# Minimising the Risk of Falls & Fall-related Injuries

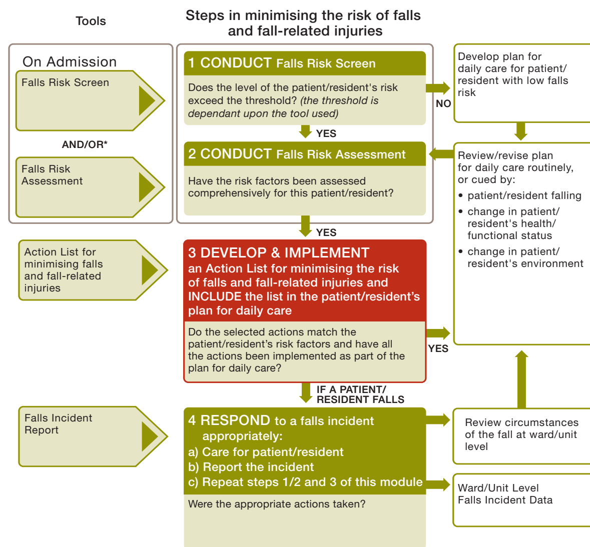
## Guidelines for Acute, Sub-acute and Residential Care Settings

Quick Reference Guide

Victoria
The Place To Be

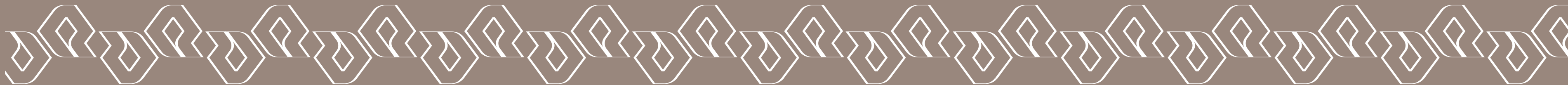
THE VICTORIAN QUALITY COUNCIL
Safety and Quality in Health

# Step 3
# Develop and Implement an Action List




## DEVELOP AND IMPLEMENT AN ACTION LIST FOR MINIMISING THE RISK OF FALLS AND FALL-RELATED INJURIES AND INCLUDE THE LIST IN THE PATIENT/RESIDENT'S PLAN FOR DAILY CARE.

1. Determine actions to minimise risk factors for falls and fall-related injuries identified by the risk assessment (Step 2 of the process model)
2. Determine when, how often and by whom the actions should be carried out
3. Prepare a falls and fall-related injury risk minimisation Action List based on the above information
4. Include the Action List in the patient/resident's plan for daily care
5. Implement the actions as indicated in the Action List.



**General falls prevention interventions which should be considered part of standard care include:**

- Identifying cause of risk factor (medical or allied health referral)
- Ensuring safety (adequate supervision, communicate mobility status to all staff, use of appropriate walking aid)
- Ensuring safe and uncluttered environment
- Keeping call bell and other personal items within reach
- Orienting patient/resident to area, and
- Identifying and addressing individual patient/resident's needs.

**The Quick Reference Guide on the following pages outlines the actions to minimise the impact of each of the personal risk factors for falls to assist in developing an Action List. The research evidence clearly supports a multifaceted approach, where multiple actions are introduced to address the full range of personal risk factors identified.**

Personal Risk Factor

# LEG MUSCLE WEAKNESS AND DECONDITIONING

## Indicator/s

- Effort associated with standing up from a chair, needing to use arms to push up when standing up

### What contributes to the risk?

Extended bed rest and diminished activity and exercise

Vitamin D deficiency

Other medical problems such as renal failure and thyroid disease

## Actions

### Activities and exercise

- Encourage safe incidental activities (activities that are part of daily living) to maintain muscle mass, balance, strength and mobility (eg walking, transferring, dressing, bathing)
- Encourage the patient/resident to participate in exercise or activity groups, or an individual exercise program
- Develop a routine for physical activity and monitor the patient/resident progress
- Incorporate physical activity goals in the patient/resident's plan for daily care

#### Hints & Tips

- Ask the patient/resident's family and friends to encourage the patient/resident to carry out the activities
- Explore the physical interests and recent activities undertaken by the patient/resident before admission
- Provide additional assistance when the patient/resident is tired or hurried (eg in a rush to go to the toilet). Discuss this need for assistance with the patient/resident and their family and friends
- Seek advice from a physiotherapist about safe exercises and activities the patient/resident can perform on their own, or with supervision
- For patient/residents limited to bed rest, ask a physiotherapist about appropriate bed exercises for the patient/resident
- Seek advice from an occupational therapist about aids/appliances to increase the patient/resident's opportunities for independent activity

### Referral

- Refer patient/resident for medical review to assess possible medical factors contributing to muscle weakness
- If necessary, refer to a physiotherapist, occupational therapist, or activity therapist for assessment and recommended actions

#### Hints & Tips

- Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach

Personal Risk Factor

# POOR BALANCE AND UNSTEADINESS IN WALKING

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| • Unsteady/veering during transfers or walking, experiencing near falls<br>• Reaching for walls or other supports while walking<br>• Overbalancing, especially when reaching, bending, straightening or turning<br><br>**What contributes to the risk?**<br><br>Acute health problems such as a chest infection, urinary tract infection or pain can cause deterioration in balance/steadiness<br><br>Neurological problems (eg stroke, Parkinson's disease, peripheral neuropathy)<br><br>Musculoskeletal problems (eg arthritis, joint instability) | **Activities and exercise**<br>• Encourage the patient/resident to participate in exercise or activity groups, or an individual exercise program<br>• Encourage safe incidental activities (activities that are part of daily living) to maintain muscle mass, balance, strength and mobility (eg walking, transferring, dressing, bathing) | • Seek advice from a physiotherapist about safe exercises and activities the patient/resident can perform on their own or with supervision<br>• Ask the patient/resident's family and friends to encourage the patient/resident to carry out the activities<br>• Determine to what extent the patient/resident can manage their own balance/unsteadiness. If necessary, initiate safety precautions until physiotherapy response is in place |
| | **Walking aids**<br>• Consider introduction of a walking aid, or change in current walking aid<br>• Ensure walking aids are within the patient/resident's reach | • Seek a physiotherapist's advice about the most appropriate walking aid, and to provide instruction and practice regarding correct use<br>• Consider strategies to manage falls risk (eg increased supervision) until patient/resident is seen by the physiotherapist |

