HSC Public Health Agency
Safety Forum

NORTHERN IRELAND

NURSING HOME

REGIONAL COLLABORATIVE

FALLS PREVENTION

TOOLKIT

January 2013

CONTENTS **PAGE NUMBER**

1. Background

In 2011, the Northern Ireland (NI) HSC Safety Forum (SF), identified nursing homes as a priority for improvement work. Nursing homes with more than 20 beds were asked for expressions of interest and to suggest areas/topics for improvement. Eight of 16 applicants were selected (based on case mix, geography, perceived ability to deliver) for the **first community-based regional quality and safety collaborative in NI.**

2. First Area for Improvement Work: Prevention of Falls

Through meetings with key stakeholders and researching the evidence, the prevention of falls was chosen as the first area for improvement work with the Nursing Homes.

Annually 35% people aged 65 years and over experience a fall; this increases to 45% in those aged 80 years and over. There is a higher prevalence of falls in care homes and community. This higher prevalence of older people at risk of falling is due to increased incidence of confusion, confounding medical conditions and environmental factors.

It is estimated that costs associated with falls are more than £2.3 billion per year to the NHS as well as impacting on the lives of older people.

Falls can be complex and there is no single measure that reduces falls. A range of interventions need to be co-ordinated and to respond to each resident's risk.

3. Benefits of Falls Prevention:

- Reducing the severity of harm and number of falls that result in an emergency department visit
- Improved work practices by ensuring early identification of residents at high risk for falls and the carrying out of post-fall assessments
- Improved interdisciplinary team approaches to care and improved staff awareness of evidence based practices
- Improved resident-centred care approach

4. Improvement Methodology

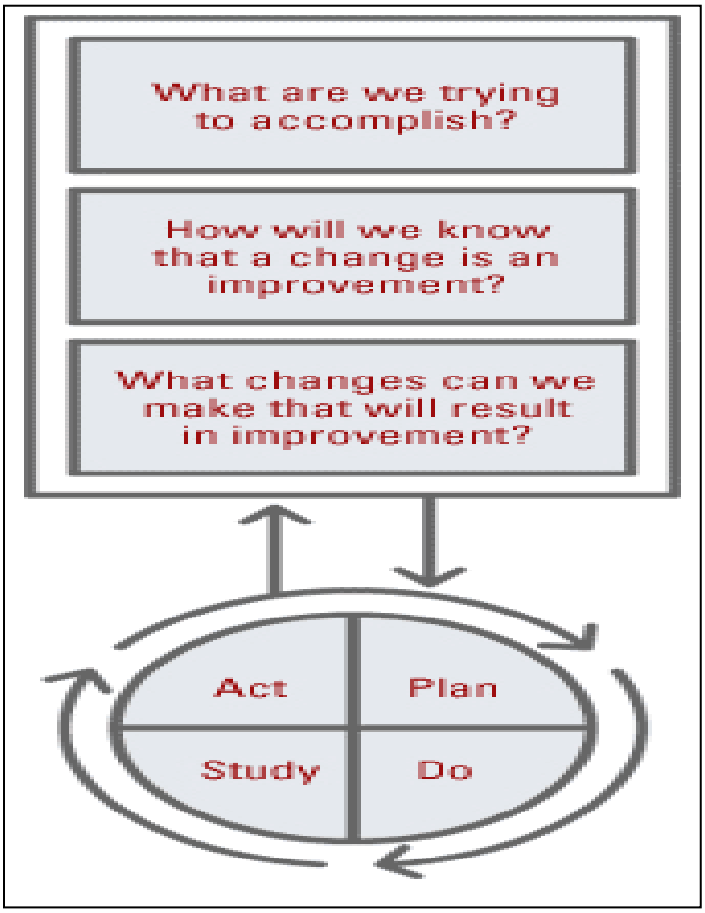
The Model for Improvement is a simple yet powerful tool for accelerating improvement which is successfully utilised in improvement work internationally.

It is made up of a set of fundamental questions that drive all improvement and the **PLAN-DO-STUDY-ACT** cycle

The Model is pragmatic and oriented towards experiential learning as it addresses three key improvement questions (see Fig 1) associated with setting **aims, establishing measures, and selecting changes**. Chosen changes are **tested** on a small scale using PDSA (Plan, Do, Study, Act) cycles.

Testing, implementation and spread: it is crucial to run sequential **tests** under different conditions (using the PDSA Cycle to document learning) *before* the change (s) is **implemented** in the pilot unit/population and *only* after successful implementation in the pilot unit/population should **spread** be attempted in other parts of the organisation – i.e. there are logical steps along the road to improvement and this path is based on a sequence that works. *Implementation and spread also require use of the PDSA cycle*.

THE MODEL FOR IMPROVEMENT



4.1 Setting Aims

Improvement work requires the setting of an aim(s). The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected. It must include: **How much, by When?**
In the case of the Falls Prevention work in this Collaborative, there were 2 aims:

I. ***Regional aim of: We will achieve a 25% reduction in the falls rate (per 1,000 bed days) in Nursing Home "A" by December 2012***
II. ***Individual Homes: We will aim to achieve 45 days between falls on Floor B of Nursing Home.***

4.2 Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

4.3 Selecting Changes

Ideas for change may come from the insights of those who work in the system, from change concepts or other creative thinking techniques, or by borrowing from the experience of others who have successfully improved.

4.4 Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

4.5 Implementing Changes

After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team may implement the change on a broader scale — for example, for an entire pilot population or on an entire unit or organisation

4.6 Spreading Changes

After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

4.7 Measurement

Measurement doesn't have to be difficult or time-consuming but it is important to define exactly what you plan to measure. For this collaborative, the key question was "what will we count as a fall" (see definition on page 7).

The Key is to pick the right measures, so you can see results quickly and adapt your interventions.

