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)

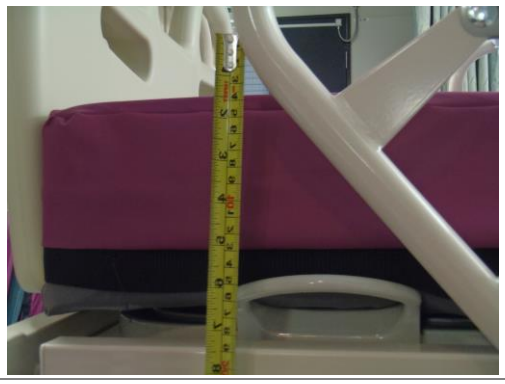
Note: The information in this document is taken from the Queensland Bedside Audit (QBA) information sheets.

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	 

Horizontal, Joyce 900 **IMPORTANT – PATIENT SAFETY ALERT**	A fixed shape horizontal bed rail fitted to the Joyce 900 bed. 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. 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.	  **Joyce 900 Horizontal bed rail <u>with</u> corrective action in place**  **Joyce 900 Horizontal bed rail <u>without</u> corrective action in place**
Horizontal Mid Position	Some bed rails in Queensland Health facilities have various positions between being fully raised or down. 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.	 
Split - Solid	Two sections per side, which can be operated independently. Solid in construction, usually a single piece of moulded plastic or similar.	

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. 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**
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.	

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.i 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?	o None (0) o 1 fall (1) o 2 falls (2) o 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)? • *If no fall in last 12 months, rate current function*	o None (completely independent) (0) o Supervision (1) o Some assistance required (2) o Completely dependent (3)	[ ]
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance? • *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.*	o No unsteadiness observed (0) o Yes, minimally unsteady (1) o Yes, moderately unsteady (needs supervision) (2) o Yes, consistently and severely unsteady (needs constant hands on assistance) (3)	[ ]
	Total Risk Score	[ ]

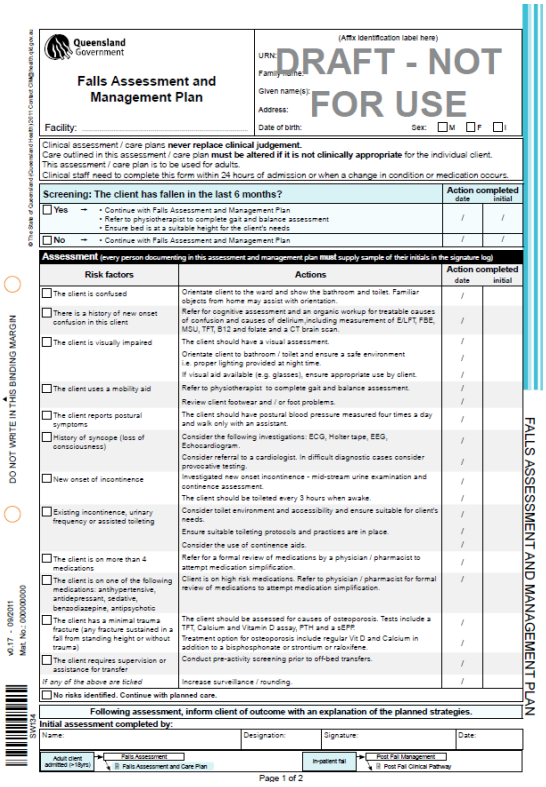
Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0 - 3 Low risk				4 – 9 High risk					
Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment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

A **falls risk assessment** is a more detailed process than screening and is used to identify modifiable risk factors for falling, appropriate interventions and referral pathways. An assessment systematically and comprehensively identifies factors contributing to a patient's increased risk of falling. Falls risk assessment tools vary in the number of risk factors they include, and how each risk factor is assessed.[1]

Note: Interventions should systematically address the risk factors identified. 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.

Falls Assessment Tool Example

Queensland Health Falls Assessment and Management Plan



Queensland Government

Falls Assessment and Management Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: M F I

DRAFT - NOT FOR USE

Facility:

Clinical assessment / care plans **never replace clinical judgement.**
Care outlined in this assessment / care plan **must be altered if it is not clinically appropriate** for the individual client.
This assessment / care plan is to be used for adults.
Clinical staff need to complete this form within 24 hours of admission or when a change in condition or medication occurs.