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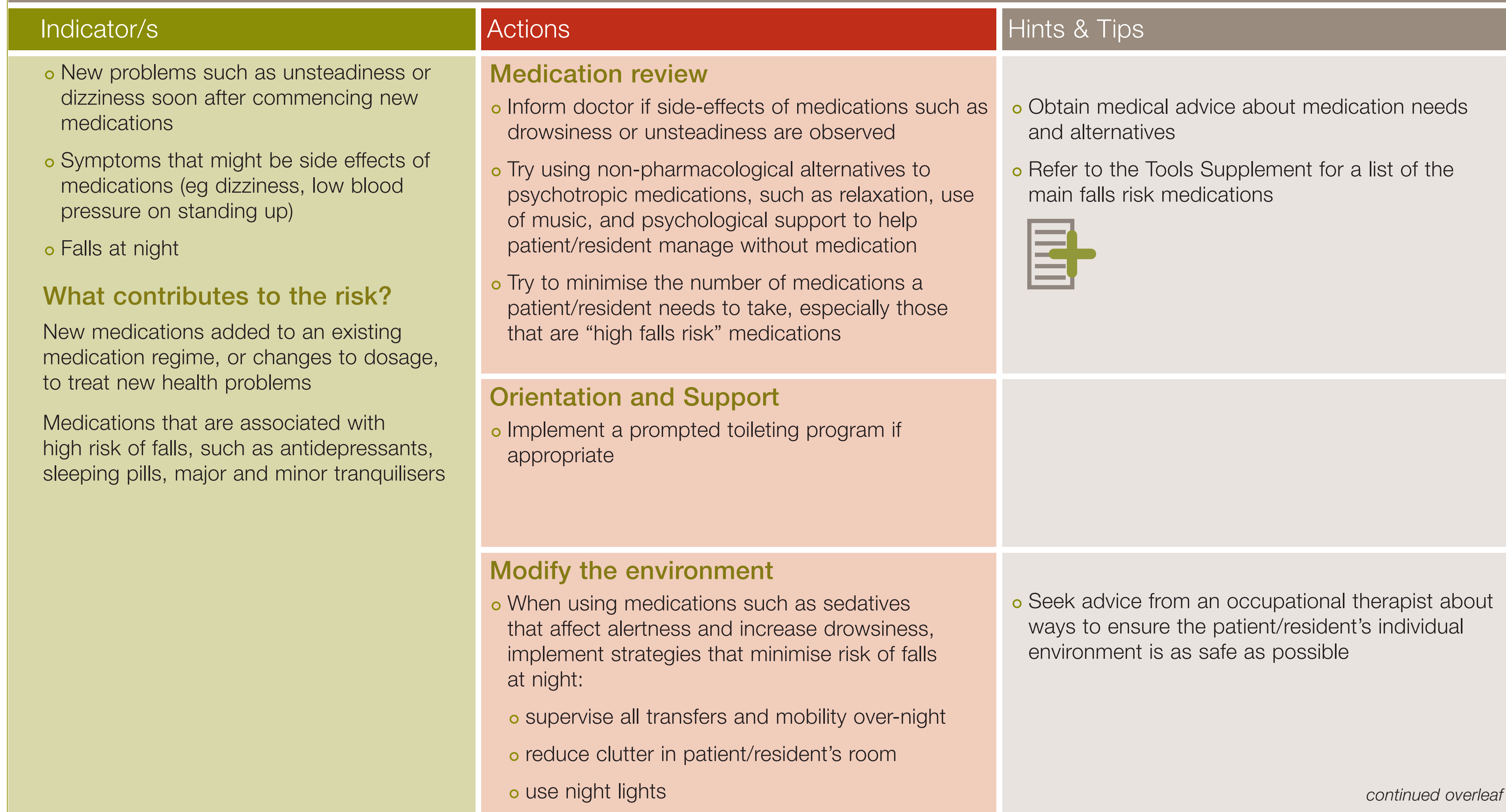
Personal Risk Factor

# POOR BALANCE AND UNSTEADINESS IN WALKING

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| | **Orientation and support**<br>o Always supervise the patient/resident when they are walking or making transfers<br>o Introduce strategies to increase observation/surveillance<br>o Discuss and reinforce all safety issues with patient/residents (eg they need supervision when ambulating; they should always use walking aid) | o Regularly check with patient/resident that needs are being met, to minimise the patient/resident's attempts to transfer or walk independently if it is not safe to do so<br>o Ask the patient/resident's family and friends to also reinforce safety issues |
| | **Modify the environment**<br>o Ensure furniture and other hand holds used to assist transfers are suitable (ie stable and sturdy) | |
| | **Injury minimisation**<br>o Consider use of hip protectors | o Consider the different types of hip protectors available, including those which incorporate continence pads, and adhesive hip protectors<br>o Encourage ongoing wearing of the hip protectors when supplied |
| | **Referral**<br>o Refer patient/resident for medical review to assess possible medical factors contributing to poor balance or unsteadiness<br>o If necessary refer the patient/resident to a physiotherapist, occupational therapist or activity therapist for assessment and recommended actions | o Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# USE OF MORE THAN 4 MEDICATIONS OR MEDICATIONS ASSOCIATED WITH FALLING



