SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Falls prevention and management for people admitted to acute and sub-acute care
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FUNCTIONAL GROUP(S)	Falls Prevention
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SUMMARY	The purpose of this document is to outline the process for the prevention and management of falls in people admitted to acute and sub-acute care within SESLHD. It details recommendations for all adults, children and women receiving maternity care. The document provides best practice guidelines and tools to facilitate clinical decision making in the prevention and management of falls in individuals identified at risk of harm. It is specific to inpatients and does not cover outpatients or those under the care of community health services. The document also describes the governance structures and processes required to facilitate proactive approaches to minimising fall-related harm among people admitted to acute and sub-acute care.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Acknowledgement of Country

South Eastern Sydney Local Health District respectfully acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians on whose land we stand. We also acknowledge Elders past, present and future, and their continuing connection to country.

Contents

1 PROCEDURE STATEMENT

South Eastern Sydney Local Health District (SESLHD) aims to provide safe and collaborative care to all patients in order to reduce harm within patient care settings. Patient harm is minimised through the use of targeted screening and assessment, comprehensive care planning and delivery of services that are timely, evidence based and delivered in partnership with patients, carers and families[1].

This procedure describes actions that SESLHD will undertake to support the prevention of falls and fall-related harm among people admitted to its acute and sub-acute care facilities, in accordance with:

- World guidelines for falls prevention and management for older adults: a global initiative
- Preventing Falls and Harm from Falls in Older People - Best Practice Guidelines for Australian Hospitals 2009
- National Safety and Quality Health Service (NSQHS) Standards including:
  - Standard 1 - Governance for Safety and Quality in Health Service Organisations
  - Standard 2 - Partnering with Consumers
  - Standard 5 - Comprehensive Care
  - Standard 6 - Communicating for Safety
  - Standard 8 - Recognising and Responding to Acute Deterioration
- SESLHDGL/088 - Standard 5 Comprehensive Care - Guideline

As in any clinical situation, there may be factors that cannot be addressed by a set of guidelines. This document does not replace the need to use clinical judgement with regard to individual patients and situations.

2 BACKGROUND

A fall is defined as “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level”[2]. For the purposes of this Procedure, this definition **includes** cases where a patient is lowered to the ground with assistance (e.g. during a therapy session or other routine care) or collapses (e.g. syncope, seizure).

Fall-related injury is one of the leading causes of hospital-acquired morbidity and mortality. While the majority of inpatient falls are associated with minor injury, more serious events such as fractures, intracranial injury and death also occur. A fall may lead to a fear of falling, a loss of confidence and decline in mobility, and an injurious fall can increase the likelihood of discharge to a residential aged care facility[3]. While older people are at highest risk, falls and injury from falls can occur at any age. Guidelines are required to manage all people identified at risk.

Risk factors for falls in hospital include cognitive impairment and/or delirium, balance and mobility limitations, incontinence, visual impairment, orthostatic hypotension, medications and environmental considerations[4].

The health service organisation providing services to people at risk of falls must have systems that are person-centred and consistent with best-practice guidelines for falls

prevention, minimising harm from falls and post-fall management. It must also ensure that equipment, devices and tools are available to promote safe mobility and manage the risks of falls[3]. Clinicians caring for patients at risk of falls must provide patients, families and carers with information about reducing the risk of falls and falls prevention strategies[3].

3 RESPONSIBILITIES

It is the responsibility of the SESLHD Executive and Facility Executives to provide both governance and appropriate resources (staff and equipment) to facilitate health care professionals to prevent and manage inpatient falls and support the implementation of:

- SESLHDPR/380 - Falls prevention and management for people admitted to acute and sub-acute care
- National Safety and Quality Health Service (NSQHS) Standards

3.1 Unit managers responsibilities

- Ensure that all nursing/ midwifery staff are trained in the use of the risk screening and assessment tools
- Ensure all nursing/ midwifery staff are trained in implementing targeted falls risk management strategies
- Support and encourage routine discussion of potential or existing patient safety risks as part of a safety huddle and/or bedside clinical handover
- Conduct regular environmental audits and where necessary, develop management plans to minimise environmental risk factors that might contribute to patient falls
- Enter identified risks into the Enterprise Risk Management System (ERMS) along with risk mitigation strategies and actions to address identified risks
- Escalate identified risks via appropriate mechanisms e.g. local quality and safety or falls prevention and management committees
- Identify and facilitate access to the equipment and devices required for the patient population being served
- Monitor availability of equipment and have processes to manage faulty equipment. Refer to the Falls Prevention intranet page for SESLHD falls prevention equipment spreadsheet
- Be familiar with relevant SESLHD guidelines used in conjunction with this procedure that support the prevention and management of falls
- Consider models of care and staffing allocation to increase observation for patients who are confused and at high risk of falling
- Consider and refer to SESLHDGL/042 - Falls Prevention and Management: Guideline for Designated High Risk Observation Room (Adult Inpatient) when setting up and allocating patients to designated high risk observation rooms
- Investigate all patient falls in the unit in accordance with NSW Ministry of Health Policy Directive PD2020_047 - Incident Management.
- Review and discuss patient falls with staff on a regular basis
- Attend or nominate a representative to attend the facility falls prevention and management committee and/or relevant quality and safety meeting

- Ensure relevant information and actions arising from falls prevention and management committee and/or quality and safety meetings is communicated to staff on a regular basis
- Lead or participate in post fall safety huddles as required

3.2 Nurse responsibilities

- Complete the electronic admission assessment within eight (8) hours of admission to the ward, using agreed processes to identify factors that may contribute to an increased risk of harm in an individual patient
- Implement and document targeted falls management strategies for people identified at risk of falls
- Be familiar with relevant SESLHD guidelines used in conjunction with this procedure that support the prevention and management of falls
- Communicate falls risk and the management strategies as a routine part of clinical handover
- Participate in routine discussion of potential or existing patient safety risks as part of a safety huddle and/or clinical handover
- Discuss falls risk and develop the care plan in partnership with patients, families and carers
- Provide information to patients and their carers on preventing falls and harm from falls
- Record fall incidents in the incident management system
- Complete post fall observations and interventions as per Section 4.1.5 of this Procedure
- Lead or participate in post fall safety huddles as required
- Update the risk screen and care plan post fall incident or when clinically indicated e.g. change in condition, ward move
- Report any identified hazards or equipment issues to the Unit Manager
- Complete nursing discharge summary for patients discharged to community nursing services or to other facilities/units including off-site rehabilitation, residential aged care or palliative care
- Complete mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff under the My Health Learning pathway: Minimising patient harm – Falls and Delirium.

  Falls related modules/online courses
  - Falls Prevention and Falls Risk Management Strategies for Clinical Staff (Course Code 40053943)
  - Falls Risk: Screening, Assessment and Management Plans for Adults (Course Code 40823720)
  - Post Falls Management for Clinical Staff (Course Code 40101665)
  - CEC Falls Program (Course Code 89858402)
  - Post Incident Safety Huddles (Course Code 221824316)

Delirium related modules/online courses

- Delirium Care (Course Code 266621954)2. Delirium (Stage 1 Course Code 233003664)
- The Confused Patient: Dementia or Delirium? (Course code 39966589)
- NSW Health Delirium Screen for Older Adults (Course Code 89858532)

3.3 Midwives responsibilities

- Recognise that falls risk factors exist in hospital for all women receiving maternity care and for newborns
- Provide information to all women receiving maternity care on preventing falls and harm from falls and discuss falls risk with regard to any individual risk factors
- Participate in routine discussion of potential or existing patient safety risks as part of a safety huddle and/or clinical handover
- Record fall incidents in the incident management system
- Complete post fall observations and interventions as per Section 4.3.4 (Maternal falls) or 4.3.7 (Newborn falls) of this procedure
- Lead or participate in post fall safety huddles as required
- Report any identified hazards or equipment issues to the Unit Manager
- Complete mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff under the My Health Learning pathway: Minimising patient harm – Falls and Delirium.
- *See MHL Modules and online course listings section 3.2 of the procedure

3.4 Medical Officers responsibilities

- Consider falls risk factors on review of patients, including history of falls, delirium and/or altered mental status, postural hypotension and centrally acting medication use
- Investigate and manage risk factors as appropriate and as part of the patient's comprehensive plan of care
- Conduct a medical review after a fall incident and document an assessment and management plan in the medical record, ensuring the relevant post fall management section of this procedure is considered
- Lead or participate in post fall safety huddles as required
- Communicate inpatient fall incidents and ongoing falls risk factors to the patient's GP and refer to appropriate services
- Document inpatient fall incidents and ongoing falls risk factors in the patients medical discharge summary.