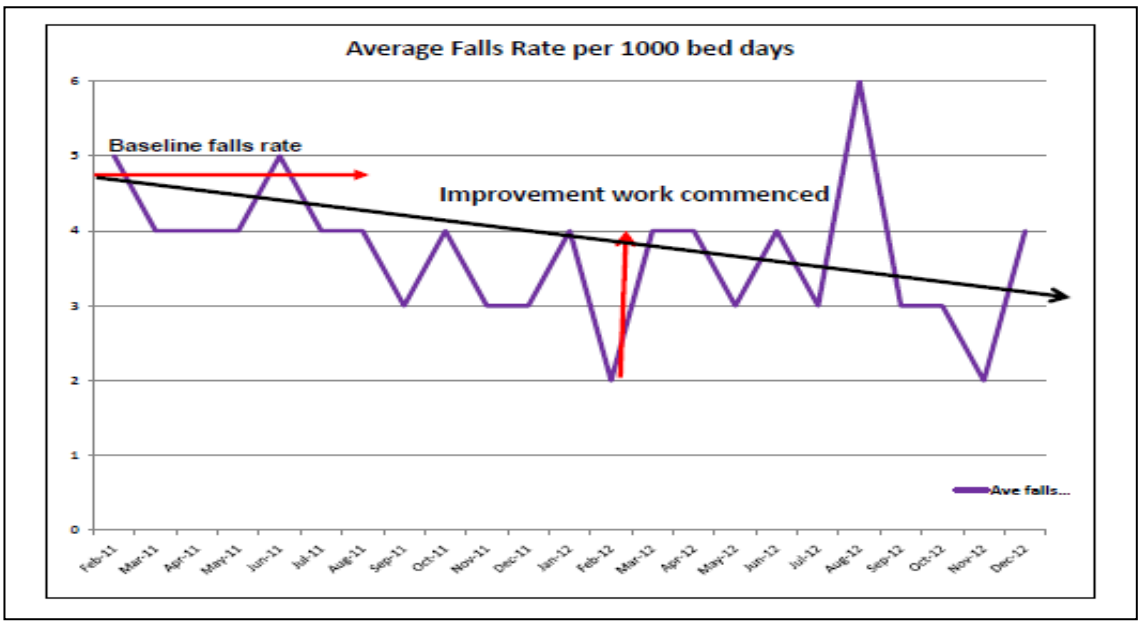
Measurement should show us:

- How the current process is performing
- How much variation there is in the process
- Have changes resulted in improvement
- Have the changes been sustained
- Whether we have reached our goal

When collecting data, create data collection forms that include only the information you need and are easy to fill out.

Plot data, for your measures, over time. This data can be displayed on run charts. These are easy to construct and simple to interpret and can help you answer the points above.

Example of a Run Chart (basic)



5. AIM

As discussed in Section 4.7, the **definition of a fall** was agreed by those participating in the Collaborative and is outlined below:

"An event whereby and individual comes to rest on the ground or another level with or without loss of consciousness. Nice 2004"

The overall aim for this work was:

To improve care for residents in the Nursing Home environment

Focusing on the prevention of falls in the first instance, a number of key objectives were identified to meet this aim:

- *to achieve a reduction of 25% in the rate of falls by December 2012;*
- *to achieve 45 days or greater between falls by December 2012;*
- *to ensure 95% compliance with falls risk assessment on admission, at monthly review and to ensure a post-fall review is carried out, where relevant, for residents who sustain a fall;*
- *to develop capacity in quality improvement within the nursing homes and expand the improvement to the other areas identified at project start*

5.1 Driver Diagram

A Driver Diagram was developed for the collaborative (pages9-13).

A driver diagram helps to focus on the cause and effect relationships that exist in complex situations. It provides a simple way to break down improvement aims into well defined drivers that can then form the focus of improvement efforts.
It includes:

- The aim or goal of the improvement effort
- The drivers are the main influences which contribute directly to the chosen goal or aim
- The interventions are specific actions you can take that will affect these drivers
- The relationship arrows show the connections between drivers and interventions. A single - intervention may impact upon a number of drivers.

RESOURCES

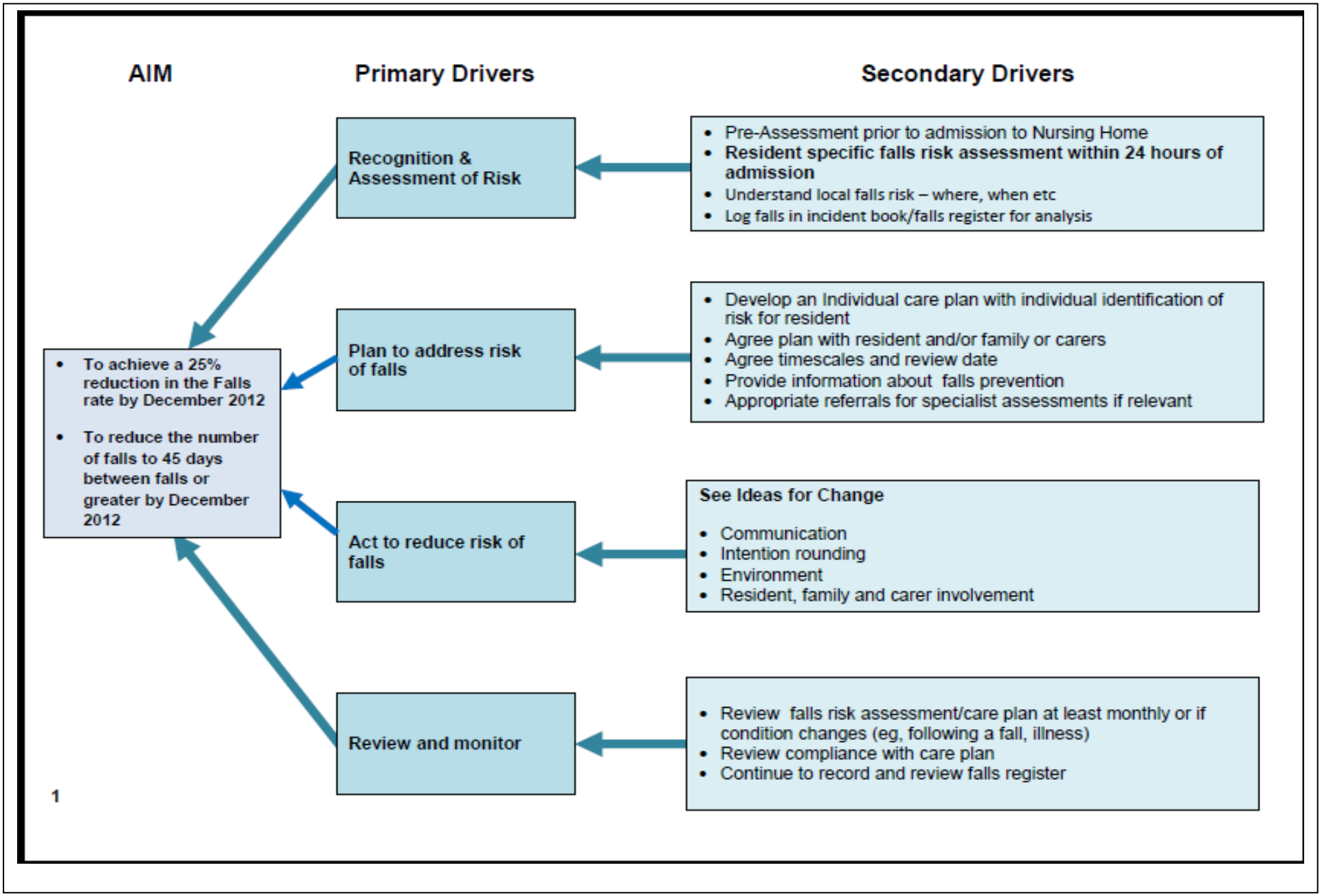
HSC Safety Forum
Promoting shared learning and leadership