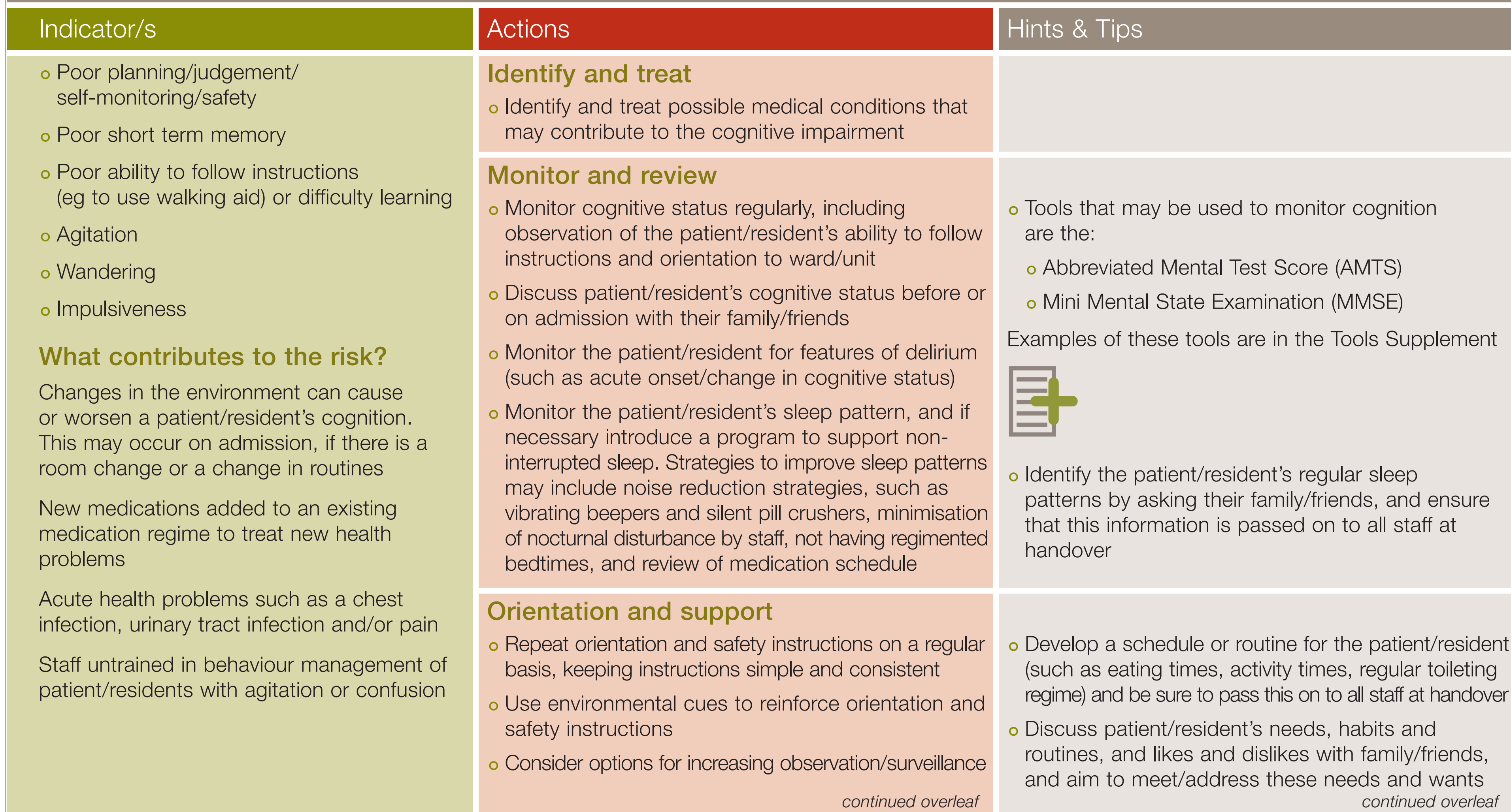
| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| • New problems such as unsteadiness or dizziness soon after commencing new medications<br>• Symptoms that might be side effects of medications (eg dizziness, low blood pressure on standing up)<br>• Falls at night<br><br>**What contributes to the risk?**<br>New medications added to an existing medication regime, or changes to dosage, to treat new health problems<br><br>Medications that are associated with high risk of falls, such as antidepressants, sleeping pills, major and minor tranquilisers | **Medication review**<br>• Inform doctor if side-effects of medications such as drowsiness or unsteadiness are observed<br>• Try using non-pharmacological alternatives to psychotropic medications, such as relaxation, use of music, and psychological support to help patient/resident manage without medication<br>• Try to minimise the number of medications a patient/resident needs to take, especially those that are "high falls risk" medications | • Obtain medical advice about medication needs and alternatives<br>• Refer to the Tools Supplement for a list of the main falls risk medications |
| | **Orientation and Support**<br>• Implement a prompted toileting program if appropriate | |
| | **Modify the environment**<br>• When using medications such as sedatives that affect alertness and increase drowsiness, implement strategies that minimise risk of falls at night:<br>  • supervise all transfers and mobility over-night<br>  • reduce clutter in patient/resident's room<br>  • use night lights | • Seek advice from an occupational therapist about ways to ensure the patient/resident's individual environment is as safe as possible<br><br>*continued overleaf* |

Personal Risk Factor

# USE OF MORE THAN 4 MEDICATIONS OR MEDICATIONS ASSOCIATED WITH FALLING

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| | **Referral**<br>o Refer patient/resident for review by a doctor or pharmacist to assess medication and recommend ongoing medication needs<br>o If necessary, refer patient/resident to an occupational therapist or a psychologist to provide alternatives to high falls risk medications such as sedatives | o Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

# COGNITIVE IMPAIRMENT (CONFUSION/DELIRIUM/DEMENTIA)



## Indicator/s

- Poor planning/judgement/ self-monitoring/safety
- Poor short term memory
- Poor ability to follow instructions (eg to use walking aid) or difficulty learning
- Agitation
- Wandering
- Impulsiveness

