FALLS PREVENTION IN MATERNITY SERVICES

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP:

1. AIM
   - To prevent falls of a woman and her baby/ies

2. PATIENT
   - Mother and baby

3. STAFF
   - Registered Midwives
   - Student Midwives
   - Medical staff
   - Physiotherapist
   - Registered Nurses
   - Ward Clerks
   - Housekeeping

4. EQUIPMENT
   - Cots
   - Baby slings
   - Shower chairs
   - Call bells
   - Bed / bed rails

5. CLINICAL PRACTICE
   Fall prevention is considered a part of standard care for all women and babies. Particular attention must be given to all women affected by recent sedation, anaesthesia, reduced mobility or impaired vision or any condition which may induce an accidental fall e.g. epilepsy

Prevention of Falls:
- Commence falls prevention education in the antenatal period
- Ensure the woman’s environment is safe and that the woman / partner / support person is made aware of general safety issues. The admitting Midwifery or Nursing staff member will undertake a specific falls risk assessment for each woman
- Conduct a Falls Risk Assessment using Appendix 1:
  - on admission
  - on transfer
  - change in clinical condition
  - following a fall
- Initiate a High Risk Falls Management Plan using Appendix 2 if the woman scores 3 or more on the Falls Risk Assessment (Appendix 1) and incorporate the strategies into the care of the woman
FALLS PREVENTION IN MATERNITY SERVICES  cont’d

- Discuss prevention strategies with woman / partner / support person
- High Risk Falls Management plan will be ceased if assessment score <3
- Ensure the woman and her family are directed to a copy of the NSW Falls Prevention Program information sheet produced by Clinical Excellence Commission: “Falls Prevention – For Maternity Services” located in the bedside information packs on the Postnatal Wards and the literature in Antenatal Ward / Acute Care and Birthing Suite (Appendix 3)

Strategies that are detailed in the High risk Falls Management Plan include:

**Supervision**
- Woman requires direct and constant supervision
- Check woman at least hourly

**Environment**
- Keep bed rails up for woman breastfeeding or settling her baby whilst in bed / under the effects of anaesthesia
- Keep bed in lowest position unless woman is being directly attended
- Ensure call bell, personal items and any walking aids are in reach

**Interventions**
- Instruct woman to call for assistance prior to getting out of bed
- Ensure adequate rest / sleep where possible

**Mobilisation Support**
- Ensure appropriate mobility aids are available
- Accompany patient when ambulating
- Refer to Physiotherapy / Occupational Therapy (if applicable)

**Other precautions that can also be initiated include but not limited to:**
- Demonstrate to woman / partner / support person how bedrails and height adjustment of bed work
- Clean up any spills on the floor safely and promptly and ensure wet floor signage is used when appropriate
- Follow RHW Clinical policy and procedures manual for the management of medical interventions i.e. Epidurals
- Use safe manual handling practices
- Ensure equipment and bed brakes are on / locked after the equipment / bed is moved

6. DOCUMENTATION
- Falls risk assessment Maternity
- High risk falls management plan
- Postnatal Clinical Pathway for Vaginal birth
- Postnatal Clinical Pathway for Caesarean section
- Integrated Clinical Notes
7. **EDUCATIONAL NOTES**
   - **Definition of a fall:**
     “a fall is an event which results in a person coming to rest inadvertently on the ground or floor or any other lower level”

   **Exclusion from the Falls Risk Assessment**
   *Neonates are excluded from formal falls risk assessments as they are unable to fall of their own volition. Most newborn falls occur when they slip from their care providers hold e.g. as a result of parent falling asleep with baby in arms. Environmental factors may play a part, for example the basinet may tip. Falls risk assessment of women who have had babies will identify “at risk” situations where extra precautions and supervision is indicated.*

   - Risk of baby falls increases overnight
   - Managing a patient after a fall
     - In the event of a patient fall, minimise the risk of personal injury to oneself by following appropriate manual handling techniques
     - If a person is found on the floor or lower level, it must be assumed that they have fallen unless there is reasonable evidence of an alternative cause such as being pushed or having a seizure

