SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Falls prevention and management for people admitted to acute and sub-acute care
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/380
DATE OF PUBLICATION	March 2020
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standard: Standard 10 – Preventing Falls and Harm from Falls
REVIEW DATE	July 2021
FORMER REFERENCE(S)	Falls Prevention and Management for Older Patients in Acute and Sub-acute Care Facilities [PD 248]
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KEY TERMS	Falls, prevention, patients, falls risk screen / assessment, management plan, intervention, post fall guidelines
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 and falls injury in individuals identified at risk of falling. 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 reduce the frequency and severity of fall related injury among people admitted to acute and sub-acute care.

1. PROCEDURE STATEMENT

This procedure describes actions that South Eastern Sydney Local Health District (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:

- National Safety and Quality Health Service (NSQHS) Standards
- Preventing Falls and Harm from Falls in Older People - Best Practice Guidelines for Australian Hospitals 2009.

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

2. BACKGROUND

For the purposes of this Procedure, 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"[1]. 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).

Falls are the most commonly reported adverse event in hospitals. Fall rates of 4-12 per 1,000 occupied bed days have been described in patients aged over 65[2]. While older people are at highest risk, falls and injury from falls can occur at any age. Guidelines are required to manage all groups identified at risk, including mental health / drug and alcohol, children, women receiving maternity care and neonates. While the majority of inpatient falls are associated with minor injury, more serious events such as fractures, intracranial injury and death also occur. Even in those patients who do not sustain serious injury, length of stay is often increased and psychological effects, such as fear of falling, are commonly reported[3]. Inpatient falls therefore result in substantial morbidity and additional healthcare costs[4].

Best practice in fall and injury prevention and management requires health service organisations to establish and maintain systems for prevention of falls and harm from falls. This includes prevention strategies as part of standard care, screening and assessing patients for falls risk, and implementing targeted multifactorial falls prevention strategies that are resourced adequately, monitored and reviewed regularly[2].

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 Manager will:

- Ensure that all nursing staff are trained in the use of the recommended falls risk screen and assessment tool
- Ensure all nursing and midwifery staff are trained in implementing individual patient falls risk management strategies
- Conduct regular environmental audits and 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 facility falls committee meetings
- Identify and facilitate access to the equipment and devices required for the patient population being served
- To be aware and familiar with SESLHDGL/054 Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatients)
- Maintain an equipment log to register and record available equipment, identify equipment needs and record equipment maintenance as it occurs. Refer to Standard 10 in Management and Planning System (MAPS) or the Falls Prevention intranet page for SESLHD falls prevention equipment spreadsheet
- Investigate all patient falls in the unit in accordance with NSW Ministry of Health Policy - PD2014_004 Incident Management Policy
- Review and discuss patient falls and prescribing data with staff on a regular basis
- Consider staffing levels for patients who are confused and at high risk of falling
- Consider and refer to SESLHDGL/042 when allocating high falls risks patients to designated observation rooms
- Attend or nominate a representative to attend the facility falls committee and/or relevant quality and safety meeting as required in accordance with SESLHDGL/057 Care Champions for Falls Prevention: Key Roles and Standards which outlines the function of a ward-based 'falls champion'
- Ensure relevant information and actions arising from falls 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 Nursing Staff will:

- Complete the electronic falls risk screen within 24 hours of admission to the ward
- Complete a paper-based Falls Risk Assessment and Management Plan (FRAMP) for adults scoring at high risk on the screen (≥9) or those deemed clinically at risk
- Communicate falls risk and the risk management plan as a routine part of clinical handover
- Discuss falls risk and develop interventions in partnership with patients, families and carers. Use interpreters (face-to-face or telephone) if necessary for people of Culturally and Linguistically Diverse (CALD) backgrounds
- Provide resource material to patients and their carers on preventing falls and harm from falls. People of CALD backgrounds should be provided with translated resources, where available, in their preferred language. Refer to NSW Health Interpreters for further information and the CEC website for translated resources
- Record fall incidents in incident management system i.e. IIMS or Riskman

- Complete post fall observations and interventions as per this Procedure and in line with the CEC Post Fall Guide
- Repeat the falls risk screen and complete / review management plan post fall incident or when clinically indicated e.g. change in condition, ward move
- Report any identified hazards or equipment needs to the Nursing Unit Manager
- To be familiar with and assess their patients in accordance with SESLHDGL/054 Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatients)
- Be familiar with and assess their patients in accordance with SESLHDGL/042 Falls Prevention and Management Guideline for Designated High Risk Observation Rooms (Adult Inpatient)
- Communicate relevant information and actions arising from falls committee and/or quality and safety meetings to the unit manager
- Complete nursing discharge summary / handover for patients discharged to community nursing services or to other facilities / units including rehabilitation, residential aged care or palliative care
- Complete mandatory and other relevant training in falls risk screening, assessment and management. Refer to the three Falls Prevention Modules on My Health Learning
- Document in clinical records in accordance to SESLHDGL/047 Standardised mobility terminology for use across SESLHD.