### What contributes to the risk?

Changes in the environment can cause or worsen a patient/resident's cognition. This may occur on admission, if there is a room change or a change in routines

New medications added to an existing medication regime to treat new health problems

Acute health problems such as a chest infection, urinary tract infection and/or pain

Staff untrained in behaviour management of patient/residents with agitation or confusion

## Actions

### Identify and treat

- Identify and treat possible medical conditions that may contribute to the cognitive impairment

### Monitor and review

- Monitor cognitive status regularly, including observation of the patient/resident's ability to follow instructions and orientation to ward/unit
- Discuss patient/resident's cognitive status before or on admission with their family/friends
- Monitor the patient/resident for features of delirium (such as acute onset/change in cognitive status)
- Monitor the patient/resident's sleep pattern, and if necessary introduce a program to support non-interrupted sleep. Strategies to improve sleep patterns may include noise reduction strategies, such as vibrating beepers and silent pill crushers, minimisation of nocturnal disturbance by staff, not having regimented bedtimes, and review of medication schedule

### Orientation and support

- Repeat orientation and safety instructions on a regular basis, keeping instructions simple and consistent
- Use environmental cues to reinforce orientation and safety instructions
- Consider options for increasing observation/surveillance

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## Hints & Tips

- Tools that may be used to monitor cognition are the:
  - Abbreviated Mental Test Score (AMTS)
  - Mini Mental State Examination (MMSE)

Examples of these tools are in the Tools Supplement

- Identify the patient/resident's regular sleep patterns by asking their family/friends, and ensure that this information is passed on to all staff at handover

- Develop a schedule or routine for the patient/resident (such as eating times, activity times, regular toileting regime) and be sure to pass this on to all staff at handover
- Discuss patient/resident's needs, habits and routines, and likes and dislikes with family/friends, and aim to meet/address these needs and wants

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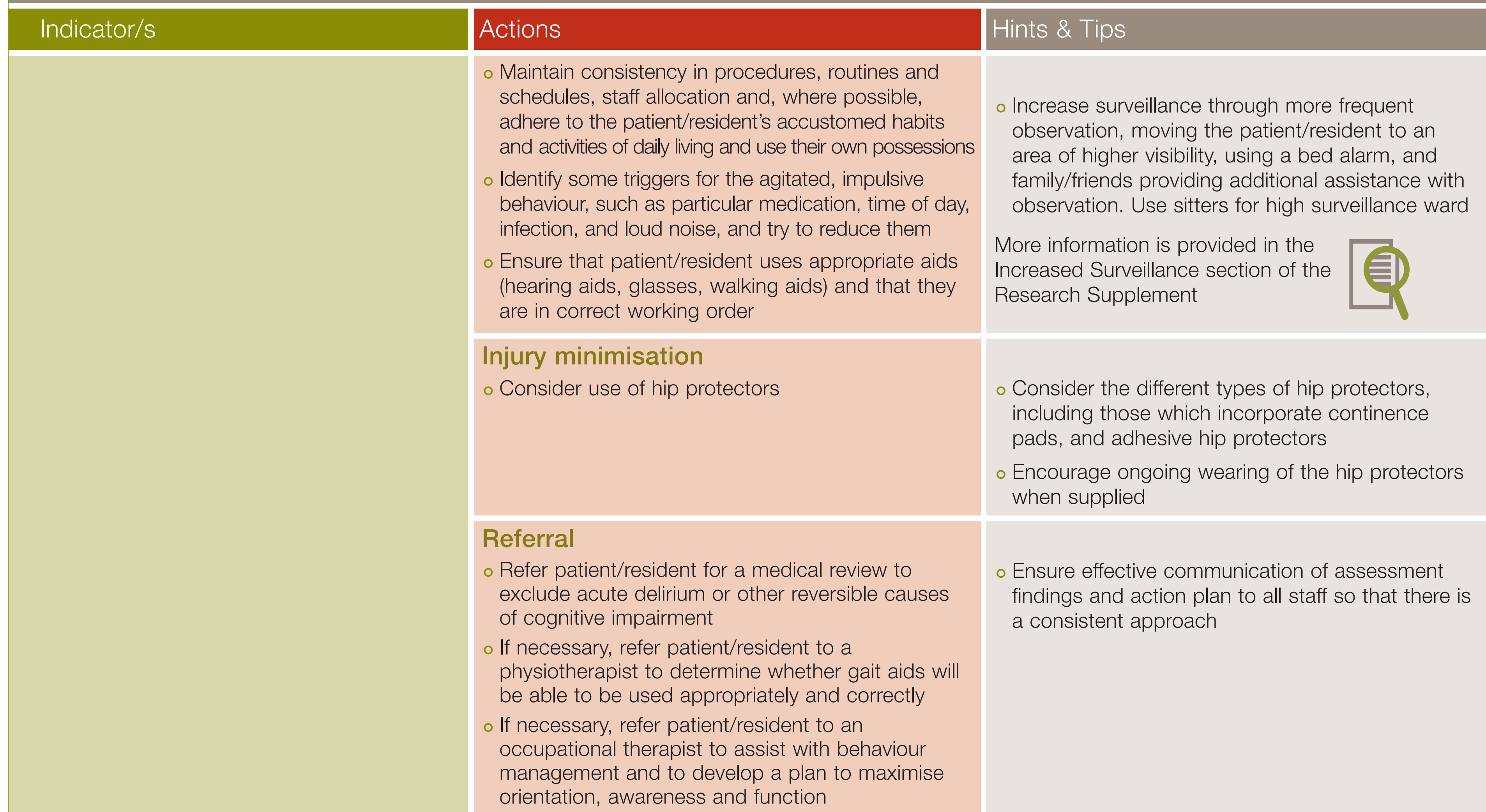
Personal Risk Factor