3.5 Allied Health managers responsibilities

- Ensure that allied health clinicians receive training in the identification of factors that may contribute to an increased risk of harm in an individual patient
- Ensure that allied health clinicians aware of their discipline-specific role in contributing to the multidisciplinary falls prevention plan

- Ensure information and actions arising from the facility falls prevention and management committee and/or relevant quality and safety meeting is communicated to staff on a regular basis
- Consider the equipment required for allied health clinicians to fulfil their responsibilities within this Procedure. Ensure systems are in place to enable equipment maintenance and provision
- Investigate all patient falls involving relevant discipline in accordance with NSW Ministry of Health Policy Directive PD2020_047 – Incident Management
- Ensure Allied Health clinicians who assess and make recommendations around patient mobility are made aware of the requirements as per SESLHDGL/047 - Standardised mobility terminology for use across SESLHD.

3.6 Allied Health clinicians responsibilities

- Contribute to the identification of factors that may increase the risk of harm in an individual patient
- Conduct discipline-specific assessment and interventions, as relevant
- Document a patient's risk of falls in the clinical record as part of initial assessment where appropriate (e.g. physiotherapy and occupational therapy)
- Implement and document targeted falls management strategies for patients identified at risk of falls
- Communicate a patient's identified risk of falls to nursing staff and as a routine part of clinical handover
- Contribute to the multidisciplinary care plan in patients at risk of falls and harm from falls
- Be familiar with relevant SESLHD guidelines used in conjunction with this procedure that support the prevention and management of falls
- Document in the clinical record in accordance with SESLHDGL/047 - Standardised mobility terminology for use across SESLHD
- Discuss falls risk and develop interventions in partnership with patients, families and carers
- Provide information to patients and their carers on preventing falls and harm from falls
- Record fall incidents in the incident management system
- Contribute to the review of fall incidents at ward/department meetings and facility falls prevention and management committee meetings and/or relevant quality and safety meeting as required
- Participate in routine discussion of potential or existing patient safety risks as part of a safety huddle
- Lead or participate in post fall safety huddles as required
- Consider referral to appropriate services on discharge. Communicate any referrals made to the medical team for inclusion in the discharge summary
- Complete a discipline-specific discharge summary for patients discharged to community health services, off-site rehabilitation or residential aged care facilities

- Complete mandatory and other relevant training around minimising patient harm. Refer to the six modules assigned to relevant staff under the My Health Learning pathway: Minimising patient harm – Falls and Delirium

*See MHL Modules and online course listings section 3.2 of the procedure

3.7 Care Champions for falls prevention responsibilities

- Be familiar with SESLHDGL/057 - Care Champions for Falls Prevention: Key Roles and Standards
- Contribute to the review of fall incidents at ward/department meetings and provide a link between local falls prevention and management committee and/or relevant quality and safety meetings as required
- Raise and maintain the profile of falls prevention at a service/unit level by facilitating the promotion and awareness of falls prevention initiatives
- Motivate staff through assertive influence and example
- Provide a proactive resource at service/unit level on matters relating to falls prevention, including involvement in service/unit audits and quality improvement projects/initiatives

3.8 Clinical Governance Unit responsibilities

- Provide leadership in the delivery of comprehensive care across SESLHD
- Provide SESLHD and Facility level Quality Improvement Database System (QIDS) falls data reports to District Steering Committee for Falls Injury Prevention in Health Facilities
- Monitor and distribute information on Hospital Acquired Complications (HACs) which include falls resulting in fracture or intracranial injury
- Assist with the analysis and interpretation of patient falls data
- Monitor Procedure compliance through assisting with the audit process, using the relevant audit reporting systems (e.g. Quality Auditing Reporting System) including compilation and distribution of audit reports
- Lead and/or facilitate the investigation of Harm score 1 or Harm score 2 fall incidents.

3.9 District Steering Committee for Falls Injury Prevention in Health Facilities

- Recognise, consolidate and strategically build upon innovation and improvement work being undertaken by SESLHD facilities, and by other local health districts and service providers
- Work collaboratively with other groups that have governance and harm minimisation responsibilities under National Standard 5 – Comprehensive Care
- Take an evidence-based approach to harm minimisation and the selection of priorities/development of new interventions and ensure these are measured for their effectiveness
- Support health facilities to comply with all relevant accreditation requirements, namely National Standard 5 – Comprehensive Care
- Review and discuss serious adverse events related to falls injury and associated recommendations, with a view to broader implementation of recommendations across SESLHD as required

- Monitor quarterly data on falls and fall related injury across SESLHD, including rates and trends of falls resulting in fracture and intracranial injury per 10,000 episodes of care (HAC falls) and rate and trend of falls per 1,000 occupied bed days at a District and facility level
- Report pertinent issues to the District Clinical and Quality Council as well as other appropriate governance and operational committees at a District and facility level.

3.10 The SESLHD Falls Prevention Program Coordinator responsibilities

- Monitor the use of policies and procedures for minimising harm from falls
- Work collaboratively to ensure that processes for preventing falls are integrated with the delivery of comprehensive care
- Develop evaluation processes for falls prevention and management procedures across SESLHD
- Support the implementation of this Procedure across SESLHD and undertake periodic review to ensure it reflects best practice recommendations.

3.11 Governance for Falls Reporting

Falls data should be reviewed, evaluated and acted upon at a number of levels including District, Facility and Unit level.

The District Steering Committee for Falls Injury Prevention in Health Facilities will review falls data on a regular basis, and at least quarterly.

Data/reports that should be reviewed include:

- Hospital Acquired Complications: Falls resulting in fracture or intracranial injury per 10,000 episodes of care at District and Facility level
- Rate and trend of falls per 1000 occupied bed days at District and facility level
- Outcomes of Serious Adverse Event Reviews and Harm Score 2 reports and associated recommendations, with a view to broader implementation of recommendations across the District/facility as required

SESLHD facilities are responsible for:

- Ensuring that incidents of patient harm and near-misses are reported via the Incident Management System, and have a system in place to monitor trends and manage incidents in line with the NSW Ministry of Health Policy Directive PD2020_020 - Incident Management Policy
- Managing and monitoring risk associated with falls and harm from falls via reporting systems, for example QIDS dashboard

4 PROCEDURE

Best practice for preventing falls in hospital includes four key components: identification of falls risk; implementation of standard prevention strategies; implementation of strategies targeting identified risks to prevent falls; and prevention of injury to those people who do fall[4]. There are separate recommendations (outlined below) for adults, children and women receiving maternity care.

4.1 ADULTS

4.1.1 Risk screening

All adults admitted to SESLHD acute and sub-acute facilities (excluding women receiving maternity care) must be screened for risk factors that contribute to falls using an agreed risk screening process to guide shared decision making. Women receiving maternity care are considered a special at-risk group. See Section 4.3 for the procedure in Maternity Units.

The Ontario Modified Stratify (Sydney Scoring) (OMS) is currently the recommended risk screening tool and is available within the Electronic Medical Record (eMR):

- As part of Adult Admission Assessment (AAA)
- As a standalone Ad Hoc form.

When	Procedure
Emergency Department (ED)	If an admitted person is identified to be at high risk of falls in the ED, this should be communicated to the ward in advance of the transfer. People over the age of 65, who are assessed by the specialist aged care services in the ED and are for discharge home, should be asked about any falls in the last 12 months. Please refer to SESLHDGL/044 for further information on falls prevention and management for non-admitted patients.
On admission to acute, sub-acute or rehabilitation services	All adults who are admitted to hospital will be screened for risk of falls through completion of the Adult Admission Assessment (AAA) within the first eight (8) hours of their admission to a ward. Risk screening must be repeated using the standalone OMS Ad Hoc form on transfer to another ward/ unit.
Following a fall	All patients who fall in hospital must have a repeat falls risk screen using the standalone OMS Ad Hoc form.

	Clinical judgement should be used to override a low-risk score. If the OMS score is lower than 9 any individual risk factors that have been identified should still be addressed and documented in patient's clinical notes.
Change in the patient's condition (Physical and/or Mental)	If there is any change to the patient's physical and/or mental condition, the falls risk screen must be updated using the standalone OMS Ad Hoc form. Altered mental status (including cognitive impairment, confusion, disorientation and agitation) is a risk factor for injurious falls. Consider **delirium** as a possible cause and refer to SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub-Acute Care Additional considerations in mental health include: • Electroconvulsive therapy (ECT) • Acute mania or psychosis • The influence of substance use or withdrawal • Depression impairing ability to concentrate or comprehend instructions • Side effects of new medication (including postural hypotension).
Post-operative patients	Patients who have had an anaesthetic should be considered at high risk of falls until a repeat risk screen ascertains their fall risk status. The repeat screen should be done once the patient is at least eight (8) hours post-surgery and within 24 hours. Due to differences between individual patients, staff are required to use clinical judgement to determine when sufficient recovery from an anaesthetic has occurred and re-screening is appropriate.

Risk screening is a guide for staff and does not preclude the need for a care plan which includes individualised falls prevention strategies where other clinical indicators identify that the patient is at risk. Standard care actions apply to all patients regardless of risk status.

