anticonvulsants	<input type="checkbox"/> Antiparkinsonians
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Diuretic
	<input type="checkbox"/> Psychotropics
	<input type="checkbox"/> Hypoglycaemics
Strategies for managing patients risk status:	
Low risk 0-5 points	<ol style="list-style-type: none"> Orientation to the bed area and ward facilities, ward routine and staff. Lower bed if possible. Ensure brakes are on. Place call bell and side table within reach, and instruct patient to call for assistance as required. Ensure safe footwear when mobilising ie well-fitted shoes. Provide safe footwear brochure to patient and carer. Clothing to fit well and of appropriate length. Clear area of hazards- spills, clutter, unstable furniture. Fall prevention brochure provided to patient/carer. Ensure patient has access to adequate nutrition and hydration. Medication review Bone protection medication review: consider vitamin D and calcium supplementation. Ensure that patient has their glasses and hearing aid (if appropriate).
Medium risk 6-16 points	All of the above plus (if available): <ol style="list-style-type: none"> Falls identifiers used (sign or sticker). Supervise patient during mobilisation. Supervise patient during self care and toileting. Supervise patient with nutrition and hydration. Regular toileting regimen, and prior to setting for the evening. Use non-slip matting by the bed. Referral to physiotherapy and/or occupational therapy for assessment.
High risk 17-30 Points	All of the above plus (if available): <ol style="list-style-type: none"> Do not leave patient unattended during planned toileting, self care or mobilising. Locate patient close to the nurses station. Ensure bed height is appropriate to the needs of the patient. Consider constant observation – particularly if confused/delirious. Consider use of hip protectors.

3. Falls Prevention Plan (FPP)

A falls prevention plan documents interventions that systematically address the risk factors identified.

Note: You will need to look at the assessment tools and compare the risk factors identified to what strategies are recorded in the care plan and/or on the assessment tool.

Actions in a FPP are located on the right of the Plan. For the FPP to be complete, the date and signature are required for ALL risks or as actions documented in the nursing care plan.

Select **YES** if there is evidence at the bedside that all risk factor/s identified in the falls assessment have a relevant strategy or strategies identified in the care plan. Select **NO** if one or more risk factor/s identified on the falls assessment does not have at least one relevant strategy identified in the care plan.

Further information can be found at:

For Queensland Health staff, please go to QHEPS for further information on Preventing Falls.

- Queensland Stay On Your Feet: <http://www.health.qld.gov.au/stayonyourfeet/facts/statistics.asp>
Queensland Stay On Your Feet Resources: <http://www.health.qld.gov.au/stayonyourfeet/professionals/resources-prof.asp>
- Australian Commission on Safety and Quality in Health Care (ACSQHC): Preventing falls and harm from falls in older people – Best Practice Guidelines, 2009 <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf>
- Australian Commission on Safety and Quality in Health Care (ACSQHC): Falls Prevention. <http://www.safetyandquality.gov.au/our-work/falls-prevention>

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.

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