# COGNITIVE IMPAIRMENT (CONFUSION/DELIRIUM/DEMENTIA)



| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| | o Maintain consistency in procedures, routines and schedules, staff allocation and, where possible, adhere to the patient/resident's accustomed habits and activities of daily living and use their own possessions<br>o Identify some triggers for the agitated, impulsive behaviour, such as particular medication, time of day, infection, and loud noise, and try to reduce them<br>o Ensure that patient/resident uses appropriate aids (hearing aids, glasses, walking aids) and that they are in correct working order | o Increase surveillance through more frequent observation, moving the patient/resident to an area of higher visibility, using a bed alarm, and family/friends providing additional assistance with observation. Use sitters for high surveillance ward<br>More information is provided in the Increased Surveillance section of the Research Supplement |
| | **Injury minimisation**<br>o Consider use of hip protectors | o Consider the different types of hip protectors, including those which incorporate continence pads, and adhesive hip protectors<br>o Encourage ongoing wearing of the hip protectors when supplied |
| | **Referral**<br>o Refer patient/resident for a medical review to exclude acute delirium or other reversible causes of cognitive impairment<br>o If necessary, refer patient/resident to a physiotherapist to determine whether gait aids will be able to be used appropriately and correctly<br>o If necessary, refer patient/resident to an occupational therapist to assist with behaviour management and to develop a plan to maximise orientation, awareness and function | o Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# POSTURAL (ORTHOSTATIC) HYPOTENSION

## Indicator/s

- Light-headedness or unsteadiness when moving from lying to sitting, or sitting to standing

### What contributes to the risk?

Bed rest or prolonged periods of inactivity

Inadequate time to adjust to changes in position (eg moving too quickly from lying to standing)

Some medications (eg major tranquilisers, antidepressants, diuretics)

Some acute and chronic illnesses (eg Parkinson's disease, diabetes, heart failure)

Dehydration

| Actions | Hints & Tips |
|---|---|
| **Identify and treat**<br>• Identify and treat acute reversible contributory factors | |
| **Monitor and review**<br>• Monitor and record blood pressure, both lying and standing (at 1 minute and 2 minutes)<br>• Supervise changes of position<br>• Encourage patient/resident to sit up from lying, and to stand up from sitting, slowly, and to wait a short time before walking<br>• Determine indications and appropriateness of elastic compression stockings | • If there is a drop in systolic blood pressure >20mmHg or diastolic blood pressure >10mmHg seek medical review<br>• Discuss strategies with the patient/resident's family/friends and ask them to reinforce these with patient/residents<br>• Ensure that elastic compression stockings fit properly, and do not have any creases. Physiotherapists or nursing staff are often responsible for supply and fitting of elastic compression stockings |
| **Orientation and Support**<br>• Encourage increased fluid intake by providing drinks at regular intervals | |
| **Referral**<br>• Refer patient/resident for medical review to assess and recommend ongoing management for the postural hypotension | • Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# INCONTINENCE

| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| o Frequency of need for toileting<br>o Poor fluid intake<br>o Strong odour of urine<br>o Urinary or bowel accidents<br>o History of nocturia | **Identify and treat**<br>o Identify and treat acute reversible contributory factors | |
| **What contributes to the risk?**<br>The patient/resident may be physically unable to get to the toilet in time, or to unfasten garments quickly enough (due to, for example, a new health problem such as a stroke or hip fracture)<br>Lack of orientation or confusion about location of the toilet<br>Some medications can increase the risk of incontinence (eg diuretics)<br>Acute health problems such as a chest infection, urinary tract infection and/or pain<br>Constipation | **Monitor and review**<br>o Identify possible causes of incontinence using the following techniques:<br>  o monitor fluid intake and bladder and bowel activity<br>  o identify medications such as anti-cholinergic medications, sedatives, narcotics, and diuretics, which may contribute to the continence problem (including review of timing and dosage)<br>  o look for signs of urinary tract infection and treat if identified<br>o Review timing and amount of caffeine intake<br>o Ensure adequate hydration by providing drinks at regular intervals | o Use a continence chart<br>o Discuss with the medical staff or pharmacist<br>o Discuss with patient/resident and family |

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Personal Risk Factor

# INCONTINENCE

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| | **Toileting program**<br>o Choose a toileting program that best matches the patient/resident's accustomed routine<br>o Implement a prompted voiding (regular toileting) program that best matches the patient/resident's accustomed routine<br>o Respond to requests for toileting promptly<br>o If possible, locate the patient/resident close to the toilet | o Discuss with patient/resident and family<br>o Ensure other staff are aware of patient/resident's needs if you are going to be away or are involved in other work for a period of time |
| | **Optimise function**<br>o Ensure patient/resident is wearing suitable clothes without fasteners, or with fasteners that are easy to undo (eg pants with an elastic waist)<br>o Encourage patient/resident to participate in exercise or activity groups, or individual exercise program<br>o Provision of appropriate continence aids eg commode by bed, non-spill urinals, pads etc | o Discuss with patient/resident and family<br>o Seek advice from a physiotherapist about safe exercises and activities the patient/resident can perform on their own, or with supervision |
| | **Referral**<br>o Refer patient/resident for a medical review to assess and recommend ongoing management for incontinence<br>o If necessary, refer to a continence specialist for comprehensive assessment and management | o Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# SENSORY LOSS

| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| **Vision**<br>o Inability to see detail in objects<br>o Not wanting to, or inability to, read or watch television<br>o Spilling drinks<br>o Bumping into objects<br>**Somatosensory**<br>o Poor skin condition<br>o Cuts or bruises on feet<br>o Lack of feeling in feet<br>o Pressure areas/ulcers<br>**Vestibular (inner ear)**<br>o Reports of dizziness<br>**Hearing**<br>o Leaning forward when listening<br>o Needing to have things repeated<br>o Speaking loudly<br>o Having radio or TV volume loud | **Identify and treat**<br>o Identify and treat acute reversible contributory factors | |
| | **Monitor and review**<br>o Identify change in sensory status over the preceding months, and how long since sensory status has been investigated<br>o Monitor skin and nail condition for people with somatosensory loss (eg diabetic neuropathy)<br>o Investigate the cause if the patient/resident reports dizziness, as some common causes of dizziness are easily treatable by medical or allied health staff (eg benign paroxysmal positional vertigo) | o Discuss with patient/resident and family<br>o Seek advice and treatment from a podiatrist to reduce problems associated with sensory loss |
| | **Modify the environment**<br>o Maintain a safe environment free of physical hazards<br>o Ensure appropriate signage, particularly leading to the toilet area<br>o Appropriate night lighting<br>o Minimise glare | o Seek advice from an occupational therapist about ways to ensure the patient/resident's individual environment is as safe as possible |