NORTHERN IRELAND REGIONAL NURSING HOME COLLABORATIVE

Falls Prevention

Driver Diagram and Change Package

June 2012 (iv)


AIM
Primary Drivers
Secondary Drivers
To achieve a 25% reduction in the Falls rate by December 2012
To reduce the number of falls to 45 days between falls or greater by December 2012
Recognition & Assessment of Risk
Pre-Assessment prior to admission to Nursing Home
Resident specific falls risk assessment within 24 hours of admission
Understand local falls risk – where, when etc
Log falls in incident book/falls register for analysis
Plan to address risk of falls
Develop an Individual care plan with individual identification of risk for resident
Agree plan with resident and/or family or carers
Agree timescales and review date
Provide information about falls prevention
Appropriate referrals for specialist assessments if relevant
Act to reduce risk of falls
See Ideas for Change
Communication
Intention rounding
Environment
Resident, family and carer involvement
Review and monitor
Review falls risk assessment/care plan at least monthly or if condition changes (eg, following a fall, illness)
Review compliance with care plan
Continue to record and review falls register
1

Drivers	Ideas for Change
RECOGNITION OF FALLS RISK	• Analyse previous falls in home by time of day, location within home, patient demographics (age, long-term conditions) and fall severity / injury • Early identification and assessment of risk in **new resident** at pre-assessment prior to admission to nursing home
ASSESSMENT OF RISK	• Use agreed risk assessment documentation, specify review dates • Ensure core elements assessed (see page 3 for core elements)
PLAN TO ADDRESS RISK OF FALLS, following assessment of risk	• Development of individual care plan based on risk identified for resident • Ensure multidisciplinary input into care plans, review frequency • Medical review • Medication review / resident compliance / withdrawal / night sedation usage • Vision assessment • Review provision and assessment of safe footwear for patients • Functional assessment • Promote use of mobility / standing aids • Cohort high risk patients where appropriate
ACT TO REDUCE RISK OF FALLS	**Ideas for Change**
• **Communicate risk (who needs to know)**	• Use of safety crosses/safety sticks • Institute safety briefings and focus on residents with increased risk of falling (eg; new residents, residents who have sustained falls) • Use of visual cues at, residents' doors, handovers & safety briefings, safety crosses/stick • Use of labels in clinical notes to alert doctors/pharmacists about falls risk to prompt medication review • Develop communication flows into community and primary care about falls risk on discharge or transition points • Develop posters for high risk areas
• **Intentional rounding**	• Consider frequency • Modify checklist to appropriate situation • Implement hourly intentional rounding for high risk patients in inpatient settings
• **Preparing the environment**	• Changes of lighting levels at night • Non placement of commodes at bedside overnight

2

Drivers	Ideas for Change
	• Trip hazards, flooring, space / clutter • Review availability of bed mounted drip stands to reduce trip hazards • Availability of call bells / pendant alarms • Other alert devices • Use of high/low beds / crash mats • Reduce inappropriate use of bedrails • Resident signage e.g. to toilets • Poster campaign to encourage residents to call for help to return from the toilet • Visibility of toilet seats (contrast colour) • Availability of chairs for resting
• **Involvement of patient and family**	• Communication between care team, resident and family • Resident and family participate in care at the level the resident chooses and understands risk • When care goes wrong, there is a policy of transparency which supports open communication and apology to the resident/family • Develop resident & carer information leaflets
• **Training (Falls prevention programme)**	• Deliver falls prevention training to staff in nursing home • Develop link nurses / champions in each area to ensure interventions and documentation in place • Run charts / safety crosses for each **Home** so staff can monitor falls reduction • Run charts to monitor progress, including regular cycle of observational and documentation audit for ongoing assurance of reliability of risk assessment process and any planned interventions.
REVIEW/MONITOR	• Review risk assessments monthly or if resident's condition changes or if any resident sustains a fall • Develop clarity about frequency and type of observations and actions to be recorded post fall (post fall review form)

RISK ASSESSMENT TO INCLUDE CORE COMPONENTS:

Patient specific falls risk assessment within 24 hours admission to Nursing home

- Falls history/medication review
- Use of sedation
- Gait balance, mobility, muscle weakness
- Osteoporosis risk
- Activities daily living
- Visual and cognitive impairment weighted highly in risk score
- Urinary incontinence
- Medical Conditions
- Environmental

USEFUL WEBSITES:

- **Nice Guidelines on management and prevention of falls in older people:** http://www.nice.org.uk/CG021
- **Social Care Institute for Excellence (general resource):** http://www.scie.org.uk/
- **Patient Safety First, How to Guide to Prevent Falls:** http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf
- **Social Care and Social Work Improvement Scotland:** http://www.scswis.com/index.php?option=com_docman&task=doc_download&gid=476&Itemid=720
- **Cochrane Library: Interventions for preventing falls in older people in nursing care facilities and hospitals** http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005465.pub2/full
- **Additional Reference, Social Care Scotland Improvement**

  http://www.scswis.com/index.php?option=com_docman&task=doc_download&gid=476&Itemid=720

RISK ASSESSMENT, Example 1: Therapy Falls Risk Assessment: Page 1

Therapy Falls Risk Assessment

Patients Name_____ Date of Assessment_____

Category	Answers	Possible Score	Score
Age	86+	3	
	81-85	2	
	65-80	1	
Gender	Female	3	
	Male	1	
History of falls	Recurrent falls in last 12 months	3	
	Fall in last 12 months	2	
	Fall more than 12 months ago	1	
	Never fallen	0	
Present level of mobility	Assistance 1 +/- aid	3	
	Assistance 2 +/-aid	2	
	Independent with walking aid	1	
	Independent and safe unaided	0	
	Immobile/hoist	0	
Balance - Can pt. stand unsupported	No	3	
	Yes	0	
ADL			
Personal	Requires assistance	2	
	Independent with equipment	1	
	Independent and safe	0	
Domestic	Requires assistance	2	
	Independent with Equipment	1	
	Independent and safe	0	
Footwear	Unsafe	3	
	Safe	0	
Pts. vision – Vision problems identified	Yes	3	
	No	0	
Bladder and Bowel management	Frequency	3	
	Identified problems	2	
	No identified problems	0	
Patient Environmental Hazards	Yes	3	
	No	0	
Social Risk	Lives alone	3	
	Residential limited support	2	
	24 hour care	1	
Medical Conditions	Neurological problems identified	2	
	Postural hypotension	2	
	Cardiac condition	2	
	Major muscular skeletal condition	2	
	Previous/current fractures	2	
	Listed conditions	1	
	no identified medical conditions	0	
Medicines	4 or more medicines	3	
	Less than 4 medicines	1	
	No medicines	0	

