Stand up to FALLS

TIPS AND RESOURCES

	TIP	LINK TO RESOURCE/S
1.	**Record and report falls** **TIP**: **Mark the safety cross daily for all to see.** *'You cannot change what you do not know.'* (Dr James Bagian)	Safety cross poster (A3) laminated, and available to download at: http://bit.ly/2kI8Xjg. Falls Prevention: Releasing Time to Care New Zealand module for in-hospital settings (see http://bit.ly/2kS3NhQ).
2.	**Understand your patient's risk factors** **TIP #1**: **Understand that every patient* is unique and has their own set of risk factors.** **TIP #2**: **Identify those with cognitive impairment.** *'Every person is different. Don't try to answer the question "what will stop older people falling" and just repeatedly ask what might stop "this person" falling?'* (Frances Healey RN PhD)	Topic 2 in the 10 Topics for reducing harm from falls (see http://bit.ly/10ZeOQM) Ask, assess, act pocket guide and supporting posters/tools (see http://bit.ly/2kep8TD)
3.	**Individualise falls prevention care planning** **TIP**: **Risks identified need to inform the patient's care plan.** *'Risk assessment is meaningless without action'*	Topic 3 in the 10 Topics for reducing harm from falls (see http://bit.ly/16VadB3)
4.	**Maintain a hazard-free environment to reduce the risk of falling** **TIP**: **Unclutter those corridors and bed spaces.** *'Staff attention and actions are needed to make even a well-designed environment and equipment more protective and supportive.'* *'A well-organised ward has everything in the right place, which saves time.'*	Topic 4 in the 10 Topics for reducing harm from falls (see http://bit.ly/18Lon8D) Falls Prevention: Releasing Time to Care New Zealand module for in-hospital settings (see http://bit.ly/2kS3NhQ). Releasing Time to Care 10-point checklist (see http://bit.ly/2kpi7kJ) Signalling system for safe mobilising (see http://bit.ly/2jsLgML) Audit tool (see http://bit.ly/2jsJjjm)
5.	**Keep bed height right for the patient** **TIP #1**: **When the patient sits on the side of the bed their feet should reach the floor.** **TIP #2**: **Use of 'low-low' beds can be considered as restraint if the beds restrict patients getting up safely.** *'A retrospective study of injurious falls in hospitals highlights the majority of falls occur in the patient's room and almost half involve getting in or out of bed.'*	Topic 4 in the 10 Topics for reducing harm from falls (see http://bit.ly/18Lon8D)

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* The term 'patient' is used interchangeably and can also mean resident, service user or consumer.

TIPS AND RESOURCES *continued*

	TIP	LINK TO RESOURCE/S
6.	**Place call bell within reach** **TIP #1: Remember that the cognitively impaired patient may never remember to use the bell.** **TIP #2: Patients will hesitate to use the bell if it took staff a long time to respond the last time they rang it.** *'Ringing the bell is not a thing patients understand in the same way as health professionals.'* (Prof Anne Marie Hill – see also video at: https://binged.it/2jsHVNJ)	Topic 4 in the 10 Topics for reducing harm from falls (see http://bit.ly/18Lon8D)
7.	**Be cautious with bedrails** **TIP: Never use bedrail for those with cognitive impairment.** *'Decision-making on bedrails needs to be based on an assessment of risks and benefits as they apply to individual patients.'*	Matrix guide (see http://bit.ly/2kXIFYF)
8.	**Encourage well-fitting, non-slip footwear** **TIP: Considers the use of non-slip socks and remember that bare feet are better than loose slippers.** *'Unsafe shoes can cause falls. Talk with patients and their family and carers about bringing appropriate footwear for use in hospital.'*	Topic 4 in the 10 Topics for reducing harm from falls (see http://bit.ly/18Lon8D) Queensland Health brochure on footwear (see http://bit.ly/2jsGn6a)
9.	**Partner with patient and their family/whānau** **TIP: Ask the patient and their family/whānau about falling and what they think will help prevent falls.** *'If health professional don't ask about falls, and patients don't mention they've fallen it's a lost opportunity.'*	Topic 2 in the 10 Topics for reducing harm from falls (see http://bit.ly/10ZeOQM) Consumer information (see http://bit.ly/2kAi5nl) Ask, assess, act pocket guide and prompts (see http://bit.ly/2kencKO)
10.	**Review every fall to understand why it occurred** **TIP: Use a human factors guide to help ask the right questions.** *'A large proportion of falls in hospital are not witnessed, so learning starts with a meaningful description of "what happened?" and "why it happened".'* *'Analysis of incidents looks at causes to determine "what would prevent it happening again?" and recommendations tell us "what actions to take to reduce the possibility of another fall in similar circumstances".'*	Analysing and learning from falls events – various resources (see http://bit.ly/2keg4hk) Human factors approach to reviewing falls incidents (see http://bit.ly/2kIhH8T)