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Personal Risk Factor

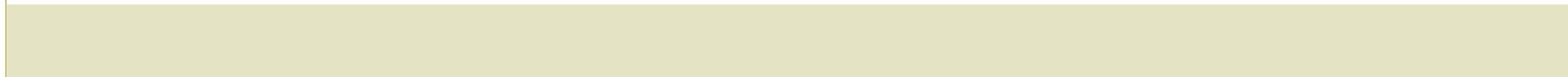
# SENSORY LOSS

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| **What contributes to the risk?**<br>Adjusting to a new environment is more difficult if there is reduced sensory input<br>Sensory loss can be due to medical problems affecting the sensory function, or by inadequate condition or use of aids to improve sensory input | **Orientation and support**<br>o Ensure that patient/residents who need them are wearing their glasses, that they are in optimal working order (eg clean) and that they are the correct prescription (eg strength may need to be upgraded)<br>o Ensure that patient/residents who need them are wearing hearing aids, that they are in optimal working order (eg batteries working) and are appropriate | o Seek advice from an occupational therapist to assist in checking sensory aids, and providing aids/supports to minimise functional impact of sensory loss |
| | **Referral**<br>o Refer patient/resident for medical review to assess and recommend ongoing management for the sensory loss<br>o Refer patient/resident to specialist for detailed assessment of sensory system/s (eg optometrist or ophthalmologist for vision problems; podiatrist for somatosensory problems) | o Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# POOR CONDITION OF FEET/INAPPROPRIATE FOOTWEAR

| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| - Limping due to pain or poor condition of feet<br>- Reddened areas on the feet (eg over a bunion)<br>- Poor condition of skin around toes<br>- Poor condition of toe nails<br>- Inappropriate footwear: loose fitting; open backed; worn sole/heel; poor or no fastenings; high heel; slippers<br><br>**What contributes to the risk?**<br>Wearing inappropriate footwear, such as slippers | **Identify and treat**<br>- Identify and treat acute reversible contributory factors | |
| | **Monitor and review**<br>- Review footwear and condition of feet on admission<br>- Provide an information brochure on appropriate footwear to patient/resident and their family/friends<br>- Action purchase and repairs as indicated | - Explain the importance of good footwear to the patient/resident and their family/friends |
| | **Referral**<br>- Refer patient/resident for medical review or to podiatrist to assess and recommend ongoing management of foot problems and appropriate footwear | - Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |



Personal Risk Factor

# LOSS OF CONFIDENCE/FEAR OF FALLING

| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| • Acknowledges being afraid of falling when asked<br>• Reluctance to walk<br>• Reaches for additional support when walking or transferring<br>• Anxious about walking or transferring<br>• Near falls or previous falls | **Monitor and review**<br>• Monitor all aspects of ambulation, transferring and related activity, and provide encouragement and support as required | • Seek advice from a physiotherapist, who will identify whether the loss of confidence is appropriate to the patient/resident's level of balance<br>• Discuss with family/friends and ask them to reinforce with patient/residents the importance of safe walking and activity |
| **What contributes to the risk?**<br>Medical condition affecting balance and mobility, such as stroke or hip fracture<br>Adjusting to a new environment<br>Inadequate sensory input (eg poor lighting)<br>Environmental hazards | **Activity and exercise**<br>• Encourage patient/resident to participate in exercise or activity groups, or individual exercise program<br>• Encourage safe incidental activities (activities that are part of daily living) to maintain muscle mass, balance, strength and mobility (eg walking, transferring, dressing, bathing) | • Seek advice from a physiotherapist about safe exercises and activities the patient/resident can perform on their own, or with supervision<br>• Ask the patient/resident's family and friends to encourage the patient/resident to do safe incidental activities |
| | **Walking aids**<br>• Consider use of walking aid or change in current walking aid<br>• Ensure walking aids are within the patient/resident's reach | • Seek advice of a physiotherapist about the most appropriate walking aid, and to provide instruction and practice regarding correct use |
| | **Referral**<br>• Refer patient/resident for medical review to assess and recommend ongoing management for the loss of confidence<br>• Refer patient/resident for physiotherapy, occupational therapy, and/or psychologist support to assess and recommend ongoing management | • Ensure effective communication of assessment findings and action plan to all staff so that there is a consistent approach |