   - Respond to the fall appropriately:
     - Attend to immediate needs for care
     - Minimise any adverse effects from the fall and stabilise the individual
     - Move the patient only after fully assessing the individuals situation
     - The portable hydraulic hoist is located on level 2 Macquarie ward in the bathroom
     - Arrange for a review of the patient by a medical officer. This should be documented in the medical record
     - Provide a factual explanation of what has happened and what will happen next to the person who has fallen and their family
     - Document the fall in the medical record, inform the Team Leader and / or Afterhours Nurse Manager and report the incident via IIMS
     - Conduct another full falls risk assessment and develop a high risk falls management plan if required

   - **Bromage score:** The bromage scale is used to measure motor blockade after epidural
     - Score motor block
     - 0 = none, full flexion knees and feet
     - 1 = partial, just able to move knees and feet
     - 2 = almost complete, only able to move feet
     - 3 = complete, unable to move feet or knees
     - Note: If Bromage scale 1, 2 or 3 DO NOT ambulate

8. **RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP**
   - Safer Sleeping Practices for Babies in NSW Public Health Organisations PD2012_062
   - Epidural / PCEA
   - Obesity and weight gain in pregnancy, labour and postpartum
FALLS PREVENTION IN MATERNITY SERVICES

9. REFERENCES
5. Women's and Children's Health Network Nursing & Midwifery Clinical Standard Falls – Prevention & Management within WCHN Adelaide South Australia
7. NSW Clinical Excellence Commission. NSW Falls Prevention Program November 2013

REVISION & APPROVAL HISTORY
Endorsed Maternity Services LOPs 11/3/14

……/Appendices and leaflet
APPENDIX 1

FALLS RISK ASSESSMENT – MATERNITY

- All women are to be assessed for their falls risk;
  - on admission
  - on transfer between wards / units
  - when clinical condition changes (excluding women in labour who are receiving 1:1 care)
  - following a fall incident
- If score ≥ 3, the score and the initiation of a High Risk Falls Management Plan must be documented into Integrated Clinical Notes

Select score for each section as indicated in heading and add scores together

<table>
<thead>
<tr>
<th>Falls Risk Screening / Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility (select one only)</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulant with no gait disturbance</td>
<td>0</td>
</tr>
<tr>
<td>Ambulate or transfer with assistive device</td>
<td>1</td>
</tr>
<tr>
<td>Ambulate with unsteady gait and no assistive device</td>
<td>1</td>
</tr>
<tr>
<td>Bromage score 1, 2, 3 as per EDB mobility assessment</td>
<td>3</td>
</tr>
<tr>
<td><strong>Behaviour / Cognition (select one only)</strong></td>
<td></td>
</tr>
<tr>
<td>Alert and appropriate</td>
<td>0</td>
</tr>
<tr>
<td>Sleep deprived / fatigued</td>
<td>1</td>
</tr>
<tr>
<td>Sedation Score / Conscious level ≥ 2 as per standard Maternity Observation Chart</td>
<td>1</td>
</tr>
<tr>
<td>Disorientated</td>
<td>2</td>
</tr>
<tr>
<td><strong>Elimination (select one only)</strong></td>
<td></td>
</tr>
<tr>
<td>Independent</td>
<td>0</td>
</tr>
<tr>
<td>Assistance with toileting / Indwelling Urinary Catheter</td>
<td>1</td>
</tr>
<tr>
<td>Independent with urinary frequency or diarrhoea</td>
<td>1</td>
</tr>
<tr>
<td><strong>History of Falls (select one only)</strong></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Yes before admission</td>
<td>1</td>
</tr>
<tr>
<td>Yes during admission</td>
<td>2</td>
</tr>
<tr>
<td><strong>Clinical factors (select one or more)</strong></td>
<td></td>
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<tr>
<td>Hypotension</td>
<td>1</td>
</tr>
<tr>
<td>Symptomatic anaemia</td>
<td>2</td>
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<tr>
<td><strong>Medication (select one or more)</strong></td>
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<tr>
<td>Anticonvulsants (regular dose), diuretics, bowel prep</td>
<td>1</td>
</tr>
<tr>
<td>Opioids, sedatives, psychoactive medications – antidepressants or benzodiazepine, anticonvulsants (increase in dose), history of illicit drug use</td>
<td>2</td>
</tr>
<tr>
<td><strong>Staff and / or Patient concern (select one only)</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
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</tbody>
</table>