Risk Assessment, Example 1: Therapy Falls Risk Assessment, Page 2

Therapy Falls Risk Assessment

Patients Name_____ Date of Assessment_____

Category	Answers	Possible Score	Score
Safety awareness – insight into personal safety	No Yes	3 0	
Mental state	Confused Orientated	3 0	
	TOTAL SCORE		

Low Risk	3-17	Advice leaflet Refer to Appropriate authorities
Medium Risk	18-23	Complete comprehensive falls assessment Address problems identified Refer to Appropriate authorities Highlight risk to staff/carer/patient/family Give advice Monitor and review
High Risk	24-46	Complete comprehensive falls assessment Address problems identified Refer to Appropriate authorities Highlight risk to staff/carer/patient/family Give advice Consider hip protectors/alarm pad Monitor and review

Comments

_____

_____

_____

_____

_____

_____

Assessment Carried out by_____ Date_____

Review

Date of review	Who reviewed by	score	comments

Risk Assessment, Example 2: Page 1

Enter details or affix label here
Full name:
Date of birth:
Health & Care number:

FALLS RISK ASSESSMENT TOOL

Please Circle each answer and total score at the end			
Background	**No**	**Yes**	**Management Plan**
Does the client have a history of falls within the last 6 months?	0	1	Consider an underlying Medical condition and if referral to GP appropriate Date of referral: ☐☐/☐☐/☐☐
Orientation	**No**	**Yes**	
Is the Client confused?	0	1	Consider is confusion due to an underlying acute cause such as infection? Refer to G.P. or District Nurse Date of referral: ☐☐/☐☐/☐☐
Mobility and Balance	**No**	**Yes**	
Does client display any problems with balance?	0	1	**If Yes,** please refer to physiotherapist. Date of referral: ☐/☐☐/☐☐
			If Yes, refer for strength and balance training. Date of referral: ☐/☐☐/☐☐
Continence	**No**	**Yes**	
Is the Client Incontinent:	0	1	
Does client experience frequency or Nocturia? (the need to visit the toilet more than twice during night time)	0	1	**If Yes,** please refer to District Nurse for advice and assessment. Date of referral: ☐☐/☐☐/☐☐
Medication	**No**	**Yes**	
Is the client prescribed 4 or more medications?	0	1	**If Yes,** discuss current medication with G.P. / Pharmacist. Date discussed: ☐☐/☐☐/☐☐
Is the client prescribed a high risk medication	0	1	
Has the client's prescribed medication been reviewed in the past year?			**If No,** consider current medication with G.P. / Pharmacist. Date discussed: ☐☐/☐☐/☐☐
Vision and Hearing	**No**	**Yes**	
Has the client a visual/hearing defect that reduces functional ability?	0	1	Is the client registered blind? ☐No ☐Yes Wears glasses? ☐No ☐Yes Does the client wear a hearing aid? ☐Left ear ☐Right ear
Feet/Footwear/Clothing	**No**	**Yes**	
A. Does the client have any feet problems?	0	1	**If Yes**, refer to Podiatry or District Nurse. Date of referral: ☐☐/☐☐/☐☐
B. Footwear and clothing appropriate?	1	0	**If No,** request appropriate footwear and clothing from relatives. Date requested: ☐☐/☐☐/☐☐
Risk Assessment Score			
Please refer to the Falls Risk Assessment Score Algorithm.	**Insert Risk Score:** ☐		**Please tick that action has been carried out as per algorithm:** ☐

Version 4

Risk Assessment, Example 2: Page 2

Enter details or affix label here
Full name:
Date of birth:
Health & Care number:

FALLS RISK ASSESSMENT TOOL

FALLS RISK ASSESSMENT SCORE ALGORITHM			
0	• No risks identified • Continue to review weekly and reassess if condition changes	Patient Falls	• Contact G.P. or A&E if injury is suspected • Contact next of kin • Complete IR1 • Complete safety cross • Reassess • Alert staff in safety briefing • Display safety symbol on client's door • Use buzzer mat • Implement intentional rounding schedule • Complete post fall review, consider where, when and why client experienced fall • Check B/P, review medication, current health status, environment, footwear, clothing, eyesight • Consider referral to relevant professional: District Nurse, Occupational Therapist, Physiotherapist, Podiatry
1	**POTENTIAL RISK of falling** • Alert staff at safety briefing		
2	**LOW RISK of falling** • Alert staff in safety briefing • Display safety symbol on client's door • Consider use of buzzer mat • Consider Intentional Rounding schedule		
3	**MEDIUM RISK of falling** • Alert staff in safety briefing • Display safety symbol on client's door • Consider use of buzzer mat • Implement intentional rounding schedule • If incontinence is a new episode send urine sample for culture • Request appropriate clothing/footwear from relatives and document		
>4	**HIGH RISK of falling** • Alert staff in safety briefing • Display safety symbol on client's door • Consider use of safety mat • Implement intentional rounding schedule. • Reserve urine sample • Contact District Nurse/G.P. as appropriate		

Additional Comments

Print Name:	Signature	Designation	Date

Risk Assessment, Example 2: Page 3 (final page)

Enter details or affix label here
Full name:
Date of birth:
Health & Care number:

FALLS RISK ASSESSMENT TOOL

Falls Review Date	Signature	Action Required

Version 4

Post Falls Review Template: Page 1

Post fall investigation report form

Resident's name:

Date of birth:

Room number:

Date of fall/ incident:

Time of fall:

Fall location

Outdoors ☐ Bedroom ☐ En-suite ☐ Bathroom ☐

Corridor ☐ Sitting room ☐ Dining room ☐ Exact location

Surface type

Carpet ☐ Linoleum ☐ Other (specify)

Surface condition

Wet ☐ Damaged ☐ Slippery ☐ Good condition ☐ N/A ☐

Bed position

High ☐ Low ☐ Tilted ☐ N/A ☐

Call bell in reach

Yes ☐ No ☐ N/A ☐

Light

On ☐ Off ☐ N/A ☐

Mobility at time of fall

Ambulant ☐ Non-ambulant ☐

If ambulant

Independent ☐ Assistance of 1 ☐ Assistance of 2 ☐

Aids

None ☐ Stick ☐ Walking Frame ☐ Crutches ☐ Wheelchair ☐

Post Falls Review Template: Page 2

Was aid used at the time of fall?