Personal Risk Factor

# POOR NUTRITIONAL STATUS

| Indicator/s | Actions | Hints & Tips |
|---|---|---|
| ○ Recent weight loss<br>○ Low Body Mass Index<br>○ Poor oral intake | **Identify and treat**<br>○ Identify and treat acute reversible contributory factors | |
| **What contributes to the risk?**<br>Different meals to those the patient/resident is used to<br>Insufficient time or assistance provided to ensure the patient/resident is able to complete meal prior to dishes being collected<br>Acute and chronic medical problems can reduce the effectiveness of swallowing<br>Inadequate dietary calcium, and lack of exposure to sunlight over a prolonged period of time can result in increased risk of bone fracture | **Monitor and review**<br>○ Monitor patient/resident's food intake<br>○ Review patient/resident's diet for adequate nutritional content<br>○ If food intake (amount) is poor, despite adequate food being provided, determine factors contributing to this<br>○ If eating is associated with coughing or choking check that the patient/resident's swallowing mechanism is intact<br>○ Identify presence of osteoporosis and osteomalacia (inadequate mineral deposit in bone, related to vitamin D deficiency) | ○ Talk to the patient/resident and their family/friends about the patient/resident's usual and preferred diet<br>○ Some factors contributing to reduced oral intake include depression, food not liked, culturally inappropriate food, reduced sense of smell, or ill fitting dentures<br>○ Seek advice from a doctor and speech pathologist if swallowing difficulties are apparent<br>○ Discuss with the doctor about the need for tests for low levels of vitamin D or osteoporosis<br>○ If osteoporosis or osteomalacia is identified consider:<br>  ○ vitamin D and calcium supplementation<br>  ○ hip protectors<br>  ○ options for sunlight exposure (especially in residential care) |
| | **Orientation and Support**<br>○ Provide assistance with eating | |
| | **Referral**<br>○ Refer patient/resident for medical or dietician review to assess and recommend ongoing management of oral intake problems or osteoporosis/ osteomalacia | ○ Ensure effective communication of assessment findings and action plan to all staff, so that there is a consistent approach |

Personal Risk Factor

# HISTORY OF PREVIOUS FALLS

| Indicator/s | Actions | Hints & Tips |
| --- | --- | --- |
| ◦ History of falls, either documented or verbal | **Monitor and review**<br>◦ Review factors that contributed to previous fall/s<br>◦ Address the risk factors contributing to previous fall/s<br>◦ Use the information from previous incidents to implement appropriate falls minimisation strategies | ◦ Record relevant falls history in the medical record, and on a falls incident report if the fall occurred during the current admission<br>◦ May need to obtain additional information from family<br>◦ Follow the Guidelines to assist the development of the falls minimisation action plan |

# ACTIONS FOR MINIMISING INDIVIDUAL ENVIRONMENTAL RISK FACTORS

The following table outlines actions to minimise the impact of individual environmental risk factors for falls to assist in developing an Action List. A multifaceted approach, where actions are introduced to address each of the identified individual environmental falls risk factors, is likely to be most effective. An Individual Environmental Audit should be carried out to identify prevailing risk factors for individual patient/residents.

| Individual Environmental Risk Factor | Actions | Hints & Tips |
|---|---|---|
| INAPPROPRIATE BED HEIGHT<br>**What contributes to the risk?**<br>Bed heights are often adjusted for assessments, nursing or domestic activities. If they are left at an incorrect height, this may increase the risk of patient/residents falling | o If the height of a bed is adjusted during an activity, return it to the correct height afterwards | o The bed should be at a height which allows ease of standing for the patient/resident. The patient/client's feet should be in contact with the ground before standing<br>o Seek advice from an occupational therapist or physiotherapist about optimal bed height for an individual patient/resident |
| BED BRAKES NOT ON OR BROKEN<br>**What contributes to the risk?**<br>Bed brakes are often unlocked, and the bed moved, during domestic activities | o Ensure bed brakes are on/locked after the bed is moved<br>o Ensure that regular monitoring and maintenance is undertaken on all beds | |
| CHAIR HEIGHT/TYPE<br>**What contributes to the risk?**<br>Different height chairs can affect the safety and ease of standing up and transfers | o Ensure that the patient/resident has a chair that is the appropriate height and type for them | o As a general rule, appropriate seating should result in a 90° hip and knee angle, and the patient/resident's feet should be in contact with the ground<br>o Seek advice from an occupational therapist or physiotherapist about optimal chair height for an individual patient/resident |

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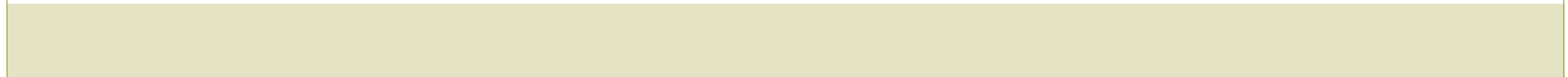

# INDIVIDUAL ENVIRONMENTAL RISK FACTOR

| Individual Environmental Risk Factor | Actions | Hints & Tips |
|---|---|---|
| CALL BELL OUT OF REACH<br>**What contributes to the risk?**<br>Call bells are often moved for assessments, nursing or domestic activities | o Ensure that the call bell or an alternative means of seeking attention is within the patient/resident's reach at all times | o Discuss with family/friends and ask them to be aware that the call bell should be in reach at all times |
| WALKING AIDS OUT OF REACH<br>**What contributes to the risk?**<br>Clients who need a walking aid may try to stand and walk without the walking aid if it is not within reach | o In consultation with the patient/resident, decide where the walking aid will be located within their room<br>o Position the aid so that the handle can be grasped easily (eg upright) | o Communicate this information to all staff |
| WHEELIE FRAME/WHEELCHAIR BRAKES BROKEN OR NOT USED PROPERLY<br>**What contributes to the risk?**<br>Moving parts on equipment, such as brakes on wheelie frames or wheelchairs, can become worn or broken, making them unsafe | o Ensure that wheelie frames, wheelchair brakes and other similar equipment are regularly checked and maintained | o Ensure your organisation has processes for checking of equipment safety to occur<br>o Seek advice from physiotherapists or occupational therapists, as they often have the role of supplying walking frames and wheelchairs, and organising repairs/replacements if required |
| WALKING AIDS NOT IN GOOD CONDITION<br>**What contributes to the risk?**<br>With prolonged use, components of walking aids can become worn (eg stoppers) or broken | o Ensure that regular checking and maintenance is undertaken on all walking aids | o Ensure your organisation has processes for checking safety of walking aids<br>o Seek advice from physiotherapists or occupational therapists, as they often have the role of supplying walking aids and repairs/replacements if required |