Total Score

A Falls Risk Assessment score ≥ 3 is considered high risk and requires a High Risk Falls Management Plan:
1. Commence the High Risk Falls Management Plan
2. Discuss fall prevention strategies with woman / partner
## APPENDIX 2

### High Risk Falls Management Plan - Maternity

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#### Falls risk assessment

- **Actual Score:**
- **Date:** / / 
- **Time:** 
- **Signed:**
- **Print Name:**
- **Designation:**

#### Tick the safety strategies that apply to the patient

<table>
<thead>
<tr>
<th>Care and Interventions</th>
<th>Date</th>
<th>Time</th>
<th>Reassessment Score</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check woman at least hourly</td>
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<tr>
<td>Instruct woman to call for assistance prior to getting out of bed</td>
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<tr>
<td>Advise woman of the importance of adequate rest/sleep</td>
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<tr>
<td>Supervise infant feeding / care</td>
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</tbody>
</table>

#### Environment

<table>
<thead>
<tr>
<th>Environment</th>
<th>Date</th>
<th>Time</th>
<th>Reassessment Score</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rails must be kept up</td>
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<tr>
<td>Keep bed in lowest position while woman is unattended</td>
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<tr>
<td>Call bell, personal items, and any walking aids are in reach</td>
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</tbody>
</table>

#### Mobilisation Support

<table>
<thead>
<tr>
<th>Mobilisation Support</th>
<th>Date</th>
<th>Time</th>
<th>Reassessment Score</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure appropriate mobility aids are available</td>
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<td></td>
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<tr>
<td>Accompany woman when ambulating</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Refer to Physiotherapy / Occupational Therapy</td>
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</tbody>
</table>

#### Other precautions (list)

<table>
<thead>
<tr>
<th>Other precautions (list)</th>
<th>Date</th>
<th>Time</th>
<th>Reassessment Score</th>
<th>Staff initials</th>
</tr>
</thead>
</table>

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The High Risk Falls Management plan has been discussed with me and I am aware of the information sheet “Falls prevention for Maternity Services”.

<table>
<thead>
<tr>
<th>Woman’s Name:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and designation of staff member Initiating High Risk Management Plan:</td>
<td>Signature of staff member:</td>
</tr>
</tbody>
</table>
Appendix 3. Patient information leaflet

NSW FALLS PREVENTION PROGRAM

Falls Prevention – For maternity services

Mothers of new born babies can fall whilst in hospital which can cause injury

As a new mother you have an increased risk of falling if you:

➤ Are very tired, disoriented or drowsy
➤ Have had an epidural, spinal, general anaesthetic, sedation or pain relief medication
➤ Have had bleeding during pregnancy, birth or postnatally
➤ Have certain medical conditions such as epilepsy, low blood pressure or diabetes
➤ Are wearing badly fitting footwear, socks or surgical stockings without shoes
➤ Have a visual or physical impairment

As a mother of a new born baby, you can reduce your risk of falling in hospital by:

➤ Using your call bell if you require assistance.
➤ Taking your time. When getting up from sitting or lying down. Let staff know if you feel unwell or unsteady on your feet. Use stable objects for support.
➤ Wearing safe footwear. Only walk around in socks or surgical stockings with non-slip soles.
➤ Using a shower chair when showering.
➤ Using the rails to get off the chair or the toilet. If you feel unsafe in the bathroom, remain seated.
➤ Familiarising yourself with your room and bathroom. Being aware of any hazards (e.g., spills and clutter) and tell staff when you see them.
➤ At night. Using the light button on the call bell to turn on the light before getting out of bed. Turning the light on in the bathroom.

If you do have a fall - do not get up on your own - wait for help.
Falls Prevention – For maternity services

How to keep your baby safe from falling:

- Place your baby to sleep on their back from birth in their safe cot next to your adult bed.
- Don’t fall asleep while holding your baby as they can fall from your hold.
- Never leave your baby unattended on an adult bed or other surface from which they may fall.
- Ask for assistance when moving your baby from their own safe cot if you feel at risk of falling.
- When transporting your baby around the unit always place your baby in their own safe cot. Walking with your baby in your arms is not encouraged.
- Take extra care when changing nappies and bathing your baby. These are situations where your baby may fall.

Please let your visitors know it is important to move your baby only in their wheeled cots.

Encourage your visitors to make sure that the bedside is clear when they leave and that any extra chairs are put away.