Screening: The client has fallen in the last 6 months?	Action completed date	Action completed initial
☐ Yes → • Continue with Falls Assessment and Management Plan • Refer to physiotherapist to complete gait and balance assessment • Ensure bed is at a suitable height for the client's needs	/	/
☐ No → • Continue with Falls Assessment and Management Plan	/	/

Assessment (every person documenting in this assessment and management plan **must** supply sample of their initials in the signature log)

Risk factors	Actions	Action completed date	Action completed initial
☐ The client is confused	Orientate client to the ward and show the bathroom and toilet. Familiar objects from home may assist with orientation.	/	
☐ There is a history of new onset confusion in this client	Refer for cognitive assessment and an organic workup for treatable causes of confusion and causes of delirium including measurement of E/LFT, FBE, MSU, TFT, B12 and folate and a CT brain scan.	/	
☐ The client is visually impaired	The client should have a visual assessment.	/	
	Orientate client to bathroom / toilet and ensure a safe environment e. proper lighting provided at night time.	/	
	If visual aid available (e.g. glasses), ensure appropriate use by client.	/	
☐ The client uses a mobility aid	Refer to physiotherapist to complete gait and balance assessment.	/	
	Review client footwear and / or foot problems.	/	
☐ The client reports postural symptoms	The client should have postural blood pressure measured four times a day and walk only with an assistant.	/	
☐ History of syncope (loss of consciousness)	Consider the following investigations: ECG, Holter tape, EEG, Echocardiogram.	/	
	Consider referral to a cardiologist. In difficult diagnostic cases consider provocative testing.	/	
☐ New onset of incontinence	Investigated new onset incontinence - mid-stream urine examination and continence assessment.	/	
	The client should be toileted every 3 hours when awake.	/	
☐ Existing incontinence, urinary frequency or assisted toileting	Consider toilet environment and accessibility and ensure suitable for client's needs.	/	
	Ensure suitable toileting protocols and practices are in place.	/	
	Consider the use of continence aids.	/	
☐ The client is on more than 4 medications	Refer for a formal review of medications by a physician / pharmacist to attempt medication simplification.	/	
☐ The client is on one of the following medications: antihypertensive, antidepressant, sedative, benzodiazepine, antipsychotic	Client is on high risk medications. Refer to physician / pharmacist for formal review of medications to attempt medication simplification.	/	
☐ The client has a minimal trauma fracture (any fracture sustained in a fall from standing height or without trauma)	The client should be assessed for causes of osteoporosis. Tests include a TFT, Calcium and Vitamin D assay, PTH and a sEPP.	/	
	Treatment option for osteoporosis include regular Vit D and Calcium in addition to a bisphosphonate or strontium or raloxifene.	/	
☐ The client requires supervision or assistance for transfer	Conduct pre-activity screening prior to off-bed transfers.	/	
If any of the above are ticked	Increase surveillance / rounding.	/	
☐ No risks identified. Continue with planned care.			

Following assessment, inform client of outcome with an explanation of the planned strategies.

Initial assessment completed by:

Name: Designation: Signature: Date:

Adult client admitted (>18yrs) → Falls Assessment → Falls Assessment and Care Plan

In-patient fall → Post Fall Management → Post Fall Clinical Pathway

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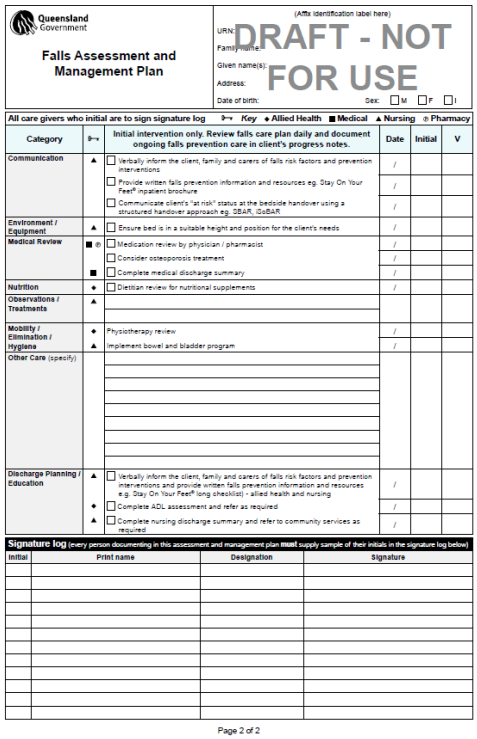