Clinical judgment can override a low risk individual score. On eMR, the clinician is able to activate the low risk score clinical judgement override function within the standalone OMS Ad Hoc form. The clinical judgment field is not accessible via the Adult Admission Assessment and can only be completed through the OMS

standalone Ad Hoc form. It is important to note that this action will not generate automatic referrals e.g. to Physiotherapy. Any required actions/ referrals will need to be done manually.

4.1.2 Identifying patients at risk of fall-related harm

Falls risk alerts will be automatically generated on eMR for patients who score greater than or equal to nine (9) on the OMS (either within the Adult Admission Assessment or on the standalone OMS Ad Hoc form). High falls risk must also be included as part of clinical handover and should be flagged via the electronic journey board where possible. If any risk factor is identified in the OMS associated mitigation strategy need to be actioned and documented in the clinical notes.

4.1.3 Falls risk management

All adults who score greater than or equal to nine (9) (i.e. at high risk of falls) on the Ontario Modified Stratify (Sydney Scoring) falls risk screen or who are deemed clinically at risk, must have a paper-based Falls Risk Assessment and Management Plan (FRAMP) completed (State form SMR060912) (Appendix 1). The FRAMP addresses the patient's individual falls risk factors.

It is expected that the paper version of the FRAMP will be superseded by an electronic comprehensive care plan, which is currently under development by eHealth. Until otherwise advised, the FRAMP will remain paper-based for all sites and must be used to document actions taken to reduce the risk of falls in people identified at risk.

Patients and carers should be involved in discussions about falls risk. Their goals of care and input should be used to develop the care plan and risk management strategies. Information on identified falls risk and prevention strategies must be provided to patients and their carers. Use Health Care Interpreters (face-to-face or telephone) and translated resources, where available, to involve patients and carers who don't speak English as a first language.

The actions undertaken as part of the care plan must be signed and dated and the completed FRAMP placed in the bedside chart. This is documented evidence of a comprehensive assessment and management plan. The FRAMP must be reviewed and updated if there is any change to the patient's risk status or if a fall incident occurs (see 4.1.6).

4.1.3.1 Individualised multidisciplinary falls assessment

Individual disciplines are required to respond to referrals made as part of the care plan. The following clinicians may be involved in the patient's care. The roles suggested are a guide as each patient will require an individualised care plan and management strategies.

Clinician	Role/s
Dietitians	Assess nutritional status, hydration, calcium dietary intake and risk of Vitamin D deficiency. High risk groups include housebound community-dwelling people and residents of aged care facilities.
Medical Officers	Review patients with identified falls risk factors including history of falls and delirium/ altered mental status. Review clinical indication for use of antipsychotics, antidepressants, sedatives/ hypnotics and/or opioids to ensure appropriate prescribing of drugs associated with an increased risk of falls. Consider postural hypotension as a potential contributor to fall risk and put in place a management plan if identified. Consider bone health. Adults with diagnosed osteoporosis or a history of a minimal trauma fracture should be offered treatment. This can be initiated in hospital or communicated to the General Practitioner.
Nurses	Consider 1:1 supervision for patients at high risk of falling who require increased observation and/or display challenging behaviours associated with delirium, dementia, substance withdrawal or mental health conditions. Consider placement in a designated high risk observation room, where available, or when 1:1 supervision is not possible. Consider a toileting plan as part of the patient's individualised management plan
Occupational Therapists (OT)	Patients considered as being at a high risk of falls, who were admitted to hospital following a fall or who have fallen in hospital should be referred for an OT functional and home environment assessment. Recommendations for home modifications and

	prescription of equipment to maximise safety should occur as appropriate.
Optometrists, Ophthalmologists and/or Orthoptists	People with an increased risk of falling due to visual impairment who have not had an eye examination for two or more years should be referred for assessment on discharge.
Pharmacists	Consider a medication review and make recommendations to medical team about potential medication changes that will reduce falls risk, particularly if the patient is taking medications such as sedatives, anti-depressants, antipsychotics and/or centrally acting pain relief. Consider and encourage a home medicine review for eligible patients on discharge from hospital.
Physiotherapists	All patients with mobility and balance difficulties should be reviewed by a physiotherapist. The level of assistance required for transfers and mobility and any necessary equipment should be clearly documented in the clinical record. Prescription of walking aids and exercise should occur as appropriate. Patients who fall in hospital should be assessed by a physiotherapist if there is a change in level of function.

4.1.3.2 Risk Management patients who are at risk of falls under infection control isolation precautions

In recent years there has been an increasing need for patients to be in single rooms in isolation for infection control risk management. This has impacted mitigation strategies for preventing falls such as increasing visibility in high observations rooms. Donning on and off PPE equipment can also impact staff's reaction to response to patient at risk. Please refer to Flowchart to determine risk falls and transmission disease or infection and bed allocation considerations to use as a guide as part of a coordinated multidisciplinary team response to implementing a management plan for this cohort of patients, considering evidenced-based risk assessment and management strategies for both falls and infection control prevention and management . Please also refer to SESLHDPR/581 Management of Acute Viral Respiratory Illness

4.1.3.3 Restrictive Practices

Restraints are not to be used as a mechanism to prevent falls. Refer to SESLHDPR/483 - Restrictive practices with adult patients. Similarly, bed rails should not be used to keep a patient in bed against their wishes. For guidelines on the appropriate use of bed rails, refer to SESLHDPR/421 - Bedrails – Adult – for use in Acute, Subacute and Residential Care Settings.

4.1.3.4 Footwear

Correctly fitting, supportive shoes can reduce the risk of a fall in hospital. Safe footwear characteristics include: a rubber sole and adequate tread; low, wide heels with a rounded edge; firm heel cup; laces, buckles, or Velcro fastenings; wide and deep toe box; and the correct length. A Clinical Excellence Commission (CEC) One page flyer Foot Care and Footwear is available to provide patients and carers with information about appropriate footwear in hospital.

Mobilising in ill-fitting slippers, socks, or surgical stockings (without non-slip soles) should be strongly discouraged.

If appropriate footwear is not available, consideration can be given to alternatives such as the provision of non-slip socks or mobilising barefoot. The decision requires staff to use clinical judgement and take into account individual patient factors (e.g. skin integrity, dressings, patient preference, sizing, fluctuating lower limb oedema, Thrombo-Embolus Deterrent (TED) stockings and infection control) as well as resource availability.

While non-slip socks are not an evidence-based falls prevention strategy or a substitute for appropriate footwear, there are circumstances in which they may be considered.

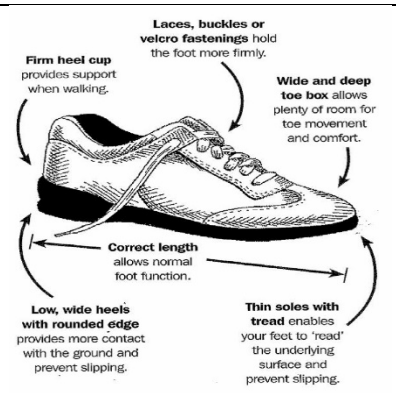
Non-slip socks are for short term use until appropriate footwear is available and should be worn when mobilising. Non-slip socks should not be worn for long periods of time without checking skin integrity as elastic can lead to pressure injuries at the malleoli.

Non-slip socks should not be supplied routinely to patients. When provided, they must be removed, changed, laundered regularly and skin integrity regularly checked.

Education should be provided to patients/ carers on appropriate footwear and management. Facilities may consider centralising the distribution of non-slip socks, including ordering via one cost centre with monitoring of their distribution.

The CEC have released a safety notice (SN 017/22) highlighting the risks of inappropriate use of non-slip socks is associated with an increased risk of pressure injuries, and may also pose an additional infection control risk.

Definitions

'Safe' Footwear[1]	
'Safe' Slippers[1]	 • firm fit • non slip soles • thin, firm sole • well supported heel
'Non-slip' socks[2]	 

	• Snug fit around the ankle • Double-sided nonslip tread • Traction tread aligned on the sole of the foot.
Clinical Judgement	The ability to make a logical, rationale decision based on knowledge, experience, and skill. This decision should be based on the ability to draw on a variety of sources of information; this includes actual observation (environment) of a patient combined with objective (screening tools) and subjective data.