3.3 Midwives will:

- Recognise that falls risk factors exist for all women receiving maternity care and for neonates in hospital
- Provide falls prevention information to all women receiving maternity care and discuss falls risk with regard to any individual risk factors. Provide translated resources and use interpreters (face-to-face or telephone) if necessary for people of CALD backgrounds. Refer to NSW Health Interpreters for further information and to the CEC website for translated resources
- Record fall incidents in IIMS
- Complete post fall observations and interventions as per this Procedure
- Document in clinical records in accordance with SESLHDGL/047 Standardised mobility terminology for use across SESLHD
- Report any identified hazards or equipment needs to the unit manager
- Complete any relevant training in falls prevention. Refer to the three Falls Prevention Modules on My Health Learning.

3.4 Medical Officers will:

- Review patients with identified falls risk factors including history of falls, delirium and/or altered mental status, postural hypotension and centrally acting medication use
- Investigate risk factors as appropriate
- Contribute to the multidisciplinary falls assessment and management plan in high risk adults
- 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.

3.5 Allied Health Managers will:

- Ensure that Allied Health clinicians receive training in the use of the recommended falls risk screen and assessment tool and are aware of their discipline-specific role in contributing to the multidisciplinary falls risk assessment and management plan
- Ensure relevant information and actions arising from relevant quality and safety meetings 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 - PD2014_004 Incident Management Policy
- Ensure Allied Health clinicians who assess and make recommendations around patient mobility are made aware of the documentation requirements as per SESLHDGL/047 Standardised mobility terminology for use across SESLHD.

3.6 Allied Health Clinicians will:

- Conduct discipline-specific assessment and interventions
- Document the patient's high falls risk in the clinical record as part of initial assessment where appropriate (e.g. physiotherapy and occupational therapy)
- Communicate a patient's identified high falls risk to nursing staff and as a routine part of clinical handover
- Contribute to the multidisciplinary falls assessment and management plan in high risk adults
- Be familiar with SESLHDGL/042 Falls Prevention and Management Guideline for Designated High Risk Observation Rooms (Adult Inpatient)
- Be familiar with and assess patients use in accordance with SESLHDGL/054 Falls Prevention and Management: Guideline for use of bed/chair alarm units (Adult Inpatients)
- Document in clinical records 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. Use interpreters (face-to-face or telephone) if necessary for people of CALD backgrounds. Refer to NSW Heath Interpreters for further information
- Provide resource material to patients and their carers on preventing falls and harm from falls. People of CALD backgrounds should be provided with translated resources, where available, in their preferred language. Refer to CEC website for translated resources
- Record fall incidents in incident management system i.e. IIMS or Riskman
- Contribute to the review of fall incidents at ward / department meetings and facility falls committee meetings as required
- Communicate relevant information and actions arising from falls committee and/or quality and safety meetings to the department / unit manager

- 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 in falls risk screening, assessment and management. Refer to the three Falls Prevention Modules on My Health Learning.

3.7 Care Champions for Falls Prevention will:

- 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 attend local falls committee 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
- Provide a link between the Falls Prevention and Management Committee and their service / unit.

3.8 CGU / CPIU Managers will:

- Provide SESLHD, Facility and Quality Improvement Database System (QIDS) falls data reports to District Steering Committee for Falls Injury Prevention in Health Facilities and Facility Falls Committees
- Collate information on SAC 1 and SAC 2 incidents
- 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. QARS) including compilation and distribution of audit reports
- Assist with the investigation of SAC 1 and SAC 2 fall incidents.

