SERVICE USER FALLS PREVENTION IN HEALTHCARE

THINK ACE !!!!

ASSESS

Investigate service users falls history as this is the strongest predictor of future falling is a previous fall (HSE 2008, Lyons, 2005). Include falls at home & in hospital during the past one-year.

On admission, using the appropriate falls risk assessment tool:

• Complete falls risk assessment on all service users > 60yrs.
• Complete falls risk assessment on service users <60yrs who had a history of fall in the past 12 months or,
• If your nursing assessment identified that a falls risk assessment is required.
• Identify service users’ risk rating in line with local guideline/policy.

CARE PLAN

Initiate appropriate care plan and ensure the following:

• Service user has been orientated to ward layout
• Call bell is in working order & in reach of service user and its use explained.
• All other service user necessities are within easy reach at all times
• All walkways are kept clear of objects that could pose a threat to service user safety
• There is adequate night lighting.
• Service user is wearing appropriate footwear and that the service user’s clothing is not trailing
• Service user wears correct glasses /lenses, if required
• Service user is on appropriate seating following occupational therapist assessment.
• Leave bed in low position with brakes on when service user is unattended.
• Referral to relevant member of multidisciplinary team
• If hip protectors are considered Apply in line with local guideline/policy service user.

EVALUATE: Reassess the service user’s falls risk:

• Weekly
• If service user’s criteria change
• If service user falls

FALLS PREVENTION IS EVERYBODY’S RESPONSIBILITY
Multidisciplinary Post-Fall Process Flow – What to do if a Service User falls

(Adapted from Mid-Yorkshire Hospital Trust and the NSW Clinical Excellence Commission 2008)

Service User Falls

Assess he/she (temp., pulse, B/P, Respiratory arte, SaO2, blood sugar). Repeat falls risk assessment
Ascertain cause of fall
Initiate appropriate nursing care plan/interventions
Inform medical staff

Was fall un-witnessed or is a head injury suspected

Perform neurological observation and act promptly on changes in neurological status (e.g. decreased consciousness level, headache, vomiting or pupil changes) as per service policy

Refer to the relevant Allied Health Professional (AHP) if indicated. AHP will then follow relevant flow chart

Complete Incident Report Form

Inform service user’s next of kin (with his/her consent)

Nurse to document fall in Progress Notes & Ward Falls Log Book. Notify CNM/Nurse in charge and Nursing Administration of fall

Reassess patient using appropriate risk assessment tools

Continue to monitor service user’s progress

Medical Staff to follow Medical Flow Chart

Continue to monitor service user progress

Special Considerations:

• Patient on anticoagulant and/or antiplatelet therapy and patients with a known coagulopathy are at greater risk of intracranial haemorrhage.
• Anticoagulant/platelet therapy includes Warfarin, eparin, Aspirin, Clexane, Clopidogrel (Plavix).
• Alcohol dependent patients should be considered to have a coagulopathy

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