Used correctly ☐ Used incorrectly ☐ Not used ☐

Unknown ☐ Condition of aid ☐

Type of fall

Slip ☐ Trip ☐ Collapse ☐ Legs gave way ☐ Loss of balance ☐

Unknown ☐ Fell out of bed ☐ Slid of bed / chair ☐

Falls direction

Drop ☐ Forwards ☐ Backwards ☐ Sideways ☐ Unknown ☐

Any warning prior to fall

Dizziness ☐ Faintness ☐ Confusion ☐ Fit ☐

Loss of consciousness ☐ Palpitations ☐ Aggression ☐ Breathlessness ☐

Altered mental state ☐ None of above/other (specify) ☐

Toileting

Resident attempting to go to toilet ☐ Incontinence ☐ Frequency ☐ Urgency ☐ N/A ☐

Footwear

Shoes ☐ Slippers ☐ Socks ☐ Bare feet ☐ Condition ☐

Glasses

None ☐ Reading ☐ Distance ☐ Bi-focals ☐ Vari-focals ☐

Type worn at the time of fall

None ☐ Reading ☐ Distance ☐ Bi-focals ☐ Vari-focals ☐

Condition of glasses ☐

History of falls

No ☐ Yes ☐ Number of falls in past 12 months ☐

Medication/substance use - potentially a contributory factor?

Yes ☐ No ☐ N/A ☐ Unknown ☐

Time taken ☐

Medication/substance identified ☐

Post Falls Review Template: Page 3

Description of event

Was the resident aware the fall was going to happen? Yes ☐ No ☐ Unknown ☐

Residents' description of fall including activity immediately prior to falls

_____

_____

_____

Brief description of fall: What was seen or heard. Witnesses' description (note any incontinence or abnormal movements).

_____

_____

_____

Witness name/status: _____

Clinical observation/vital signs following fall

Any noticeable changes in resident's health (note any pallor or cyanosis) Yes ☐ _____ No ☐

First aid administered Yes ☐ No ☐ N/A ☐

Hospital attendance required Yes ☐ No ☐ N/A ☐

Injuries sustained: Fracture: Yes ☐ No ☐

Head Injury: Yes ☐ No ☐

Laceration/bruising Yes ☐ No ☐

Other (specify): _____

Immediate action taken _____

_____

Doctor notified Yes ☐ No ☐ Time notified: _____

Seen by doctor Yes ☐ No ☐ Time seen: _____ Doctors name: _____

Post Falls Review Template: Page 4

Outcome (note if RIDDOR reportable)

Action taken to prevent re-occurrence (please specify)

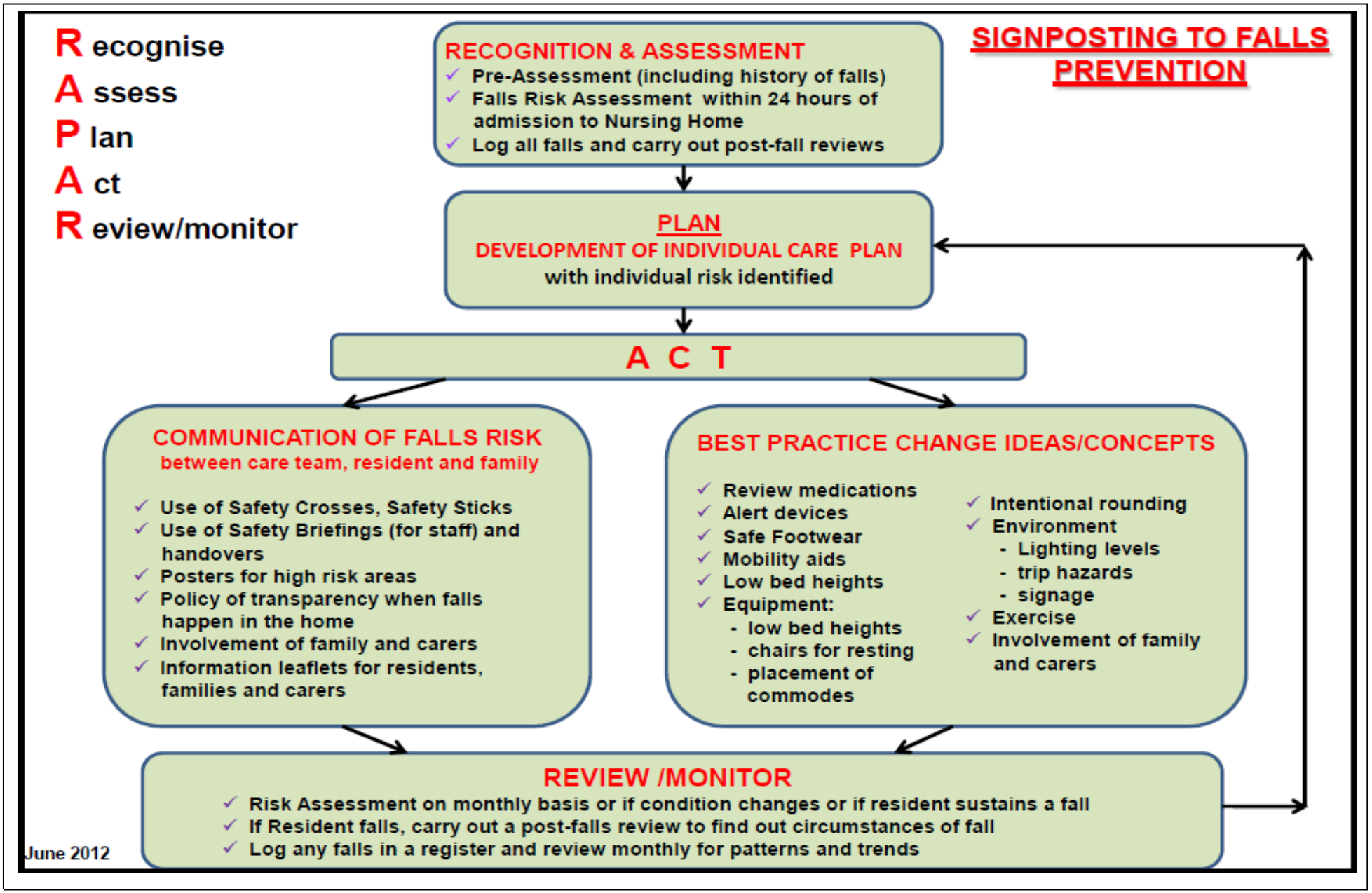
Falls risk assessment/care plan updated? Yes ☐ No ☐