3.9 District Steering Committee for Falls Injury Prevention in Health Facilities will:

- Monitor the use of policies and procedures for preventing falls and harm from falls
- Develop evaluation processes for falls prevention and management policies and procedures across the organisation
- Take a collective, strategic approach to falls injury prevention in SESLHD facilities
- Monitor compliance with all relevant accreditation requirements and address issues as identified
- Be aware of policy updates and regularly review the relevant literature, ensuring the promotion of best practice and evidence-based interventions within our facilities
- As the opportunity arises, advocate for policy reform in areas which increase the risk of falls and harm from falls in health facilities.

3.10 The Falls Prevention Program Coordinator will:

- Monitor the use of policies and procedures for preventing falls and harm from falls
- 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 is to be evaluated and acted upon at a number of levels including District, Stream, Facility and Unit level.

Responsibility for reviewing falls data and implementing strategies rests with Directors of Operations / General Managers and Department Heads. This responsibility can be delegated to a member of the Facility Executive who ensures that there is regular and consistent falls data evaluation and a mechanism to ensure that recommended falls prevention strategies are implemented.

Each facility should have a falls committee or other peak Clinical and Quality Committee with representatives across the facility reviewing falls data and providing input and recommendations about prevention strategies. The Falls Committee should have a Chair of appropriate seniority and the capacity to influence meaningful clinical change within the facility. The Chair should be elected by the committee members and be supported by the Facility Executive Sponsor.

The Falls Committee should review falls data on a regular basis, and at least bimonthly. Data / Reports that should be reviewed include:

- Raw falls data
- Rate and trend of SAC 2 falls per 1,000 occupied bed days at facility level
- Rate and trend of falls per 1,000 occupied bed days at a facility and unit level
- Outcomes of SAC 1 Root Cause Analyses and SAC 2 reviews and associated recommendations, with a view to broader implementation of recommendations across the facility as required
- Trends of antipsychotic and sedative dispensing
- Trends of Vitamin D dispensing or prescription in adults
- Annual audit evaluating compliance with Standard 10 and this Procedure.

The Facility Falls Committee should report outcomes of discussions with recommendations for action to the facility-based Clinical Quality Council, to the District Steering Committee for Falls Injury Prevention in Health Facilities and to the appropriate wards / units. The District Steering Committee will report to the District Clinical and Quality Council as issues for escalation arise and on a regular basis.

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[5]. There are separate procedures (outlined below) for adults, children and women receiving maternity care.

4.1 ADULTS

4.1.1 Use of a best practice screening tool

All adults admitted to SESLHD acute and sub-acute facilities (excluding women receiving maternity care) will be screened for falls risk using the Ontario Modified Stratify (OMS) falls risk screen[6]. This is currently available as part of the Electronic Medical Record (eMR2):

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

Women receiving maternity care are considered a special at-risk group. See 4.3 for the procedure in Maternity Units.

Please note: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge an inpatient to be clinically at risk of a fall, this always overrides an individual risk score. A comprehensive assessment and management plan is required in these cases (see 4.1.4).

4.1.2 Falls risk screening is conducted on all adults admitted to a SESLHD acute or sub-acute unit

When	Procedure
Emergency Department	All people who present to the Emergency Department and are **admitted to** hospital must be screened for risk of falls within 24 hours of admission. If an admitted person is identified to be at high risk of falls in the Emergency Department, 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 Emergency Department and are for discharge from the Emergency department, 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 falls risk through completion of the Adult Admission Assessment (AAA) within the first 24 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.
Change in the patient's condition (Physical and/or Mental)	A repeat falls risk screen using the standalone OMS Ad Hoc form must be completed if there is any change to the patient's physical and/or mental* condition. Additional considerations in mental health include: • Electroconvulsive therapy (ECT) • Acute mania or psychosis • The influence of drugs and alcohol • Withdrawal from drugs and alcohol • Depression impairing ability to concentrate or comprehend instructions • Side effects of new medication (including postural hypotension). ** Altered mental status (including confusion, disorientation and agitation) is a risk factor for 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.*
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.

Standard care actions apply to all patients regardless of risk status.

The falls risk screen is a guide for staff and a score of less than 9 does not preclude the need for a comprehensive management plan where other clinical indicators identify that the patient is at risk.

Clinical judgment can override a low risk individual score. On eMR2, 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 Ontario Modified Stratify standalone Ad Hoc form.

It is important to note that this action will not generate a high falls risk alert under 'alerts view' or generate automatic referrals, e.g. to Physiotherapy. These tasks will need to be done manually.