Contraindications	Non-slip socks are not a substitute for appropriate footwear (when available). Inappropriate use of non-slip socks is associated with an increased risk of pressure injuries, additional infection control risks and hygiene issues. Non-slip socks are not designed to be worn with footwear or outdoors
Alerts	Patients may have additional comorbidities that must be considered before provision of non-slip socks: • Lower limb infections; wounds/surgical procedures; vascular disease/diabetes; identified risk of pressure injuries; lower limb oedema; impaired sensation; medications that increase risk of skin breakdown, and existing foot conditions. Any concern around the patient's mobility and gait must be discussed with the admitting medical team and consideration needs to be given for further gait and/or balance assessment. Referral to Physiotherapists, Podiatrist, Occupational Therapist for further assessment maybe required. Non-slip socks are for individual patient use only.
Step 1 **Patient justification**	Patient identified based on one or more of the criteria below: • Identified as being risk of a fall **and**: • Individualised risk assessment for provision, fitting and use of non-slips for relevant inpatients. • No appropriate footwear available (Refer to definition) • High risk of patient wandering and / or mobilising around the ward without footwear as a result of cognitive impairment and / or delirium. • Anti-embolism stockings (TEDS) are medically prescribed, and no appropriate footwear is available. • Oedematous feet or bandages that limit the use of appropriate footwear * Clinical judgement is to be used when considering the need for non-slip socks.
Step 2 **Sizing**	Measure the patient's feet as per the sizing with the non-slip sock to ensure that the **foot tread pattern aligns with the sole of the foot.** • A well fitted sock is recommended. • Special attention must be given to the patient ankle circumference ensuring that the non -slip socks are appropriately fitted and are not loose around ankle region, nor too tight as to cause swelling

	• Inappropriately loose fitted non-slip socks will increase the risk of the tread pattern turning around unevenly on the patient's foot resulting in the socks potentially becoming a falls hazard. • Ensure patient or carer has not applied socks incorrectly e.g. inside out, twisted • Non- slip socks are for individual patient use only
Step 3 Infection Control	Minimum of **two** pairs of non- slip socks are given to patients, to allow for washing and rotation for infection control. *Non-slip socks **must not** be put through the hospital laundering system as it may damage the tread.
Step 4 Pressure Injury Prevention	Non-slip socks must be removed at least daily to review skin integrity and for personal hygiene in line with: • SESLHDPD/326 - Pressure Injuries-screening, preventing and managing Ward staff to use clinical judgement to determine if non-slip socks need to be changed more often based on individual needs. If socks to be worn in bed, the rationale should be documented e.g. high falls risk, and mobilising without shoes/slippers at night.
Step 5 Education patient and carers	Discuss and educate patient/ family/ carer about appropriate footwear and the use of non - slip socks as an alternative option to reduce risk of falls when appropriate footwear is not available. If non-slip socks are supplied, provide the patient/ family/ carer with the SESLHD 'Non-Slip Socks – a guide for Patients and Carer's' Brochure. (This includes laundering instructions) and Clinical Excellence Commission (CEC) Foot Care and Footwear
Step 6 Documentation	Document in patient's medical record the rationale for the provision of non-slip socks and sizing. The patient's relevant Falls Risk Assessment and Management Plan (FRAMP) must be updated to reflect this additional fall management strategy and rationale for use be incorporated in the bedside clinical handover at every shift.
Step 7 Review footwear	Regular review and documentation ongoing need for non-slip socks e.g. appropriate footwear has now been supplied

4.1.3.5 Equipment

Equipment and devices should be available to implement prevention strategies for patients at risk of falling. Each unit should identify and facilitate access to the equipment and devices required for the patient population being served. Equipment may include, but is not limited to, alarm devices, lo lo beds, non-slip socks, non-slip mats, head protectors and hip protectors.

Refer to SESLHDGL/054 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatients) for recommendations and considerations for use of bed/chair alarm units. Instructional videos for correct use of alarm units are also contained within this guideline as a resource for staff.

Availability of equipment should be monitored and processes should be in place to identify equipment needs and manage faulty equipment. Refer to the Falls Prevention intranet page for SESLHD falls prevention equipment spreadsheet, which details equipment available for procurement. It includes information about purchase of various types of equipment including alarm devices, lo lo beds on State contract, the Visilert rounding device, hip protectors, head protectors, non-slip socks and non-slip mats.

Equipment should be a standing agenda item at each facility falls prevention and management/ quality committee meeting, enabling equipment issues to be raised and escalated as required.

4.1.3.6 Standardised Mobility Terminology

Consistent language is vital so all members of the healthcare team who provide patient care are aware of the level of supervision and/or assistance that a patient requires when mobilising and carrying out daily tasks. SESLHDGL/047 - Standardised mobility terminology for use across SESLHD outlines the approved terminology to describe patient transfers and mobility and the meaning of these terms.

4.1.3.7 Orthostatic Hypotension

Orthostatic hypotension, also known as postural hypotension, is a drop in blood pressure (BP) on changing positions, such as from lying to standing. Clinically significant orthostatic hypotension is defined as:

a. A drop in systolic BP of 20mmHg or more (with or without symptoms)
b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms)
c. A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP).

It is an established contributing factor to falls and is commonly found in older people[5]. Assessment of orthostatic hypotension is usually indicated for any patient presenting with a history of falls; unexplained syncope or pre-syncope; variable blood pressure control; dehydration; visual disturbances; dizziness; general weakness; fatigue; cognitive decline; leg buckling; and shoulders and neck ache[5].

Patients with orthostatic hypotension may not be identified at high risk in the OMS, therefore clinical judgement is required.

A CEC Guide detailing the recommended practice for Orthostatic Hypotension assessment as part of a falls assessment is available (Appendix 2).

Interventions to address orthostatic hypotension in hospital may include:

- Medical officer review

- Close monitoring and supervision, particularly with toileting and in the bathroom
- Adjusting medication
- Assessment and treatment of dehydration
- Provision and application of compression stockings
- All clinical staff should be aware of the patients with OH and provide education to the patient on changing positions slowly, in stages and with close supervision[5].

A CEC one page flyer is available to provide patients/ carers with information about postural hypotension.

4.1.4 Minimising injury from falls

4.1.4.1 Vitamin D supplementation

Assess those at risk of falls and injury from falls for Vitamin D deficiency. For most older adults living in residential care, it is appropriate to supplement with 1000 IU Vitamin D daily without measuring 25(OH) D blood levels.

4.1.4.2 Osteoporosis screening and management

Patients with a history of falls should be considered for a bone health assessment. Patients who sustain a minimal trauma fracture should be assessed for their risk of falls. People with diagnosed osteoporosis or a history of a minimal trauma fracture should be offered treatment for which there is evidence of benefit. This can be initiated in hospital or communicated to the General Practitioner.

Additionally, staff should consider risk factors for fracture when developing a patient's care plan. These include[6]:

- Corticosteroids - commonly used for asthma, rheumatoid arthritis and other inflammatory conditions
- Low hormone levels: in women - early menopause; in men - low testosterone
- Thyroid conditions: overactive thyroid or parathyroid
- Conditions leading to malabsorption e.g. coeliac disease, inflammatory bowel disease
- Some chronic diseases e.g. rheumatoid arthritis, chronic liver or kidney disease
- Some medicines for breast cancer, prostate cancer, epilepsy and some antidepressants
- Lifestyle factors
    - Excessive alcohol intake
    - Low levels of physical activity
    - Smoking
- Weight: thin body build and excessive weight

4.1.5 Post fall management

- Management of fall incidents must be in line with the CEC Post Fall Guide(Appendix 3) for adults and CEC Post Fall Assessment and Management Guide for All adult Patients (Appendix 4).
- Immediate response should assess need for Basic Life Support. Local Clinical Emergency Response Systems must be followed. Refer to:
  - SESLHDPR/697 – Management of the Deteriorating ADULT inpatient (excluding maternity)
  - SESLHDPR/705 – Management of the Deteriorating MATERNITY woman
- Undertake a rapid assessment to check for pain, bleeding, injury e.g. fracture
- Ask for assistance. If the patient is **safe** to be moved, help the patient back to a chair or bed using appropriate equipment and/or manual handling techniques.
  If you are unsure if the patient is safe to transferred to a bed or chair due to pain or suspected injury, complete head to toe assessment considering potential unknown/ unseen injuries and/or await medical review before moving the patient.
  Consider clinical reasoning cervical spine immobilisation following suspected injury.
- Take baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, pain). Repeat all vital signs **at least hourly for the first four (4) hours** and then four (4) hourly for 24 hours This frequency and duration of observations is the minimum and may be increased as clinically indicated.
- Neurological observations are mandatory post fall, regardless of whether the patient hit their head. Observations should be undertaken **at least hourly for first four (4) hours** and then four (4) hourly for 24 hours. Frequency and duration of neurological observations may be increased as clinically indicated
- All patients must be referred for a medical review after the incident. The Medical Officer who reviews the patient must document an assessment and management plan in eMR and as per the CEC post fall guide CEC Post Fall Guide ongoing observations and monitoring for:
  - Sepsis - CEC Adult Sepsis Pathway
  - Delirium - SESLHDPR/345 - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub-Acute Care
- Head Injury **- Intracranial bleeding can occur even in the absence of a direct injury to the head**. A number of patient factors can contribute to an increased risk of intracranial bleeding. These include: use of anti-thrombotic agents (anti-coagulants and anti-platelet agents); haematological disorders; end-stage renal failure (including dialysis patients); and liver disease. Presence of these factors should lower the threshold for CT scanning of the head.

- Head injury management should be in line with NSW Health Initial Management of Adult Mild Close Head Injury (Appendix 5)and NSW Ministry of Health Policy Directive PD2012_013 - Closed Head Injury in Adults- Initial Management.

