Medical Falls Risk Assessment (Adult) Procedure

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TARGET AUDIENCE and SETTING

All Monash Health medical staff.

This procedure applies to all in-patient clinical areas at Monash Health.

This procedure **does not** apply to residential care settings.

PURPOSE

To provide clinicians with a detailed description for the safe and effective clinical assessment and management required to prevent falls and harm from falls.

PRECAUTIONS/CONTRAINDICATIONS

Some patients have a higher risk of harm from falls. These include patients:

- with a bleeding disorder;
- on anticoagulant medications such as warfarin, heparin infusions, dabigatran, apixaban, rivaroxaban or low molecular weight heparins at therapeutic doses (e.g. enoxaparin);
- on antiplatelet medications such as clopidogrel, prasugrel or ticagrelor;
- chronic liver disease with low platelets or prolonged INR;
- who are malnourished.

STANDARD REQUIREMENTS

When undertaking any clinical interaction with a patient, staff are expected to:

- Perform routine hand hygiene. Refer to the Hand Hygiene Procedure.
- Introduce themselves to the Patient and Carer/ Family if in attendance.
- Check patient identification. Refer to the Patient Identification Procedure.
- Obtain consent as per the Consent to Medical Treatment Procedure.

- Keep the patient/carer informed and involve them in decision making.
- Document interaction in the electronic medical record or health record using black pen; including date, time, signature and designation.

PROCEDURE

As part of admission, all patients must have a medical falls risk assessment. Always consider the following elements of history and examination (with investigations as indicated) in patients who are high risk for falls.

ON ADMISSION

1. **Medical history**
    a. History of falls
        i. Number, setting, prodromal symptoms, previous fractures, mobility and gait aid.
    b. Risk factors for falls
        i. Delirium and/or cognitive impairment
            - Screen all patients with risk factors (age >65, pre-existing cognitive impairment, severe medical illness, current wrist or hip fracture) for delirium using the 4AT tool for delirium detection.
            - Refer patients who screen positive on the 4AT to the admitting medical team for further comprehensive assessment.
            - Refer to: Delirium in hospital Clinical Guideline
        ii. Medications
            - Review medications that contribute to risk of falling such as cardiac medications, psychotropic medications, opioid analgesics, Parkinson's Disease medications and anti-epileptics. Refer to: Falls Risk and medications Implementation Tool
            - Avoid night sedation.
        iii. Postural hypotension
            - This can be delayed, up to 5 minutes.
            - Consider causes such as autonomic nervous system dysfunction dehydration and anti-hypertensive agents (most common), and if present in the morning, overnight hypertension (which can cause dehydration through high nocturnal urine output).
        iv. Nutritional status
            - Screen all patients for nutrition risk using a validated tool for the target population to identify patients at risk of malnutrition. Patient screened at 'high risk" are referred to Nutrition and Dietetics
            - Presence of nutrition impact signs and symptoms, and poor oral intake can contribute to malnutrition and causes must be investigated
            - Refer to: Malnutrition: Identification, Assessment, Management & Escalation (Adult Inpatients) Clinical Guideline

v. Check for medical conditions which may increase risk of falls, e.g. peripheral neuropathy, Parkinson's Disease, stroke, etc.

c. Risk factors for injury from falls
   i. Increased risk of bleeding
      - Patients who have a history of frequent falls or are at very high risk of falls and are on antiplatelets (e.g. aspirin, clopidogrel, prasugrel, or ticagrelor) and/or anticoagulants at therapeutic doses (e.g. warfarin, heparin, enoxaparin, apixaban, rivaroxaban or dabigatran) will have their reason for anti-coagulation reviewed and an assessment of risk versus benefit made.

   ii. Bone health
      - Check if patient has ever been screened for and treated for osteoporosis.
      - Check vitamin D level. If patients have had a fracture, they may be eligible for an anti-osteoporotic medication; this is only to be started once the patient is vitamin D replete (>75 nmol/L).

2. Targeted physical examination

a. Screen for delirium using the 4AT tool.

b. Targeted neurological and musculoskeletal examination especially of lower limb.
   i. In particular, examine for peripheral neuropathy, upper motor neuron (UMN) signs, root lesion, weakness, and evidence of arthritis and deformity.

c. Gait and transfers.
   i. Watch the patient transfer and walk. If they look unsteady or unsafe on transfers, then they are a high falls risk.
   ii. Review their safety and adherence using their gait aid, if any.

d. JVP and postural hypotension.
   i. Use a manual sphygmomanometer as you may have missed the drop before the automatic machine reads the blood pressure.
   ii. Record blood pressure in lying, standing immediately, 1 minute, 3 minute, and 5 minute post standing.
   iii. Lying and standing blood pressure is part of the nursing admission.

e. Perform a continence assessment and manage (Refer to: Urinary Continence Assessment (Adult) Procedure). Specifically:
   i. Ensure call bells are within patient reach.
   ii. Respond in a timely manner to the client's request for assistance with toileting.

f. Assess patient's footwear and check the patient's feet for long toenails and calluses which may adversely affect gait. If present, then consider a podiatry referral.

3. Document falls risk and falls prevention strategies.

- Strategies to minimise falls risk and harm from falls may include (not limited to): lo-lo bed, patient observation (continual or regular rounding), target blood pressure, medication modifications
- Document in relevant section in admission notes or in the health record.
- Review the Falls Prevention and Management Care Plan in EMR to ensure all required interventions are active

- the Falls Risk Assessment results are viewable in iView and Results Review

DURING ADMISSION

4. **Ongoing review**
    a. If the patient has a fall in hospital, repeat the medical falls risk assessment at the time of post-fall review and implement any changes required
        i. EMR based clinical areas: EMR Post Falls Review in Adhoc forms
        ii. Paper based clinical areas: Post Fall Management MRI72 (i)
    b. Be aware of making medication changes in high risk patients that increase the risk of falls (e.g. cardiac medications, psychotropic medications, opioid analgesics, Parkinson's Disease medications and anti-epileptics) Refer to: Falls Risk and Medications Implementation Tool.
    c. Aim to reduce postural blood pressure drop to less than 15 mmHg. Nursing staff to check postural blood pressure regularly (daily or twice daily) for all patients with symptomatic dizziness and falls/collapses for at least 3 days after an event
    d. Ongoing monitoring for delirium: changes in arousal, fluctuation and attention months of the year backwards
    e. Check the daily weighs and fluid balance intake
    f. Consider whether the patient is becoming dehydrated and if medications such as diuretics can be reduced and/or changed to disease modifying agent.
    g. Consider need for ongoing anti-psychotic medication use and aim to reduce if not necessary
    h. Consider if level of supervision is adequate and document any recommendations, including, but not limited to, moving patient to a high visibility room, need for Constant Patient Observer (CPO), regular rounding.

RELATED DOCUMENTATION

Delirium in hospital Clinical Guideline

Falls Risk and Medications Implementation Tool

Urinary Continence Assessment (Adult) Procedure

Malnutrition: Identification, Assessment, Management & Escalation (Adult Inpatients) Clinical Guideline

KEY STANDARDS, GUIDELINES OR LEGISLATION

National Safety and Quality Health Service Standards, Standard 5: Comprehensive Care

REFERENCES

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- Falls Prevention Guideline, Bayside Health
- JMO Checklist Handbook, Monash Health
- Falls – A Quick Guide, Monash Health Aged Care

KEYWORDS

Slip, trip, fall

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