4.1.3 Identifying high risk patients

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 should also be included as part of clinical handover and flagged via the electronic journey board.

4.1.4 Falls risk assessment and 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 Falls Risk Assessment and Management Plan (FRAMP) completed (State form SMR060912). The FRAMP addresses the patient's individual falls risk factors. Refer to Appendix 1 for a copy of the FRAMP.

If a patient scores three (3) or more in the Mobility and Transfer section on the AAA, an automatic referral is made to Physiotherapy. Clinicians should avoid reliance on automatic referrals and should demonstrate clinical reasoning in making separate referrals to Physiotherapy.

It is anticipated that the paper version of the FRAMP will be replaced by an electronic comprehensive care plan. Until otherwise advised, the FRAMP will remain paper-based for all sites.

Patients and carers should be involved in discussions about falls risk and the advice from carers acknowledged and used to develop the patient's management plan. Information on identified falls risk and prevention strategies must be provided to patients and their carers in a format that is understood and meaningful. Use Health Care Interpreters (face-to-face or telephone) and translated resources, if available, to involve patients / carers from a CALD background.

The actions undertaken as part of the management plan must be signed and dated and the completed FRAMP should be placed in the bedside chart. This is documented evidence of a comprehensive assessment and management plan. Duplication of the actions taken in the progress notes of the clinical record is not required. 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).

4.1.4.1 Individualised multidisciplinary falls assessment

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

Clinician	Role/s
Dietitian	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.
Nursing	Consider 1:1 supervision for patients at high risk of falling who require increased observation and/or display challenging behaviours associated with delirium, dementia, drug and alcohol withdrawal or mental health conditions.
Occupational Therapist (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.

Optometrist / Ophthalmologist	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.
Pharmacist	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.
Physiotherapist	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 (re-)assessed by a physiotherapist if there is a change in level of function.
Podiatrist	Where available, refer high risk patients to a podiatrist for inpatient assessment of foot problems and footwear or consider referral as part of discharge planning.

4.1.4.2 Restraints

Restraints are not to be used as a mechanism to prevent falls. Refer to SESLHDPR/483 Restraint use 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 Bed rails - Adult Inpatient use

4.1.4.3 Footwear

Correctly fitting, supportive shoes can reduce the risk of a fall in hospital. Safe footwear characteristics include: thin soles with 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 one page flyer 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 should 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. wounds, dressings, patient preference) as well as resource availability.

4.1.4.4 Equipment

Equipment and devices should be available to implement prevention strategies for patients at risk of falling[2]. Each unit should identify and facilitate access to the equipment and devices required for the patient population being served[2]. Equipment may include, but is not limited to, alarm devices, lo lo beds, non-slip socks 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 is also contained within this guideline as a resource for staff.

A falls equipment log should be kept at unit level. A SESLHD equipment log template and procurement list is available and can be accessed via Standard 10 in Management and Planning System (MAPS), Falls Prevention intranet page or through the facility falls committee Chair. A hazard register and a suggested environmental audit are included in the log to ensure the safety of the ward environment is regularly reviewed. Equipment should be a standing agenda item at each facility falls / quality committee meeting, enabling equipment issues to be raised and escalated as required.

4.1.4.5 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. Clinicians and managers involved in patient care are expected to adhere to this guideline.

4.1.4.6 Orthostatic Hypotension

Orthostatic hypotension (OH) is a drop in blood pressure on changing positions such as from lying to standing. Clinically significant OH 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 [7]. Assessment of OH 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.[7]
Patients with OH may not be identified at high risk in the OMS, therefore clinical judgement is critical in the care and management of patients with OH.

Please refer to Appendix 2 for a copy of the CEC Guide detailing the recommended practice for *Orthostatic Hypotension assessment* as part of a falls assessment.

Interventions to address OH in hospital may include:

- Medical Officer review
- Close monitoring and supervision, particularly in the shower
- Adjusting medication
- Assessment and treatment of dehydration
- Provision and application of compression stocking
- 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.[7]

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

4.1.5 Minimising injury from falls

4.1.5.1 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 without measuring 25(OH) D blood levels.

4.1.5.2 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.