  Strong indication for a CT scan if:
  - GCS <15 at two (2) hours post injury
  - Deterioration in GCS
  - Focal neurological deficit
  - Clinical suspicion of skull fracture
  - Vomiting (especially if recurrent)
  - The patient is on anticoagulants, anti-platelets or has a known coagulopathy or bleeding disorder, such as haematological disease or chronic renal failure
  - Age >65 years
  - Seizure
  - Prolonged loss of consciousness (>5mins)
  - Persistent post traumatic amnesia (A-WPTAS <18/18 at four (4) hours post injury)
  - Persistent abnormal alertness / behaviour / cognition
  - Persistent severe headache

  Relative indication for a CT scan if:
  - Large scalp haematoma or laceration
  - Multi-system trauma
  - Dangerous mechanism
  - Known neurosurgery / neurological impairment

- Immediate and ongoing prescription of anti-thrombotic agents following a fall should be considered on an individual basis by the treating clinical team. This is of particular relevance to those at increased risk of bleeding
- Inform the patient's family/ carer as soon as is practicable (with consent where able) of the fall incident and the strategies put in place to prevent further falls in line with SESLHDGL/058 - Open Disclosure
- A post fall management form must be completed. This is available as a standalone Ad Hoc form on eMR.
- All patients who fall in hospital must have a repeat falls risk screen using the standalone OMS Ad Hoc form. Clinical judgement should be used to override a low-risk score. The Falls Risk Assessment and Management Plan (FRAMP) **must** be completed or revised post fall incident. Currently, this document remains paper based for all sites across the district (See 4.1.3)
- Falls risk status, prevention strategies in place, inpatient fall incident and post fall management details must be included in clinical handover (See 4.1.6)
- A multidisciplinary approach should be taken to identify strategies to prevent falls and protect the patient's safety. Consider a post-fall huddle at

the patient's bedside as a mechanism to review the incident, ensure optimal post fall management and prevent further falls as per SESLHDGL/072 Post Incident Bedside Safety Huddles and Effective use of the Huddle Up Tool.

- Use the SESLHD HUDDLE UP Post incident Safety Huddle tool available on eMR.
- Record fall **in the incident management system** and document the Incident ID on the post fall management form.
- Inform the Unit Manager, in-charge or After-Hours Nurse Manager
- Injurious falls (Harm score 2) events must be reviewed using an approved SESLHD incident investigation template (Appendix 7)

4.1.6 Clinical handover

Accurate information during clinical handover is key to patient safety.

'ISBAR' framework should be followed for all clinical handovers as per SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles and the National Safety and Quality Health Service Standards (NSQHS) Standard 6 - Communicating for Safety.

Information that must be included as part of clinical handover varies depending on the point of handover but includes:

- Risk of falls
- Falls prevention strategies in place
- Inpatient fall incident details and post fall management
- Referrals requiring follow up.

Points of clinical handover include:

- Before transfer between units to assist in appropriate bed and staffing allocation
- After a patient has fallen (for immediate risk mitigation)
- When transferring temporarily to other departments (e.g. for diagnostic procedures and operating theatres) to ensure appropriate supervision is provided. This includes instructing porters/ orderlies, technical aids of the level of assistance required during transit.
- At each shift handover so that commencing staff are aware of the patient's falls risk status and staff can be allocated accordingly
- Multidisciplinary team meetings such as ward rounds, case conferences or whiteboard meetings.

4.1.7 Discharge planning and management

At a minimum, the patient and/ or their carer, GP or treating doctor and residential aged care facility (if applicable) should be informed that the patient was identified as having a high risk of falls during their hospitalisation. Discharge summaries

should also include management strategies used during admission e.g. medication review, increased observation/ supervision, assistance with mobility, etc..

Medical Officers responsible for completing the medical discharge should include details about any inpatient fall incidents and any ongoing falls risk factors, including recommendations or referrals made to appropriate services.

Nurses are responsible for completion of transfer discharge summaries, such as the Residential Aged Care Facility Transfer / Discharge Summary and to any other relevant community-based service providers.

Allied Health clinicians are responsible for completing discipline specific discharge summaries which may include the patient's falls risk status, functional status, and any referrals made to community-based service providers. These discharge summaries should be provided when the patient is being transferred to an off-site sub-acute, private hospital or residential aged care facility or discharged with a home-based rehabilitation team.

Discharge referrals to community-based service providers that may be appropriate include:

- Specialist medical practitioners such as a Geriatrician or Ophthalmologist
- Specialist clinics e.g. falls clinic, bone health clinic or aged care clinic
- Home medicines review
- Community health services
- Allied health and other health professionals e.g. physiotherapists, occupational therapists, dietitians, podiatrists, continence advisors
- Evidence-based multifactorial falls prevention such as Stepping On
- Evidence-based exercise such as Tai Chi.

4.2 PAEDIATRICS

4.2.1 Introduction

Paediatrics refers to children aged between one (1) month and 16 years.

Most falls in children are associated with normal stages of development – learning to walk, climb, run, jump and explore their physical environment – and the majority do not result in significant injury[7]. However, falls risks do exist for children in hospital and include factors related to the child's medical history, presenting condition and subsequent treatment, as well as environmental factors including cot-sides being left down and the height of the ward beds / cots[8].

4.2.2 Fall risk screening

All children admitted to SESLHD acute and sub-acute facilities must be screened for risk factors that contribute to falls using an agreed risk screening process to guide shared decision making and the development of the child's care plan.

The NSW Health Paediatric Falls Risk Assessment (Appendix 8) is currently the recommended risk screening tool for children and is available within the Electronic Medical Record (eMR):

- As part of Paediatric Admission Assessment
- As a standalone Ad Hoc form.

When	Procedure
On admission to acute or sub-acute facility	All children who are admitted will be screened for falls risk using the Paediatric Falls Risk Assessment within the first eight (8) hours of their admission through completion of the Paediatric Admission Assessment. Risk screening must be repeated using the standalone Paediatric Falls Risk Assessment Ad Hoc form on transfer to another ward/ unit.
Following a fall	All children who fall in hospital must have a repeat falls risk screen using the standalone Paediatric Falls Risk Assessment Ad Hoc form.
Change in the child's condition (Physical and/or mental)	If there is any change to the child's physical and/or mental condition (e.g. following surgery, sepsis) a repeat falls risk screen must be completed using the standalone Paediatric Falls Risk Assessment Ad Hoc form.
Every 3 days after admission	Repeat falls risk screen using the standalone Paediatric Falls Risk Assessment Ad Hoc form

Risk screening is a guide for staff and does not preclude the need for a care plan which includes individualised falls prevention strategies where other clinical

indicators identify that the child is at risk. Clinical judgment should be used to override a low risk score in these cases.

4.2.3 Guide to completion of the Paediatric Falls Risk Assessment tool[8]

- Age can be based on the chronological or developmental age of the child
- Gender
- Diagnosis:
  - Neurological (diagnosed or possible diagnosis): seizures, brain injury, hydrocephalus, cerebral palsy, spinal cord injury etc.
  - Alterations in oxygenation: any diagnosis that can result in a decrease in oxygenation. Alteration in oxygenation goes beyond respiratory diseases and may include dehydration, anaemia, anorexia, syncope, etc.
  - Psychiatric/behavioural disorders: can include mood disorders (major depression, bi-polar disorder) and impulse control disorders.
  - Other diagnoses: anything that does not come into the other categories (examples include but are not limited to cellulitis, fracture, impaired vision).
  - If the child has multiple, secondary or underlying diagnoses, the score is based on the highest acuity diagnosis.
- Cognitive Impairment:
  - Not aware of limitations: can refer to children in any age group and is dependent on ability to understand the consequences to their actions (e.g. severe head trauma, infancy)
  - Forgets limitations: can refer to children in any age group. The child has the ability to be aware of their limitations; however, due to the factors such as current presenting symptoms, medications or alteration in function, may forget their limitations
  - Oriented to ability: able to make appropriate decisions, understands consequences of actions.
- Environmental Factors:
  - History of falls: leading to admission, during current or previous admission
  - Infant / toddler placed in bed: refers to inappropriate placement of infant / toddler in a bed versus a proper placement in a cot
  - Child uses assistive devices: includes but not limited to crutches, walking frames or sticks, orthotic devices
  - Outpatient area: inpatient receiving services in an outpatient area e.g. placed on an examination table/plinth without rails
- Child has had Surgery / Sedation / Anaesthesia:
  - Score according to the length of time since the procedure / sedation.
- Medication Usage:
  - Identify children who may be at risk of falls due to medications that alter alertness or mobility or cause other side effects such as dizziness or increased need to rush to the toilet including but not limited to sedatives, hypnotic anti-epileptics, antidepressants, antipsychotics, opioids, laxatives, and diuretics

After allocating a score to each of the seven categories, the cumulative total will provide an indication to the degree at which the child is at risk of a fall.