Completed by:

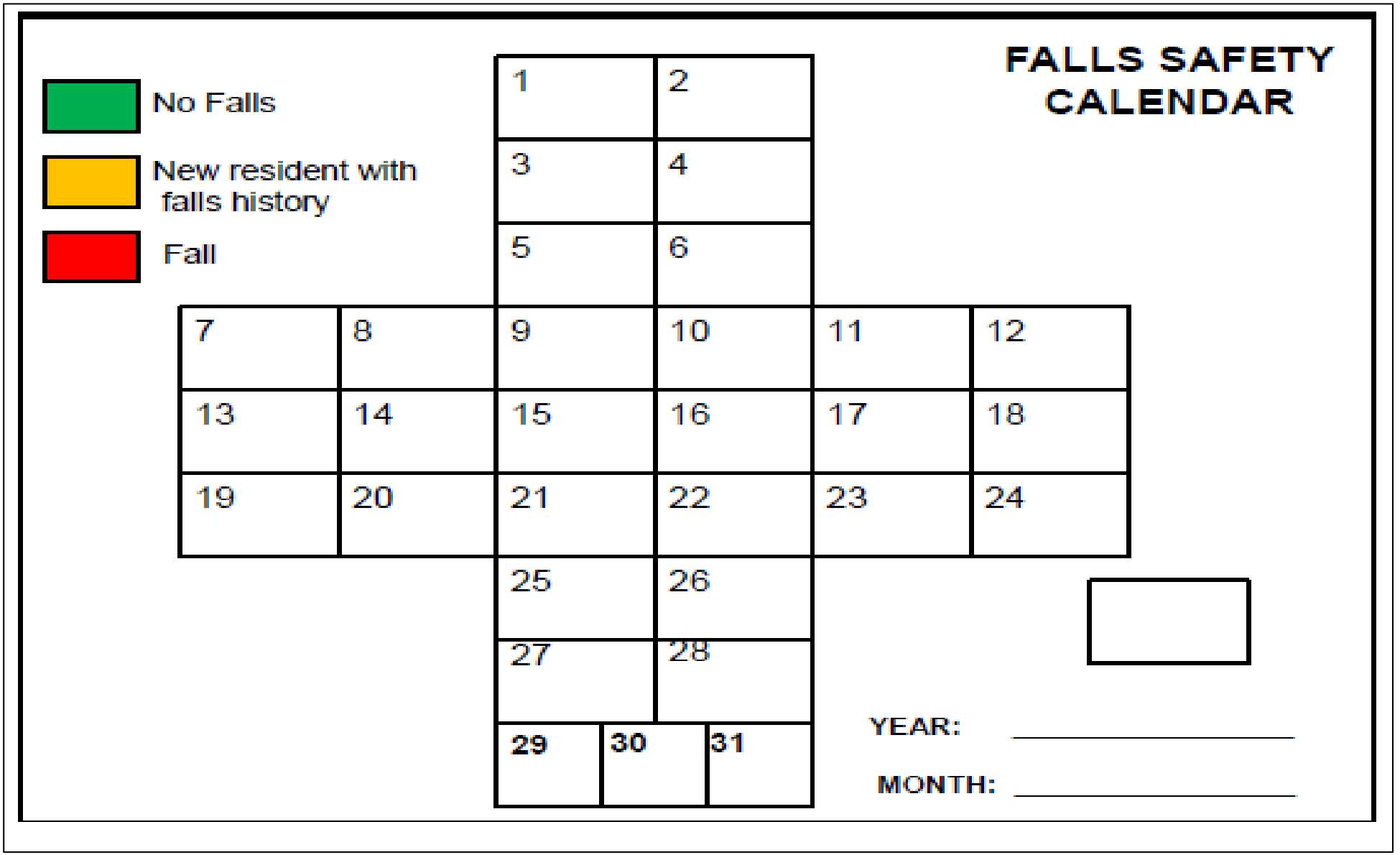
Date:

Tool adapted from NHS Tayside and Jerry Forfeath, Angus Council Social Work and Health

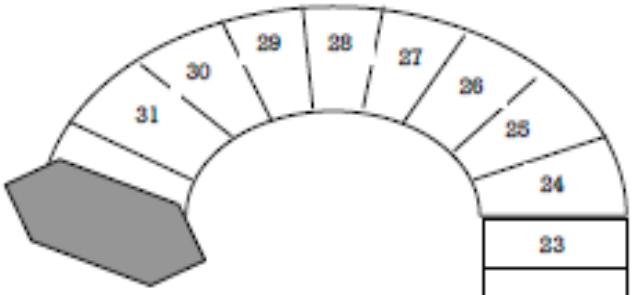
Prevention of Falls, Flow Chart



SAFETY CROSS/CALENDAR

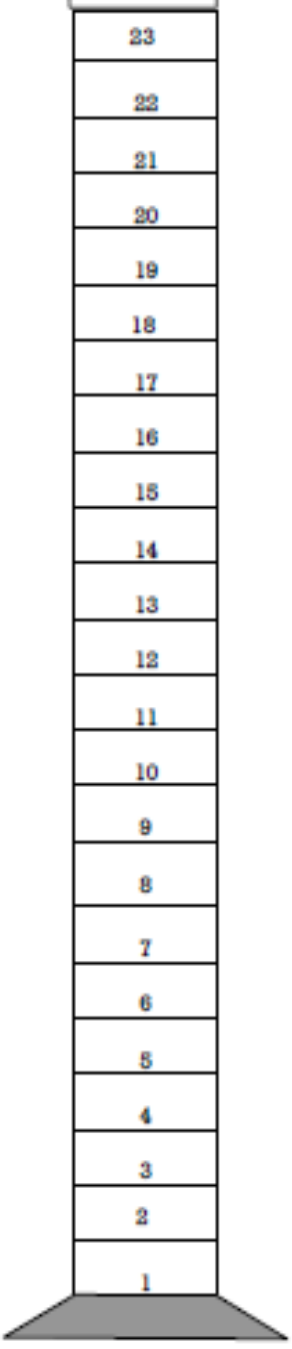


FALLS SAFETY STICK



Green – NO FALL

Red = FALL



FALLS SAFETY STICK

Month: _____

SAFETY BRIEFINGS

These are a simple, easy to use tool that frontline staff can use to share information about potential resident safety problems and concerns on a daily basis.