4.1.6 Post fall management

- Management of fall incidents must be in line with the Clinical Excellence Commission Post Fall Guide. Refer to Appendix 3 for a copy of the guide
- Immediate response must assess the need for Basic Life Support. SESLHDPR/283 Patient with Acute Condition for Escalation (PACE): Management of Deteriorating ADULT and MATERNITY Inpatient and protocols must be followed
- Undertake a rapid assessment to check for pain, bleeding, injury, possible fracture
- Ask for assistance. If the patient is able to be moved, help the patient back to a chair or bed using appropriate manual handling techniques
- 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 **or** 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 **or** 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 the medical record
- Check for sepsis, delirium and head injury as per the Clinical Excellence Commission Post Fall Guide. Refer to Appendix 3 for a copy of the guide
- **Intracranial bleeding can occur even in the absence of a direct injury to the head**. A number of patient level 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 Ministry of Health Policy - PD2012_013 Initial Management of Closed Head Injury in Adults. Refer to Appendix 4 for a copy of the relevant algorithm.

  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 / carers 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 and NSW Ministry of Health Policy - PD2014_028 Open Disclosure Policy
- Documentation must be completed for all post fall management. This form is available as a standalone Ad Hoc form on eMR2 and replaces the orange post fall sticker
- All patients who fall in hospital must have a repeat falls risk screen using the standalone OMS Ad Hoc form
- Falls risk alerts will be automatically generated for patients who score greater than or equal to nine (9) in the 'alerts view' tab, as outlined in 4.1.3. These alerts must be manually added when clinical judgement is 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 4.1.4)
- Falls risk status, prevention strategies in place, inpatient fall incident and post fall management details must be included in clinical handover. (See 4.1.7)
- A multidisciplinary approach should be taken to identify strategies to prevent falls and protect the patient's safety. Consider a MDT post-fall huddle at the patient's bedside as a mechanism to review the incident, ensure optimal post fall management and prevent further falls. Refer to CEC Post Fall Huddle Information
- Record fall incident in incident management system i.e. IIMS or Riskman and document the Incident ID in the medical record. If using IIMS, all fall incidents should be allocated a minimum SAC 3 rating. Refer to Appendix 5 for a copy of the Memo on Severity Assessment Code ratings in SESLHD Falls Incidents
- Inform the Unit Manager, in-charge or After Hours Nurse Manager
- SAC 2 events must be reviewed using the approved SESLHD SAC 2 review template. Refer to Appendix 6 for a copy of the template.

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

- Current falls risk status
- 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 / technical aids of the level of assistance required during transit
- At 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.

4.1.8 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 falls risk during their hospitalisation. Discharge summaries should also include management strategies used during admission e.g. medication review, use of designated high risk observation room, etc.

Medical Officers are responsible for completing the medical discharge / GP summary to detail any inpatient fall incidents and any ongoing falls risk factors, including recommendations or referrals made to appropriate services.

Nursing staff 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 staff are responsible for completing discharge summaries which includes the patient's falls risk status, details of any inpatient falls, falls prevention management strategies and any referrals made to community based service providers (as appropriate). These discharge summaries should be provided when the patient is being transferred to a sub-acute or residential aged care facility.

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, osteoporosis 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[8]. 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[9].

4.2.2 Use of a best practice screening tool

Screening for falls risk in children will be undertaken using the NSW Health Paediatric Falls Risk Assessment. This is currently available as part of the Electronic Medical Record (eMR2):

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

4.2.3 Falls risk screening is conducted on all children admitted to an acute or sub-acute unit

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 24 hours of their admission through completion of the Paediatric Admission Assessment.
Following a fall	All children who fall in hospital must have a repeat falls risk screen using the standalone Ad Hoc form.
Change in the child's condition (Physical and/or mental)	A repeat falls risk assessment must be completed using the standalone Ad Hoc form if there is any change to the child's physical and/or mental condition e.g. post-operative.

4.2.4 Guide to completion of the Paediatric Falls Risk Assessment tool[9]

- Age can be based on the chronological or developmental age of the child
- Gender
- Diagnosis:

- If the child has multiple, secondary or underlying diagnoses, the score is based on the highest acuity diagnosis. For example, a child with sickle cell anaemia and a history of seizures would receive the highest score of four (4) for a neurological 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: related to admission, during current admission or previous admission
  - Infant / toddler placed in bed refers to inappropriate placement of infant / toddler in a bed versus a proper placement in a crib or cot
  - Child uses assistive devices: includes but not limited to crutches, walking frames or sticks, orthotic devices
  - Infant / toddler in crib: appropriate crib / cot placement
  - Child placed in bed: appropriate bed placement
  - Outpatient area: inpatient receiving services in an outpatient area.
- Child has had Surgery / Sedation / Anaesthesia:
  - If the child has had surgery / sedation / anaesthesia, score according to the length of time since the procedure / sedation.
- Medication Usage:
  - The purpose of this section is to identify children who may be at risk of falls due to medications that alter alertness or cause other side effects such as dizziness or increased need to rush to the toilet.