It is important to note that a child's mobility is not included in the risk assessment tool but can influence the child's risk of falling. For this reason it is essential to consider a child's mobility when determining the level of risk:

- Ambulant Mobility: Children with impaired or limited mobility for transfers and walking are at increased risk of a fall, inclusive of those who have received sedation or general anaesthetic.
- Bed Mobility: Children with impaired or limited mobility within the bed/cot are at an increased risk of entrapment between equipment such as bed rails and mattresses due to the inability to reposition themselves. Similarly, children with uncontrolled movements (e.g. movement disorder or seizures) are at increased risk of injury and entrapment.

4.2.4 Identifying children at risk of fall-related harm

Children who score greater than or equal to 12 or where clinical judgement is used to override a lower score are considered at high falls risk. High risk status should be documented on the care plan and communicated to relevant clinical staff as a routine part of bedside clinical handover. Local procedures may vary but whiteboard alerts and electronic journey boards may also be used to flag high risk status.

Parents/carers of the child should be informed of the high falls risk. Use Health Care Interpreters (face-to-face or telephone) and translated resources, where available, to involve parents/carers who do not speak English as a first language.

4.2.5 Falls risk management

Standard care actions should be completed on admission and as a component of ongoing clinical care for all children, regardless of risk status. All children under the age of three (3) are at high risk of falls and falls prevention should be part of the routine care of these children.

Children, where appropriate, and carers should be involved in discussions about the potential risk of a fall. Goals of care and input from carers should be used to develop the care plan and risk management strategies.

Information on identified falls risk and prevention strategies must be provided to patients and their carers. Use Health Care Interpreters (face-to-face or telephone) and translated resources, where available, to involve patients and carers who don't speak English as a first language. Refer to Keeping your child safe from falling in hospital - Fact sheet.

Refer to Page 2 of the Paediatric Fall Risk Assessment for recommended care actions for all children (Appendix 8). These are also detailed below.

Care actions for all children on admission:

- Orientate child/parents/carers to room

- Educate child/parents/carers about the potential fall risk and interventions and provide information
- Educate child/parents/carers on how to use the call bell - ensure nurse call bell and light is within easy reach
- Document that a plan of care has been discussed with the child/parents/carer in clinical progress notes
- Bed/cot rails up. Assess for risk of entrapment as per Section 4.2.7
- Place child in developmentally appropriate bed with brakes on (see Paediatric Cot and Bed Allocation Guide, Appendix 9)
- Ensure child has non-slip footwear and appropriate clothing to prevent tripping

Care actions relevant for all children as a component of ongoing clinical care:

- Assess toileting needs and assist as required
- Bed heads and foot ends must be in place on all beds at as per hospital protocol
- If child mobilises with IV pole, ensure equipment is placed close to the centre of the pole, and IV lines are secure
- Ensure environment is clear of clutter and bed area is clear of trip hazards
- Curtains should be pulled back to enable full view of child, unless otherwise indicated
- Ensure adequate lighting and leave nightlight on where appropriate
- Keep room door open at all times unless specified isolation precautions are in use

Children over the age of three (3) who score ≥12 on the Paediatric Falls Risk Assessment are at high risk of a fall. Additional consideration should be given about how to best manage their risk. The care plan and management strategies must be documented in the clinical record and be included as a routine part of bedside clinical handover.

Additional considerations for high risk (score of 12 or above) children:

- At clinical handover communicate high fall risk status and interventions in place
- At a minimum check the child every hour if they are unattended
- Accompany the child when they are ambulating
- Consider moving child to a bedspace where they are more easily observed
- Assess need for 1:1 general observation
- Review medication administration times for children
- Engage child's parents/carers in falls prevention interventions

4.2.6 Post fall management

- Management of fall incidents must be in line with the CEC Post Fall Guide for Paediatrics (Appendix 8)
- Immediate response should assess need for Basic Life Support. Local Clinical Emergency Response Systems must be followed. Refer to SESLHDPR/284 - Management of the Deteriorating PAEDIATRIC Inpatient
- Take baseline vital signs - blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, blood glucose level (if indicated), pain score and neurological observations
- If there is a possibility that the child may have hit their head:
  - Perform a systematic A-G assessment
  - Continue neurological observations **hourly for 4 hours**, then as clinically indicated
- Initiate a clinical review or rapid response call as per the CEC Post Fall Guide for Paediatrics (Appendix 8). The child must be reviewed by a medical officer
- Inform the Unit Manager, in-charge or After Hours Nurse Manager
- The frequency and type of observations required on an ongoing basis will be determined by the medical officer after review
- Document the fall in child's clinical record
- Record the fall incident in the incident management system and document the Incident ID in the medical record.
- Inform parents/carers if not present at time of fall as soon as is practicable of the incident and the strategies put in place to prevent further falls in line with SESLHDGL/058 - Open Disclosure
- Provide child and parents/carers with falls prevention information
- Repeat the Paediatric Falls Risk Assessment
- Update the care plan and management strategies
- Refer to the Paediatric Cot and Bed allocation guide (Appendix 10)
- Communicate the fall incident and management as part of clinical handover
- A multidisciplinary approach should be taken to identify strategies to prevent falls and protect the child's safety. Consider a post-fall huddle at the child's bedside as a mechanism to review the incident, ensure optimal post fall management and prevent further falls. Use the SESLHD HUDDLE UP Post incident Safety Huddle tool available on eMR.
- Injurious falls (Harm score 2) events must be reviewed using an approved SESLHD incident investigation template (Appendix 6).

4.2.7 Reducing the risk of entrapment

The following information is from the CEC Paediatric Fall and Entrapment Prevention and Management Guideline. It has been reproduced here with permission from the Clinical Excellence Commission to reduce the risk of entrapment to children in hospital.

Infants and children who are unable to reposition themselves independently are at a higher risk of entrapment[8]. A child's risk of entrapment is to be assessed in

addition to their potential fall risk. Staff are required to use their clinical judgement to determine a child's risk of entrapment, in consultation with the child and their carers.

Carers should not co-sleep with their young children. Co-sleeping increases the risk of entrapment for the child and is not recommended. Refer to NSW Ministry of Health Guideline GL2021_013 – Recommended Safe Sleep Practices for Babies.

Bed rail protectors/bumpers and pillows are **not to be used in cots**.

It is recommended that beds **are not** routinely fitted with bed rail protectors/bumpers unless staff have determined the child's potential risk of injury increases in the absence of fitted bed rail protectors/bumpers. Bed rail protectors/bumpers may be used in certain circumstances, following a risk assessment, to reduce the risk of bed rail protector/bumper entrapment and/or suffocation.

A risk assessment must be completed to determine if bed rail protectors/bumpers are required for a child to reduce the potential risk from bed rail injury or entrapment. Staff must use clinical judgement to determine a child's risk based on:

- Medical condition of the child – acute and chronic/long term
- Bed Mobility of the child: Children with impaired or limited mobility within the bed/cot are at an increased risk of entrapment between equipment such as bed rails and mattresses due to the inability to reposition self. Similarly, children with uncontrolled movements (e.g. movement disorder or seizures) are at increased risk of injury and entrapment
- Age of the child
- Staffing levels and skill mix

Children who are at risk of entrapment must have a prevention management plan implemented in collaboration with the child, where appropriate, and their carers.

Information on identified entrapment risk and prevention strategies must be provided to children, where appropriate, and their carers. Use Health Care Interpreters (face-to-face or telephone) to involve children and carers who don't speak English as a first language. Refer to Keeping your child safe from bed entrapment in hospital - Fact sheet.

The management plan must be clearly documented in the child's medical record and communicated to staff through multidisciplinary handovers, bedside clinical handovers and safety huddles. Interventions to reduce a child's risk of entrapment are to be implemented in addition to any interventions required to prevent their risk of a fall.

Safe use of bed rail protectors/bumpers

If children require bed rail protectors/bumpers:

- Clearly document the requirement in the child's medical record and communicate to staff through multidisciplinary handovers, bedside clinical handovers and safety huddles.
- Place the child in a bed/room that can be closely supervised by staff
- Close and frequent observation/supervision is required
- Bed rail protectors/bumpers must be fitted according to the manufacturer's instructions.
- Only use bed rail protectors/bumpers endorsed by the manufacturer of the bed
- Pillows and/or blankets can create a risk of suffocation and should be used with caution.

The use of bed rail protectors/bumpers does not mitigate the requirement for regular observation and assessment of the child. There may be other observations recommended depending on the child's medical condition and admission purpose e.g. Neurological observations

Refer to the **Cot and Bed Allocation Guide (CaBAG)** (Appendix 9) for assistance in assessing appropriate use of bed rail protectors/bumpers. It is designed to reduce the risk of harm (falls and/or entrapment) to a child whilst in a bed or cot.

High or extreme risk of entrapment

If a child's risk of entrapment and injury from bed ends or bed rails is assessed as very high or extreme, consider placing the mattress on the floor. Placing a mattress on the floor is a potential Work Health and Safety (WHS) risk and requires a WHS risk assessment. Risks must be assessed and control measures implemented to eliminate or effectively mitigate risk so far as reasonably practicable in accordance with WHS legislation, Codes of Practice and Standards.