They help increase staff awareness of patient safety issues and create an environment in which staff share information openly and make resident safety an integral part of daily work.

1. Getting Started

- Identify a specific care area: **FALLS PREVENTION**

- Capture briefing on:
  - Data collection form or
  - Daily diary (specific heading)

- Test on a small scale and obtain feedback on the process (eg for one week on day shift)

2. Safety Briefings should be

- Inclusive and open

- All staff have something to share and learn. Briefings must be easy to use so that all staff feel confident to participate

3. Brief

- Safety Briefings should last only a few minutes and do not require a formal meeting (use handovers or other suitable mechanisms – what works for you)

4. Focused

- Staff should share any concern that they have regarding the resident at risk of a fall and share any ideas for solutions to safety problems

  (see example of data collection form for key questions – these can be modified as required)

5. Improvement Driven

- Staff should feel assured that the information collected is for learning and improvement purposes only

Falls Daily Safety Briefings
(Template)

Date: _____

Time: _____

	Comments - or Yes/No	Action
Has there been a resident admitted with recent history of falls?		
Has a resident fallen in last 24 hours?		
Is there a resident at high risk of falls?		
Is there a resident on high risk medication?		
Is there a resident with any form of infection?		
Signatures Designation(s)		

Intentional Rounding

One intervention introduced to the Collaborative was that of the Intentional Rounding methodology. This aims to provide better than expected care by using a regular routine of individualised resident checks within the home. This methodology has been widely used in the UK and the US with excellent "patient" outcomes.

The interest in rounding comes in the wake of research that shows that a strategy of consistently checking on patient/resident needs effectively reduces monthly call-light use by 38%, patient falls by 50%, and skin breakdowns by 14%, while simultaneously increasing satisfaction scores.

This can be implemented for all residents or those deemed most at risk. There is the "Four Ps" vital for successful rounding as outlined in the figure below.

Whilst initially beginning with hourly rounding, his interval can be reviewed and increased upon discussion with staff and residents. Some nursing homes, after implementing the hourly rounding found that they could increase the time interval to 2 hours between rounds. This could be the case during late-night hours when residents may not want to be disturbed.

Rounding can be shared by both nurses and care assistants and the following pages provide 2 templates that will facilitate the rounds.

The "Four Ps"

The "Four Ps," vital for successful rounding, consist of:

- **Positioning**: Making sure the patient is comfortable and assessing the risk of falls or pressure ulcers.
- **Personal needs**: Scheduling patient trips to the bathroom to avoid unsafe conditions.
- **Pain:** Asking patients to describe their pain level on a scale of zero to 10.
- **Placement**: Making sure the items a patient needs are within easy reach, such as water, tissues, the TV remote control, and the telephone.

Intentional Rounding Template: Example 1

Enter details or affix label here
Full name:
Date of birth:
Health & Care Number:

PATIENT CARE ROUND

KEY: A= ASLEEP RF=REFUSED V=VISITOR

Frequency of Rounding:
Day:
Night:

Exclusion criteria: Residents not assessed as high risk

Please tick and sign this form on each rounding												
DATE:												
INSERT TIME:												
SIGNATURE												
PAIN	Ask resident if they have any pain. Consider analgesia											
POSITION	Does resident need to change position? e.g. stand up / walk / 30° tilt											
TOILET	Does resident require toileting regime?											
ENVIRONMENTAL FACTORS:												
Check footwear appropriate												
Falls Hazard-Bed in low position												
Belongings and bed call within easy reach. Check environment clean & tidy												
PRIOR TO LEAVING PATIENT:												
'Is there anything else I can do? '												

Intentional Rounding Template: Example 2

INTENTIONAL ROUNDING

DAY:

INFORMATION: Day 1 half hourly checks increasing to two hourly checks
Day 2 two hourly checks increasing to normal routine checks

TIME	0800	0830	0900	0930	1000	1030	1100	1130	1200	1230	1300	1330	1400	1430	1500	1530	1600
ARE YOU ALRIGHT?																	
DO YOU WANT A DRINK?																	
ARE YOU IN PAIN?																	
WOULD YOU LIKE TO USE THE TOILET?																	
CAN I DO ANYTHING FOR YOU?																	
I WILL BE BACK SOON.																	
SIGNATURE																	
TIME	**1630**	**1700**	**1730**	**1800**	**1830**	**1900**	**1930**	**2000**	**2030**	**2100**	**2130**	**2200**	**2230**	**2300**	**2330**	**2400**	
ARE YOU ALRIGHT?																	
DO YOU WANT A DRINK?																	
ARE YOU IN PAIN?																	
WOULD YOU LIKE TO USE THE TOILET?																	
CAN I DO ANYTHING FOR YOU?																	
I WILL BE BACK SOON																	
SIGNATURE																	

COMMENTS;

Intentional Rounding Template: Example 3

NAME OF NURSING HOME

INTENTIONAL ROUNDING CHART

RESIDENT: ..... Date: .....

Time	Are you Hungry Y/N	Are you Thirsty? Y/N	Are you in Pain? Y/N	Are you Bored? Y/N	Are you cold or warm? Y/N	Do you need the toilet? Y/N	Do you want a neck rub? Y/N	Do you want company or left alone?	Staff Signature

Medicines Associated with Falls Information Leaflet

March 2013

Health and Social Care Board

Medicines associated with falls

Taking certain medicines can make you more likely to fall. However, while they may contribute to falls in some people, they don't cause falls in everyone. Medicines act in different ways, e.g.

- **Medicines acting on the brain** can cause drowsiness, loss of balance and slow reaction times
- **Medicines that lower blood pressure or slow the heart** can cause faintness, dizzy spells or 'legs to give way' e.g. blood pressure may suddenly fall when standing up or stretching.

People on FOUR or more medicines (polypharmacy) are at greater risk of falling. Regular medication reviews play an important part in preventing medicines-related falls.