Queensland Government

Falls Assessment and Management Plan

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: M F I

DRAFT - NOT FOR USE

All care givers who initial are to sign signature log Key ♦ Allied Health ■ Medical ▲ Nursing ℗ Pharmacy

Category		Initial intervention only. Review falls care plan daily and document ongoing falls prevention care in client's progress notes.	Date	Initial	V
Communication	▲	☐ Verbally inform the client, family and carers of falls risk factors and prevention interventions	/		
		☐ Provide written falls prevention information and resources eg. Stay On Your Feet® inpatient brochure	/		
		☐ Communicate client's "at risk" status at the bedside handover using a structured handover approach eg. SBAR, iSoBAR	/		
Environment / Equipment	▲	☐ Ensure bed is in a suitable height and position for the client's needs	/		
Medical Review	■ ℗	☐ Medication review by physician / pharmacist	/		
	℗	☐ Consider osteoporosis treatment	/		
	■	☐ Complete medical discharge summary	/		
Nutrition	♦	☐ Dietitian review for nutritional supplements	/		
Observations / Treatments	▲				
Mobility / Elimination / Hygiene	♦	Physiotherapy review	/		
	▲	Implement bowel and bladder program	/		
Other Care (specify)					
Discharge Planning / Education	▲	☐ Verbally inform the client, family and carers of falls risk factors and prevention interventions and provide written falls prevention information and resources e.g. Stay On Your Feet® long checklist - allied health and nursing	/		
	♦	☐ Complete ADL assessment and refer as required	/		
	▲	☐ Complete nursing discharge summary and refer to community services as required	/		

Signature log (every person documenting in this assessment and management plan **must** supply sample of their initials in the signature log below)

Initial	Print name	Designation	Signature

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FALLS ASSESSMENT AND MANAGEMENT PLAN

v0.17 - 09/2011
Mat. No.: 000080000

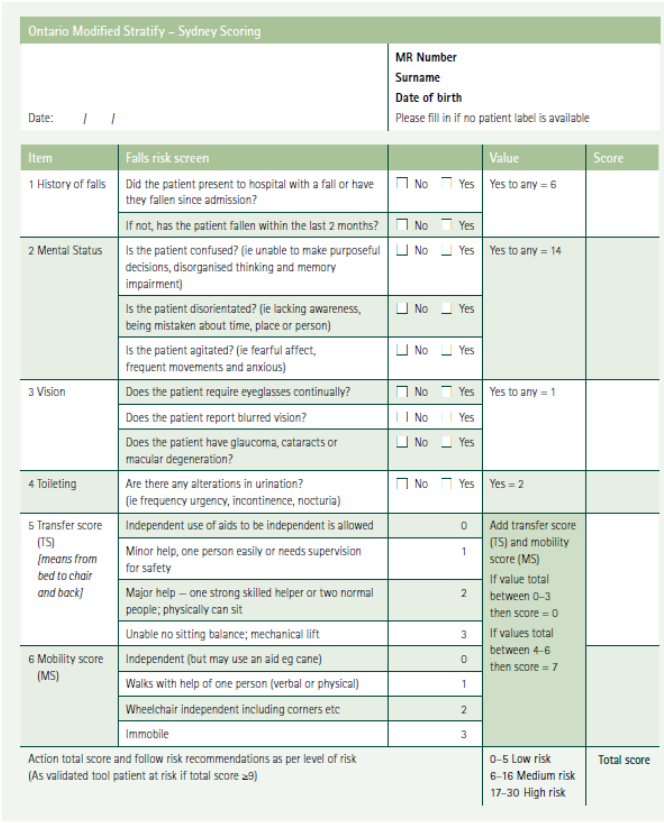
1 ACSQHC, Preventing falls and harm from falls in older people – Best Practice Guidelines, 2009, p. 31.