Post-entrapment management

In the event a child becomes entrapped, safely release and clinically assess the child for injury. In addition to this, the mechanism of the entrapment should be assessed, and interventions implemented to mitigate the risk of the entrapment recurring.

The local Clinical Emergency Response System (CERS) should be activated to ensure prompt escalation and assessment of the child following entrapment. Refer to SESLHDPR/284 - Management of Deteriorating PAEDIATRIC Inpatient. Details of the entrapment and post-entrapment management plan must be documented in the child's medical record, as well as entering the entrapment into the incident management system.

4.2.8 Resources

Refer to the CEC website for further information and resources about preventing falls and entrapment in children.

4.3 MATERNITY AND NEONATAL CARE

4.3.1 Introduction

Risk factors for falls exist for all women receiving maternity care.

Antenatal risk factors include pre-existing maternal factors such as diabetes, epilepsy, neurological conditions, antepartum haemorrhage (APH), mobility problems, developmental delay, mental health problems or visual impairment.

Postnatal risk factors include maternal fatigue and sleep deprivation, caesarean section, the effects of anaesthesia e.g. epidurals (weakness and/or lack of sensation in lower extremities), sedative and pain medications (affecting level of consciousness, balance, cognition and sleep pattern), post-partum haemorrhage (PPH), hypotension and poor footwear.

4.3.2 Identifying women at risk of fall-related harm

All women receiving maternity care should be considered at risk of falling and falls prevention should be a part of standard care for all women.

4.3.3 Standard care actions for all women receiving maternity care

- The woman and partner/support person must be informed of the risk of a fall, with specific reference to any individual risk factors and written falls prevention information provided
- Refer to the 1 page flyer CEC Falls Prevention for Maternity Services. Use Health Care Interpreters (face-to-face or telephone) and translated resources, where available, to involve women/their partner/ support person who do not speak English as a first language.
- Follow local operating procedures for the management of medical interventions e.g. epidurals
- Orientate the woman and partner/support person to the room and bathroom
- Place the call bell and other frequently used items within the woman's reach especially after an epidural, caesarean-section or PPH
- The bed should be kept at the lowest with bed brakes on and returned to appropriate height for midwifery or medical procedures as required
- Consider the use of bed rails on an individual basis and in discussion with the woman. It is recommended that the bed rails are up for women breastfeeding or settling their baby whilst in bed and/or if under the effects of anaesthesia
- If the woman has had an epidural, assess the Bromage score. The Bromage scale is used to measure motor block after epidural:
  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
  If the Bromage score is 1, 2 or 3, do not attempt ambulation.
- Instruct the woman to move slowly when changing position e.g. from lying to sitting or sitting to standing and to alert staff if feeling dizzy or unwell

- Provide instruction on how to obtain assistance when getting in/out of bed, transferring to chairs and mobilising to the toilet post-birth
- Supervise the woman when they first mobilise to the toilet/shower post-birth. Assess the need for ongoing assistance
- Orientate the woman to the shower chair and encourage use when showering
- If there are ongoing concerns about the safety of a woman moving about without assistance, where available, refer for physiotherapy or occupational therapy assessment
- Emphasise importance of rest/sleep when possible
- Encourage women to wear appropriate footwear when mobilising and discourage mobilising in bare feet, socks, surgical stockings or slippers without adequate grip.

4.3.4 Post fall management for women receiving maternity care

- Immediate response should assess need for Basic Life Support. Local Clinical Emergency Response System must be followed in the event that Basic Life Support is required. Refer to SESLHDPR/705 - Management of the Deteriorating MATERNITY Woman
- Undertake rapid assessment to check for any pain, injury, bleeding
- Ask for assistance if needed to help the woman back to a chair or bed using appropriate equipment and/or manual handling techniques
- Take baseline vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, temperature, pain score, neurological observations)
- If the woman is post birth, check fundus and blood loss
- Head injury management should be in line with NSW Health Initial Management of Adult Mild Close Head Injury (Appendix 5)and NSW Ministry of Health Policy Directive PD2012_013 - Closed Head Injury in Adults- Initial Management.
- All women must be referred for a medical review after the incident.
- Record the fall incident in the incident management system and document the Incident ID in the medical record.
- Inform the Unit Manager, in-charge or After Hours Midwifery Manager
- Once the woman has been reviewed by a Medical Officer, consider referral to the physiotherapist for assessment
- Review the falls prevention information with the woman/partner/support person and discuss the falls prevention strategies with them
- Document any appropriate falls risk management strategies in the clinical record
- Injurious falls (Harm score 2) events must be reviewed using an approved SESLHD incident investigation template (Appendix 6).

4.3.5 Resources

Refer to the CEC guidelines Key messages for Maternity Units - managing risk of falls for further information for staff regarding falls risk management in maternity units.

4.3.6 Falls prevention in neonates and Neonatal Intensive Care Units

Falls risks exist for neonates in hospitals.

Newborn falls are rare but are most frequently associated with maternal sedation and sleep deprivation, when a neonate falls out of the arms of a sleeping parent.

Women who have just given birth should be encouraged to place their baby back into the cot prior to going to sleep.

Parents/support people should be made aware of the risks of a baby slipping from the bed or chair if they fall asleep while holding their baby.

Parents/support people should also be advised never to leave their baby unattended on an adult bed or another surface from which they may fall.

Ensure adequate guidance and assistance is provided to the mother and partner/support person when moving a newborn from cot to the mother/partner/support person for feeding and cuddling.

Parents and visitors should be discouraged from walking with the baby in their arms and advised to transport newborn babies around the ward in a wheeled cot.

Parents should be guided about safety issues when changing nappies, bathing and other situations where the baby may be at risk of falling.

All babies who sustain a fall **must** receive a medical review.

Refer to the following documents for more information:

- NSW Ministry of Health Guideline GL2021_013 – Recommended Safe Sleep Practices for Babies.
- CEC: Falls prevention information for women and their families

4.3.6 Post fall management for newborns

- Management of fall incidents must be in line with the SESLHD Post Fall Guide for Newborns (Appendix 10)
- Immediate response must assess the need for Basic Life Support. Local Clinical Emergency Response System must be followed in the event that Basic Life Support is required. Refer to SESLHDPR/340 - Management of the Deteriorating NEONATAL Inpatient.
- If Basic Life Support and Code Blue activation are NOT required, activate a Neonatal Rapid response call

- Place baby on open plan and undertake a rapid assessment to check for injuries
- Complete set of observations including:
  - Level of consciousness (LOC)
  - Respiratory rate (RR)
  - Respiratory distress assessment
  - Oxygen saturation (SPO2)
  - Heart rate (HR)
  - Scalp check (head obs)
  - Temperature
  - Blood glucose level (BGL) - if indicated.
- These should be documented on the Standard Newborn Observation Chart (SNOC).
- Transfer to the Special Care Nursery (SCN) for a **minimum of four (4) hours** after rapid response review. Place on open plan with continuous cardiorespiratory monitoring
- Complete observations **hourly for the first four (4) hours and then as clinically indicated** including:
  - Level of consciousness (LOC)
  - Respiratory rate (RR)
  - Respiratory distress assessment
  - Oxygen saturation (SPO2)
  - Heart rate (HR)
  - Scalp check
  - Temperature
  - Blood Pressure (BP)
  - Blood glucose level (BGL) - if indicated
- Complete neurological observations **hourly for first four (4) hours and then as clinically indicated**. These should be documented on the modified Paediatric GCS chart
- Ongoing observations should be specified by the Paediatrician
- Consult with Admitting Medical Officer (AMO) regarding the need for imaging such as a skull x-ray, head CT or MRI
- Neurosurgical review must be arranged if any clinical or radiological abnormality is identified as a result of the imaging and/or neurological observations
- Baby must remain in the SCN for a minimum of four (4) hours. Transfer back to the post-natal ward can only occur if:
  - The neonate has been reviewed by a Paediatrician **and**
  - Observations are within normal limits **and**
  - Observations **are not** required to be carried out more frequently than standard newborn observations **and**
  - There are no signs of neurological deterioration or other injury
- If the baby's parent/s or carers are not present at the time of the fall, inform them as soon as is practicable of the fall incident and the post fall management plan in line with SESLHDGL/058 - Open Disclosure.

- If any signs of deterioration are noted, refer to SESLHDPR/340 - Management of the Deteriorating NEONATAL Inpatient and inform the AMO. Signs of deterioration include but are not limited to: decreased GCS, vomiting, seizures, high BP with low HR (Cushing response), tense fontanels, scalp swelling and irritability
- Record fall incident in the incident management system and document the Incident ID in the medical record
- Injurious falls (Harm score 2) events must be reviewed using an approved SESLHD incident investigation template (Appendix 6).

