Policy Applies to

All Mercy Hospital clinical staff.

Related Standards

- Code of Health & Disability Services Consumers Rights 1996: Right 4: Right to services of an appropriate standard.
- NZS 8134.3:2021– Ngā Paerewa Health and disability service standard. Outcome 4: Person-centred and safe environment.
- EQuIP Standard 1.5: The organisation provides safe care and services.
- EQuIP Criterion 1.5.4: The incidence of falls and fall injuries is minimised through a falls management programme.
- EQuIP Standard 3.2: The organisation maintains a safe environment.
- EQuIP Criterion 3.2.1: Safety management systems ensure safety and wellbeing for consumers/patients, staff, visitors and contractors.

Cultural Considerations:

Māori and Pacifica patients will be cared for following the principles outlined in the Te Whare Tapa Whā model of Māori wellbeing. Specifically, this involves addressing not only the physical (taha tinana) aspects of fall prevention and management, but considering whānau, spiritual (wairua), and mental health (taha hinengaro) dimensions as well.

Information regarding falls prevention will be provided to each individual patient in a way that they can understand, and that is acceptable and accessible to them.

If requested, local Māori healthcare providers will be consulted to help with the ongoing care of patients who fall during their stay at Mercy.

Rationale:

The purpose of this policy is to prevent falls by standardising a patient centred approach to hospital falls prevention and management guidelines, using falls prevention strategies that align nationally.

Definitions:

Fall: An unexpected event in which the participant comes to rest on the ground, floor, or lower level *(Lamb et al cited in HQSC, Reducing Harm from Falls, Topic 2)*

Falls Risk Screening: A process to identify those patients with an increased falls risk who need either increased supervision or a detailed falls risk assessment (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2009).

Falls Risk assessment and care planning: Processes fundamental to ensuring that individual patients receive the interventions and support which address their particular risks. (HQSC 2017)

Objectives:

- To provide framework and tools for clinical staff to identify and communicate about / to the patients at risk of falling
- Provide relevant education to staff and patients/whānau regarding fall prevention
- Minimise (eliminate) falls and/or harm to patients in Mercy Hospital
- To ensure a safe process is followed for supporting a patient who has fallen
- Create strong governance and process to ensure falls are monitored and results are communicated at service level.

Implementation:

- All patients are screened using the Mercy Hospital Falls risk (adapted from HQSC). If risk is identified, an individual falls care path way is completed (online or written). This would be communicated at every point of transitions of care, i.e. between departments and at inpatient bedside handovers
- A red bracelet to visually indicate patient is at risk of falling should be applied at the point of assessment (but can be added if condition changes) and the high risk assessment alert put on patients clinical file
- A management Plan is reviewed and signed each shift (inpatients) and is discussed with the patient during handover as appropriate
- If the patient's condition changes or they have a fall, they must be reassessed
- In the event of a fall, a patient should be assessed for injury prior to moving, then when safe, moved to a bed for further assessment. The Credentialed Specialist and patient's whanau will be notified and an incident/ and ACC form generated as required.
- Falls Prevention strategies such as non-stick socks, appropriate footwear, and educational material are used and should be clearly documented in partnership with patient and/or whānau.

Documentation:

- Following a fall, an incident form must be completed
- Any patient fall must be documented in the patients clinical notes including actions taken, any injury sustained, and notification of patients relatives & credentialed specialist
- A repeat falls assessment to be completed post fall and appropriate strategies implemented
- Appropriate elevation of the frequency of clinical assessment period post fall.
- ACC (45) completed if required.

Discharge:

- Where appropriate, information relating to an inpatient fall shall be included in the patients discharge summary
- Appropriate referrals made to community allied health for any follow up concerns.

Education (staff and family):

- The patient & whānau/family are included in falls screening /assessment and are provided with information and education material regarding falls prevention.
- Staff having patient contact are provided with education on falls, falls screening and assessment, and prevention and management strategies during their orientation to the organisation and at regular intervals.
- Falls Prevention Staff E-Learning Package (refer to HealthLearn)
- Highlight current New Zealand Programmes on the ACC & HQSC websites in relation to the falls risk and prevention education and community support programmes they may be interested in post discharge.

Evaluation:

- Trend number of falls with injury; SAC 1 & 2 falls are included in reports to the Quality and Risk Committee and the Health Quality & Safety Commission (HQSC)
- Audit appropriate documents to ensure that the tools are being used correctly
- Audit the incidence of falls appropriate actions taken
- Feedback from patient/family/staff included in the incident process
- Incidents reviewed and communicated with Clinical Staff

Associated Documents:

- Code of Health & Disability Services Consumers Right 1996
- ACC falls prevention – Staying safe from trips and falls
- HQSC – Reducing Harm from falls

Internal Documents:

- Clinical Records Management
- Consumer Engagement
- Cultural Policy
- Discharge of Patients
- Nursing Model of Care and Clinical Handover
- Patient Assessment
- Patient Restraint Minimisation Policy
- Environmental Cleaning

- Hazard Management
- Health and Safety
- Incidents
- Risk Management
- Safe Handling and Moving

In the Clinical Services Work Manual

- Bed Rails – How to use Safely

References / Acknowledgements:

- Health Quality and Safety Commission New Zealand: Reducing Harm from Falls retrieved from: https://www.hqsc.govt.nz
- Retrieved from Health Quality safety commission New Zealand https://www.hqsc.govt.nz

Appendices:

- Appendix 1 – Universal Falls Prevention Strategies
- Appendix 2 – Responding to a Patient Fall