*continued overleaf*

# INDIVIDUAL ENVIRONMENTAL RISK FACTOR

| Individual Environmental Risk Factor | Actions | Hints & Tips |
|---|---|---|
| **WALKING AIDS NOT USED PROPERLY**<br>**What contributes to the risk?**<br>If a walking aid is used incorrectly (eg a stick in the wrong hand or wrong height or incorrect sequence of stepping and moving the walking aid) it can result in increased risk of falling | o Monitor patient/resident's use of the walking aid, compared to mobility instructions<br>o Provide regular feedback to improve appropriate use of the walking aids | o Seek advice from physiotherapists or occupational therapists about correct use of walking aids<br>o Communicate this information to all staff |
| **IV DRIP STANDS, POWER CORDS, ETC NOT POSITIONED PROPERLY**<br>**What contributes to the risk?**<br>Objects like IV drip stands and power cords are potential tripping hazards | o Position IV drip stands that are in use so that they are out of general walkway areas<br>o Store IV drip stands that are not in use away from areas accessed by patient/residents<br>o Avoid running power cords across general walkway areas and secure other cords flush to the floor | o Identify areas on the ward/unit for storage of equipment and communicate this to all staff<br>o Use an extension lead to provide extra length to allow running a power cord along a wall rather than across walkways |
| **SLIPPERY SURFACES**<br>**What contributes to the risk?**<br>Regular cleaning/polishing of floors in wards/units may result in slippery surfaces | o Identify areas with slippery surfaces, both when wet and dry, explore options for minimising slipperiness, and work towards implementation<br>o Clearly mark wet areas due to cleaning, and ensure alternative paths are available for patient/residents<br>o Remind all staff that any spills must be cleaned up promptly<br>o Report the need for an upgrade of floor surfaces | o Seek advice from occupational therapists or the Occupational Health and Safety representative about floor surface modifications to increase safety |
| **LOOSE FLOOR COVERINGS eg RUGS**<br>**What contributes to the risk?**<br>Loose floor coverings can turn up at the edges and be a tripping risk | o Avoid use of loose floor coverings such as rugs<br>o If loose floor coverings are used ensure that they are non slip, and that all edges are stuck down properly | o Seek advice from occupational therapists or the Occupational Health and Safety representative about safety associated with floor coverings |

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# INDIVIDUAL ENVIRONMENTAL RISK FACTOR

| Individual Environmental Risk Factor | Actions | Hints & Tips |
|---|---|---|
| CLUTTER<br>**What contributes to the risk?**<br>There is often a need for personal items, mobility and other aids, and medical equipment to be located within the patient/residents individual bedroom area | o Review need for all items contributing to clutter<br>o Discuss with patient/resident/family about the best location for items to minimise clutter and maximise availability<br>o Modify the environment to provide for improved placement and storage of personal possessions and equipment (eg shelving) | o Communicate this information to all staff |
| INADEQUATE LIGHTING (POOR LIGHTING, LACK OF NIGHT LIGHTS, EXCESSIVE SUN GLARE)<br>**What contributes to the risk?**<br>Many patient/residents have visual problems that are made worse if lighting conditions are not optimal | o Review lighting available at different times of day and night, and the vision needs of patient/residents<br>o Ensure appropriate opening/closing of curtains to minimise effect of sun glare<br>o Replace existing light globes with higher wattage globes<br>o Replace incandescent lights with fluorescent lights which provide greater illumination<br>o Ensure available lights are in working order and switched on when required<br>o Enhance available light through use of non-reflective light colours on walls | o Night lights with movement sensor can be useful for patient/residents needing to get up during the night<br>o Seek advice from occupational therapists about lighting options |
| INADEQUATE RAILS/SUPPORTS IN BATHROOM AND TOILET<br>**What contributes to the risk?**<br>Bathrooms and toilets are common locations for falls | o Review patient/resident needs within bathroom/toilet<br>o Consider long term needs for permanent changes, such as fitting of rails to bathroom and toilet | o Temporary aids such as an over toilet seat can provide additional support in some instances<br>o Seek advice from occupational therapists about rails and supports/aids in the bathroom/toilet |

*continued overleaf*

# INDIVIDUAL ENVIRONMENTAL RISK FACTOR

| Individual Environmental Risk Factor | Actions | Hints & Tips |
| --- | --- | --- |
| **RESTRAINTS/COTSIDES IN USE**<br>Restraint use is "the intentional restriction of a person's voluntary movement or behaviour by the use of any manual, physical, or mechanical device [or medications] that restrict freedom of movement… or where part of the intended pharmacologic effect of a drug is to sedate a person for convenience or disciplinary purposes"<br>Restraint can include any of the following:<br>o cot-sides<br>o vests<br>o waist restraints<br>o wrist/ankle restraints<br>o other mechanical restraints, such as tables locked onto chairs<br>o medications, which are used with a primary purpose of limiting a person's movement and activity<br>**What contributes to the risk**<br>Restraints can increase a patient/residents agitation and increase likelihood of getting up unassisted<br>Patient/residents climbing over cotsides will fall from a greater height, increasing risk of serious injuries | o Adhere to professional standards and organisation protocols<br>o Seek a team review of the issue<br>o Investigate causes of agitation, wandering, or other behaviour warranting consideration of restraints. Treat reversible causes (eg delirium)<br>o Investigate alternatives to restraint use<br>  o Incorporate strategies to increase surveillance of the patient/resident (eg move to higher observation area, use of bed alarm)<br>  o Use very low (adjustable) beds<br>  o Encourage increased mobility (with supervision/ assistance as required)<br>  o Reduce environment noise and activity<br>  o Provide repeated reality orientation if required<br>o Investigate and treat falls and fall-related injury risk factors<br>o Incorporate other injury minimisation approaches (eg hip protectors) | o Discuss the patient/resident's routines prior to admission (timing of meals, rest, sleep, toileting) and where possible accommodate these |