5 AUDIT

Compliance with this procedure will be audited using a standardised documentation audit at least once per year. Separate audit content will exist for adult, children and maternity groups. Consult your local Falls Prevention and Management Committee or Clinical Safety and Improvement Team for information on current audit content. The results will be reported to Facility Falls Prevention and Management Committee and to the District Steering Committee for Falls Injury Prevention in Health Facilities. The facility Clinical Safety and Improvement Team will be responsible for determining the audit schedule. If audit results demonstrate poor procedure compliance, units/ facilities may be required to complete more regular audits in a one-year period as evidence of clinical practice improvement. This will be determined by the facility Clinical Safety and Improvement Team and Falls Prevention and Management committees.

Quality Informatics are available on eMR, which allows clinicians to generate reports on the completion rates of the Ontario Modify Stratify (Sydney Scoring) falls risk screen. This can be done at a facility or ward level with specified date ranges, allowing the clinician to obtain a snapshot of the completion rate at a local level. For further information, please refer to the Quick Reference Guides: Configuring Quality Informatics and Viewing Quality Informatics.

In addition, a post fall management audit will also be carried out at each site on an annual basis and include information that requires retrospective review of patient files. The facility Falls Prevention and Management Committee and Clinical Safety and Improvement Team will be responsible for determining how best to complete this audit.

6 RESOURCES

Global Guidelines for Falls in Older Adult

World guidelines for falls prevention and management for older adults: a global initiative

Australian Commission on Safety and Quality in Healthcare:

Preventing Falls and Harm from Falls in Older People - Best Practice Guidelines for Australian Hospitals 2009
The National Safety and Quality Health Service (NSQHS) Standards
Hip fracture clinical care standard

Clinical Excellence Commission (CEC):

Falls Prevention Program
Paediatric Fall and Entrapment Prevention and Management Guideline
CEC Post Fall Guide
CEC Safety Huddle Information

NSW Ministry of Health:

PD2012_013 - Initial Management of Closed Head Injury in Adults
IB2020_041 - Paediatric Clinical Guidelines
GL2021_013 – Recommended Safe Sleep Practices for Babies
PD2020_047 - Incident Management Policy
PD2014_028 - Open Disclosure Policy
PD2017_044 - Interpreters - Standard Procedures for Working with Health Care Interpreters
Sydney Health Care Interpreter Service – covers South Eastern Sydney Local Health District

South Eastern Sydney Local Health District (SESLHD):

Falls Prevention

Falls Prevention Program Intranet site
SESLHDGL/042 - Falls Prevention and Management Guideline for Designated High Risk Observation Rooms (Adult Inpatient)
SESLHDGL/044 - Falls Prevention and Management for non-admitted patients
SESLHDGL/047 - Standardised mobility terminology for use across SESLHD
SESLHDGL/054 - Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatients)
SESLHDGL/057 - Care Champions for Falls Prevention: Key Roles and Standards

Adult Inpatients

SESLHDPR/345 - Delirium - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub-Acute Care
SESLHDPR/421 - Bedrails – Adult – for use in Acute, Subacute and Residential Care Settings
SESLHDPR/483 - Restrictive practices with adult patients
SESLHDPD/326 - Pressure Injuries - screening, preventing, and managing

SESLHDPR/581 - Management of Acute Viral Respiratory Illness(including influenza and COVID-19)

Deteriorating Patients
SESLHDPR/697 – Management of the Deteriorating ADULT Inpatient (excluding maternity)
SESLHDPR/705 - Deterioration of the MATERNITY Woman
SESLHDPR/284 - Management of the Deteriorating PAEDIATRIC Inpatient
SESLHDPR/340 - Management of the Deteriorating NEONATAL Inpatient

Communicating for Safety
SESLHDPR/303 - Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
SESLHDGL/058 - Open Disclosure

NSW Falls Prevention and Healthy Ageing Network:
Resources

Agency for Clinical Innovation (ACI):
Care of Confused Hospitalised Older Persons

7 REFERENCES

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8 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
November 2014	0	Jamie Hallen, Falls Prevention Program Coordinator
December 2014	1	Endorsed by Clinical and Quality Council
October 2016	2	Jamie Hallen, Falls Prevention Program Coordinator. Addition of post fall management and guide for newborns. Review tool approved by Julie Dixon, Executive Sponsor
June 2018	3	Sub-committee of District Steering Committee for Falls Injury Prevention in Health Facilities.
June 2018	3	Processed by Executive Services prior to submission to SESLHD Clinical and Quality Council – Major review.
July 2018	3	Endorsed by SESLHD Clinical and Quality Council
March 2021	4	Major review commenced.

April 2021	4	Draft for comment period.
May 2021	4	Feedback incorporated and final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
June 2021	4	Endorsed by SESLHD Clinical and Quality Council.
May 2023	5	Minor review: links updated, wording changes, addition of risk management for patients who are at risk of falls under infection control isolation precautions, footwear and non-slip sock information, updates to post-fall management guidance. Approved by Executive Sponsor. Formatted and published by SESLHD Policy.

Appendix 1
Falls Risk Assessment and Management Plan (FRAMP)

Appendix 2
CEC How to measure lying and standing blood pressure as part of a falls assessment

Appendix 3
CEC Post Fall Guide for Adults

Appendix 4
CEC Post Fall Assessment and Management Guide for All adult Patients

Appendix 5
Initial Management of Adult Mild Closed Head Injury

Appendix 6
SESLHD Injurious Fall Incident Investigation template (Harm score 2)

Appendix 7
Paediatric Falls Risk Assessment

Appendix 8
CEC Post Fall Management Guide for Paediatrics

Appendix 9
Paediatric Cot and Bed Allocation Guide (CaBAG)

Appendix 10 – SESLHD Post Fall Management Guide for Newborns

SESLHD POST FALL GUIDE – NEWBORNS

Newborns who fall require observation and ongoing monitoring
Staff must follow local Clinical Emergency Response Systems (CERS) and can call for a Clinical Review at any time if they are concerned about a newborn

IMMEDIATE RESPONSE

Assess the need for Basic Life Support
Danger, Responsive, Send for Help, Airway, Breathing, CPR (DRSABC). Follow Local Clinical Emergency Response System (CERS) & SESLHDPR/340

Call 2222
If BLS **required**, activate NEONATAL CODE BLUE
If BLS **not required**, activate NEONATAL RAPID RESPONSE

Rapid assessment
Undertake a rapid assessment to check for injuries

Complete Observations: Refer to Standard Newborn Observation Chart (SNOC)
Level of consciousness (LOC), Respiratory Rate (RR), Respiratory distress assessment, Oxygen saturation (SpO2), Heart rate (HR), Scalp check (head obs), Temperature, Blood glucose level (BGL)

ONGOING OBSERVATIONS & MONITORING

After Rapid response review, transfer to the Special Care Nursery (SCN)
In SCN, place on open plan with continuous cardiorespiratory monitoring

Check for Head Injury

- Complete **neurological observations hourly for first four (4) hours and then as clinically indicated**. These should be documented on the modified Paediatric GCS chart
- Consult with Admitting Medical Officer (AMO) regarding the need for imaging such as a skull x-ray, head CT or MRI
- Neurosurgical review must be arranged if any clinical or radiological abnormality is identified as a result of the imaging and/or neurological observations

Ongoing observations
LOC, RR, Respiratory distress assessment, SpO_2, HR, Scalp check, Blood Pressure (BP) & Temperature at least **hourly for a minimum of 4 hours, then as clinically indicated**

The baby must remain in SCN for a minimum of four (4) hours and until review by a Paediatrician. Ongoing observations should be specified by the Paediatrician. The baby should not be transferred back to the post natal ward if more frequent observations, above standard newborn observations, are required

Continue to monitor

- Does the neonate have observations in the Yellow or Red Zone?
- Are you concerned about this neonate or have the family/carer reported any concerns?
- If any signs of deterioration are noted follow the Local CERS and inform the AMO. Signs of deterioration include but are not limited to: *decreased GCS, vomiting, seizures, high BP with low HR (Cushing response), tense fontanels, scalp swelling & irritability*

CLINICAL REVIEW

RAPID RESPONSE

COMMUNICATE

Communicate

- If the baby's parent/s or carers are not present at the time of the fall, inform them as soon as is practicable of the fall incident and the post fall management plan in line with NSW Health PD2014_028 Open Disclosure
- Provide reassurance to the neonates parent/carer and explain all treatment and investigations
- Communicate and provide written falls prevention information to parents/carer to prevent a reoccurrence
- Implement plan of care and inform all staff involved in the neonates care
- Communicate at clinical handover

DOCUMENT

Document

- All actions taken, treatment, escalation process and outcome should be documented in the clinical record
- Record fall incident in incident management system i.e. IMS+ and document the Incident ID in the medical record.
- Harm score 2 events must be reviewed using an approved SESLHD injurious fall investigation template

Acknowledgement to SGH Women's and Children's Health, SNSWLHD and the Clinical Excellence Commission upon whose work this Guide was based