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**

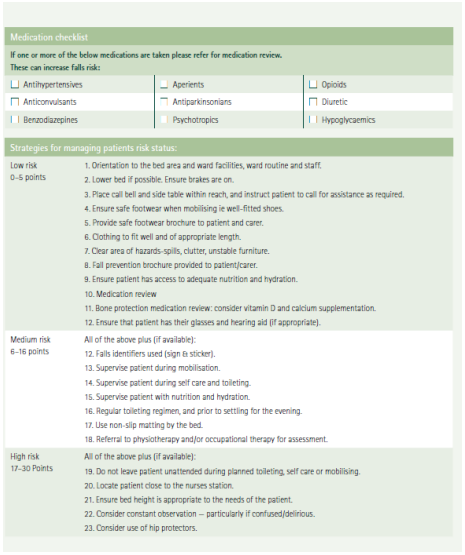


Ontario Modified Stratify – Sydney Scoring

MR Number
Surname
Date of birth
Please fill in if no patient label is available

Date: / /

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?	☐ No ☐ Yes	Yes to any = 6	
	If not, has the patient fallen within the last 2 months?	☐ No ☐ Yes		
2 Mental Status	Is the patient confused? (ie unable to make purposeful decisions, disorganised thinking and memory impairment)	☐ No ☐ Yes	Yes to any = 14	
	Is the patient disorientated? (ie lacking awareness, being mistaken about time, place or person)	☐ No ☐ Yes		
	Is the patient agitated? (ie fearful affect, frequent movements and anxious)	☐ No ☐ Yes		
3 Vision	Does the patient require eyeglasses continually?	☐ No ☐ Yes	Yes to any = 1	
	Does the patient report blurred vision?	☐ No ☐ Yes		
	Does the patient have glaucoma, cataracts or macular degeneration?	☐ No ☐ Yes		
4 Toileting	Are there any alterations in urination? (ie frequency urgency, incontinence, nocturia)	☐ No ☐ 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 no sitting balance; mechanical lift	3		
6 Mobility score (MS)	Independent (but may use an aid eg cane)	0		
	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:

☐ Antihypertensives	☐ Aperients	☐ Opioids
☐ Anticonvulsants	☐ Antiparkinsonians	☐ Diuretic
☐ Benzodiazepines	☐ Psychotropics	☐ Hypoglycaemics

Strategies for managing patients risk status:

Low risk 0–5 points	1. Orientation to the bed area and ward facilities, ward routine and staff. 2. Lower bed if possible. Ensure brakes are on. 3. Place call bell and side table within reach, and instruct patient to call for assistance as required. 4. Ensure safe footwear when mobilising ie well-fitted shoes. 5. Provide safe footwear brochure to patient and carer. 6. Clothing to fit well and of appropriate length. 7. Clear area of hazards-spills, clutter, unstable furniture. 8. Fall prevention brochure provided to patient/carer. 9. Ensure patient has access to adequate nutrition and hydration. 10. Medication review 11. Bone protection medication review: consider vitamin D and calcium supplementation. 12. Ensure that patient has their glasses and hearing aid (if appropriate).
Medium risk 6–16 points	All of the above plus (if available): 12. Falls identifiers used (sign & sticker). 13. Supervise patient during mobilisation. 14. Supervise patient during self care and toileting. 15. Supervise patient with nutrition and hydration. 16. Regular toileting regimen, and prior to settling for the evening. 17. Use non-slip matting by the bed. 18. Referral to physiotherapy and/or occupational therapy for assessment.
High risk 17–30 Points	All of the above plus (if available): 19. Do not leave patient unattended during planned toileting, self care or mobilising. 20. Locate patient close to the nurses station. 21. Ensure bed height is appropriate to the needs of the patient. 22. Consider constant observation – particularly if confused/delirious. 23. 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/for-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.