Common examples of medicines acting on the brain:

- Sleeping tablets and anxiety treatments e.g. temazepam, diazepam, zolpidem, zopiclone,
- Some antidepressants may cause drowsiness* e.g. amitriptyline, mirtazapine, citalopram, fluoxetine
- Some antidepressants may cause dizziness e.g. venlafaxine, duloxetine
- Strong painkillers e.g. codeine, tramadol, fentanyl
- Antipsychotics* (medicines for mental health problems and agitation) e.g. olanzapine, quetiapine, risperidone, haloperidol
- Medicines for Parkinson's disease* e.g. co-beneldopa and co-careldopa
- Some antihistamines e.g. chlorphenamine and cinnarizine
- Medicines for epilepsy e.g. phenytoin and carbamazepine
- Medicines for nausea, vomiting, travel sickness e.g. cyclizine

*these medicines can also lower blood pressure

Common examples of medicines that lower blood pressure or slow the heart:

- Medicines to treat high blood pressure and heart disease e.g. digoxin, doxazosin, lisinopril, losartan, amlodipine, diltiazem, atenolol, glyceryl trinitrate, fluid tablets (examples below)

Other commonly-used medicines known to increase the risk of falls:

- Medicines for dementia may cause fainting or dizziness e.g. donepezil, galantamine, rivastigmine and memantine
- Medicines for diabetes may cause dizziness e.g. insulin, pioglitazone, gliclazide
- Medicines for bladder overactivity may cause blurred vision e.g. oxybutynin, tolterodine
- Some eye drops or eye ointments may cause blurred vision e.g. latanoprost, pilocarpine
- Fluid tablets may cause rushing to the toilet e.g. bendroflumethiazide, indapamide, furosemide
- Laxatives may cause rushing to the toilet e.g. senna, macrogols

Refer to British National Formulary (BNF) latest edition for further examples of medicines listed above

If a resident seems to be at an increased risk of falling due to their medicines, the care-home nurse or manager should discuss this with the resident's pharmacist or GP.

Footwear Information Leaflet

Slippers

Ill fitting slippers can be a major cause of slips trips and falls. Sensible, well fitted and secure slippers are equally as important as well fitted shoes.

Poor Quality Slippers

Poorly fitting slippers, like these shown above, will give no support and do not securely hold the foot in place. They may cause a fall.

A good quality slipper should:

- Have a durable non-slip sole
- Have a secure fastening
- Be well fitting
- Give as much support as possible

Good Slippers

These excellent slippers are widely available and will significantly reduce your risks of falling.

Your Information:

Name: _____

It is important that shoe size is measured to ensure correct fitting of any new shoes. If in doubt as to the correct size consult a reputable shoe fitter

For more information please contact:

_____

_____

Adapted from the Northern HSC Trust
Developed by the NI Regional Nursing Home Collaborative:
March 2012

HSC

Footwear Information Leaflet

For residents, families and staff

Footwear Information Leaflet contd.

Badly fitting shoes can cause a number of significant foot problems, as well as greatly increasing your chance of falling.

Well fitted shoes are a future investment in safety.

The advice in this leaflet is designed to help you when purchasing shoes or slippers.

There are a number of specialist shoe shops in Northern Ireland where staff will be happy to measure your feet and advise on suitable shoes. If you want information on the shoe shops in your area your podiatrist will be happy to advise.

Well fitting slippers are equally as important as shoes and this leaflet also gives advice on what types of slippers should be avoided.

Recommended footwear

Types of shoes

A well-fitting shoe, boot or trainer with laces or a strap fastening will give your feet the best support. These fastenings will help to keep your foot firmly in place inside your footwear, which will help prevent rubbing. Avoid slippers and shoes that slip-on as they give less support.

Low heels

Your heel should not be more than 3 Centimetres (1¼ inches). The heel should be wide and not tapered, so as to give maximum stability.

Natural materials

Where possible the uppers (top) of your shoes should be made from a natural material such as soft leather. Leather will fit to your foot without causing any rubbing and will help to prevent your feet from sweating.

Well fitted

The shoe should be wide enough, long enough and deep enough to accommodate your foot and fasten securely. The shoe should not be gaping at the heel or slipping. The facings should not be meeting when the shoe is tied.

The shoe should not be excessively long as this may cause trips and falls.

AUDIT TOOLS

The Regional Collaborative agreed key measures for the improvement work in preventing falls:

- Regional falls rate per 1,000 bed days
- Compliance with key measures (see below). The target was set as 95% compliance with Measure 1 and 2
- Days' between Falls : Aim was to strive towards the achievement of 45 days between falls. An excel spreadsheet was made available to the nursing homes to chart days' between and this can be accessed through the Safety Forum website:

www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/hsc-safety-forum

MEASURES

Measure 1

A falls risk assessment to be carried out on every new resident within 24 hours.

This must be documented using agreed proforma, contained within notes, actioned and communicated to colleagues as appropriate.

Measure 2

The falls risk assessment will be reviewed:

- At least monthly (depending on severity identified on original assessment)

And

- If resident's condition changes and in all cases if a resident sustains a fall

The review will be recorded in the notes, progress recorded and future management and agreed actions set - timetable agreed for action. Homes included the completion of a Post-Fall Review in this section and Data Collection Sheet Example 2 refers to this.

The Data collection tools designed for the Collaborative are included over the next 2 pages.

Data Collection Tool Example 1

HSC Safety Forum

NURSING HOME COLLABORATIVE MONTHLY MEASURES AUDIT:

DATA COLLECTION FORM

Please record your answers to each measure as: Yes, No or Not Applicable

Resident ID	MEASURE 1: Risk Assessment within 24 hours admission to Nursing Home				MEASURE 2: Risk Assessment Reviewed – monthly or if resident's condition changes (eg. following a fall)				
	Documented in notes – agreed proforma	Actioned	Communicated to staff	Measure Met	Review documented in notes	Progress recorded	Future Management /Action taken recorded	Timetable agreed for action	Measure Met

Data Collection Tool Example 2

HSC Safety Forum

NURSING HOME COLLABORATIVE MONTHLY MEASURES AUDIT: DATA COLLECTION FORM

Please record your answers to each measure as: Yes, No or Not Applicable

Resident ID	MEASURE 1: Risk Assessment within 24 hours admission to Nursing Home				MEASURE 2: Risk Assessment Reviewed – monthly or if resident's condition changes (eg. following a fall)									
	Documented in notes – agreed proforma	Actioned	Communicated to staff	Measure Met	Documented in notes (for review and post-fall)		Progress recorded		Future Management /Action taken recorded		Timetable agreed for action		Measure Met	
					Rev	Post Fall	Rev	Post Fall	Rev	Post Fall	Rev	Post Fall	Rev	Post Fall

Some comments from the participating homes … …

This is a good thing to be involved in

(nurse)

We have had some excellent ideas that will be useful to raise staff awareness about falls

(care assistant)

This has given us time to reflect on our own work and has helped us to build relationships with staff from other homes

(nurse)

Great information, … great networkinig

(care assistant)

Our residents are now asking us about falls and the Falls Safety Cross

(nurse)

NOTES

For further information please contact:

Janet Haines-Wood, Regional Patient Safety Advisor, HSC Safety Forum:

Tel: 02892665181, Ext 4530. E-mail: janet.haines-wood@hscni.net