Falls Prevention - Maternity Centre

Related Documents and Resources:

1. B-00-07-10011 - Falls Injury Prevention and Management Acute and Sub Acute Care
2. B-00-07-10042 – Newborn Falls Prevention

Skill Level:

Basic: Registered Nurses and Licensed Practical Nurses in the Maternity Centre, Physicians, Registered Midwives

Need to Know:

Definition of a fall: The unintentional coming to rest at a lower level than where the person started

Significance of falls: In acute care settings, up to 84% of adverse events are related to falls

The Purpose of this protocol is to support a goal of preventing falls of patients in our care while preserving patient freedoms and quality of life to the greatest extent possible and to minimize the severity of injury that may occur as a result of a fall.

PRACTICE GUIDELINE

1. Screening Trigger Questions:

Assess all patients for their risk of falls on admission, during labour, and postpartum at least once a shift:

- History of falls within the last 6 months
- Difficulty walking
- Known mobility impairment
- Requires use of assistive aid or device
- History of vasovagal or fainting response to invasive medical procedure
- Has received or uses sedating medications – analgesia, anaesthetic agents (regional and general)
- Unstable mental status
- Multiple medical diagnoses
- Following surgery or other medical procedures (e.g., D&E, Forceps assisted delivery)
- Has an intravenous line or other access
- Known use of illicit substances
- Multiple pieces of equipment
- Known excessive blood loss following delivery

2. Falls Risk Assessment Screen:

- Complete Falls Risk Assessment. (Check box on BC Perinatal Triage and Assessment Record. "Is patient at risk of falling? Yes/No)
- Include assessment of use of psychotropic medications, antidepressants or tranquilizers.

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Questions, concerns, comments about PHC guidelines can be emailed to: nursingstds@providencehealth.bc.ca

- Review Med Reconciliation

3. Precautions for Patients Identified as at Risk for Falls:

- Provide support and teaching to enhance safe mobility and falls prevention during hospital stay:
  - Call bell in place
  - When to call for assistance
  - Review with partner, alternate caregiver when to ask for assistance, specifics to watch for related to mobility concern
  - Review safe use of assistance aids or devices
- Assess physical and emotional limits of patients with known mobility issues. Assess specific mobility needs and outline plan of care by all appropriate health care providers. Include how the woman will safely care for her newborn (utilize the assistance of her partner, alternate caregiver, and NICU as required). See also Newborn Falls Prevention
- Document fall prevention care plan in the BC Postpartum Clinical path and/or Interprofessional Progress Notes, Complex Care Plan as required.

4. Safety Precautions for all Patients:

- Maintain awareness at all times to the patient's risk of falling. Provide assistance as required.
- Room Safety Check – call light, personal items close by, signage for wet floors and spills, clear clutter – bags, suitcases, electrical cords
- Provide general room orientation each time patient is moved/transferred to different room/area of the Maternity Centre - location of call bell, bed operation, etc.
- Instruct patient and partner when to call for assistance e.g., when getting up to bathroom for first time after delivery or removal of indwelling catheter, feeling faint, dizzy
- When language is a concern, use sign language or translation instructions to ensure patient understands when to ask for assistance.
- Assess postpartum women q shift and PRN, following the BC Postpartum Clinical Path for motor, sensory function, vital signs.
- Assess and document sensory and motor power following placement and administration of epidural according to Epidural protocol. Use quick mobility screen before mobilizing. (Appendix D of Falls Injury Prevention and Management guideline)

5. Interventions and Further Assessment:

- Universal Falls Prevention Precautions: - See Safe Step (Appendix C of Falls Injury Prevention and Management guideline)

- Safe mobilization/Activation:
  - Ensure patient's physical condition is stabile prior to mobilizing – e.g., vitals signs stable, no active bleeding, absence of dizziness, etc.
  - All monitoring and infusion lines are organized so that they do not impede mobilization, e.g., IV lines/pumps, EFM cords disconnected.
  - Floor space is clear of miscellaneous equipment, etc

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  - Brakes are on bed.
  - Utilize Quick Mobility Screen for patients with epidural infusion or who have, received any medication that could potentially impair balance, mobility, or neurological status.
  - Instruct all patients and their partners to wear non-slip footwear
- Pregnant women and postpartum women are at higher risk of postural hypotension. Teach them and their partners how to move from lying to sitting to standing gradually to avoid syncopal episodes.

When a fall occurs:

- Call for assistance and secure patient safety
- Do not try to stop the fall, rather, ease the patient safely to a chair, bed, or onto the floor.
- Ensure that medical assessment is done and documented after a fall.
- If patient is identified as spinal cord injury or head injury, refer to algorithm Patient Management Immediately Post Fall
- If a patient falls and is found unconscious or has experienced head trauma, call Code Blue and request immediate assistance – use emergency nurse call bell or bathroom call bell and Code Blue buttons
- Complete Patient Safety and Learning System. Report to Operations Leader or Clinical Coordinator.
- If a pregnant woman has fallen and requires hospitalization, management will depend on extent on injury, location of injury, and gestational age.

Documentation:

- Patient Safety & Learning System – all patient falls
- BC Labour Partogram – document maternal assessment and sedation scale
- BC Postpartum Clinical Path – document Sedation Scale
- BC Perinatal Triage and Assessment Record - document Mobility concerns or history of falls
- Surgical Safety Checklist – document mobility concerns or history of falls

References:

1. Morse, J.M. (2009). Preventing Patient Falls. New York, NY. Springer Publishing.
2. Patient Safety & Learning System
3. Mosby Nursing Skills (2013). Fall Prevention. St. Louis, MO. Elsevier. Retrieved May 28 2013from www.mosbysnursingskills.com
4. Schartz, L. revised October 2012. PHC IDG1052.Falls Injury and Prevention. Vancouver: PHC.

Persons/Groups Consulted:
Maternity Safety & Quality Council
Perinatal Directions Committee

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