4.2.5 Identifying children at high risk

Children who score greater than or equal to 12 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 may also be used to flag high risk status. Electronic journey boards should reflect the patient's high falls 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, if available, to involve parents / carers from a CALD background.

4.2.6 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 over the age of three (3) who score ≥12 are at high risk. Additional consideration should be given about how to best manage their risk. The management plan should be documented in the clinical record and be included as a routine part of bedside clinical handover.

Parents and carers should be given written information on falls risk and how to help prevent falls in hospital. Refer to Falls prevention for children in hospital: Information for parents and carers. They should be engaged and involved, where possible, in the management plan, as well as informed of any strategies in place. Use Health Care Interpreters (face-to-face or telephone) and translated resources, if available, to provide information to carers / families from CALD backgrounds.

4.2.7 Post fall management

- Management of fall incidents must be in line with the Clinical Excellence Commission Post Fall Guide- Paediatrics. Refer to Appendix 7 for a copy of the guide
- Assess the child and provide immediate care. Local Clinical Emergency Response System and protocols should be followed
- Notify the child's medical team for review
- Inform the Unit Manager, in-charge or After Hours Nurse Manager
- Take baseline vital signs- Blood Pressure, Heart Rate, Respiratory Rate, oxygen saturation, temperature, blood glucose level (if indicated), pain score and neurological observations
- 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 IIMS and document the Incident ID in the medical record. All fall incidents should be allocated a minimum SAC 3 rating. Refer to Appendix 5 for a copy of the Memo on Severity Assessment Code ratings in SESLHD Falls Incidents
- 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 in line with SESLHDGL/058 Open Disclosure and NSW Ministry of Health Policy - PD2014_028 Open Disclosure Policy
- Repeat the Paediatric Falls Risk Assessment and update the care plan
- Communicate the fall incident and post fall management during bedside clinical handover
- SAC 2 events must be reviewed using the approved SESLHD SAC 2 review template. Refer to Appendix 6 for a copy of the template.

4.2.8 Resources

Refer to the Clinical Excellence Commission website for further information and resources about preventing falls 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 falls 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

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, Clinical Excellence Commission Falls Prevention for Maternity Services. Use Health Care Interpreters (face-to-face or telephone) and translated resources, if available, to involve women / partners from a CALD background.
- Follow local operating procedures for the management of medical interventions e.g. epidurals
- Orientate the woman and partner / family 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. SESLHDPR/283 Patient with Acute Condition for Escalation (PACE): Management of Deteriorating ADULT and MATERNITY Inpatient and protocols should be followed
- 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 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 Ministry of Health Policy - PD2012_013 Closed Head Injury in Adults - Initial Management. Refer to Appendix 4 for a copy of the relevant algorithm
- All women must be referred for a medical review after the incident
- Record the fall incident in IIMS and document the Incident ID in the medical record. All fall incidents should be allocated a minimum SAC 3 rating. Refer to Appendix 5 for a copy of the Memo on Severity Assessment Code ratings in SESLHD Falls Incidents
- SAC 2 events must be reviewed using the approved SESLHD SAC 2 review template. Refer to Appendix 6 for a copy of the template
- 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.

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 often associated with maternal sedation and sleep deprivation and many falls occur 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.

New parents should be made aware of the risks of a baby slipping from the maternal bed or chair if they fall asleep while holding their baby.

New parents 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 new 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.

New parents should be guided about safety issues when changing nappies, bathing and other potential falls risk situations.

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

Refer to the following documents for more information:
NSW Ministry of Health Policy - PD2012_062 Maternity - Safer Sleeping Practices for Babies in NSW Public Health Organisations

Clinical Excellence Commission Falls prevention information for women and their families

4.3.7 Post fall management for newborns

- Refer to Appendix 8 for a copy of the post fall guide for newborns
- 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

- If Basic Life Support and Code Blue activation are not required, activate a Neonatal PACE TIER 2 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 Tier 2 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)
  - Blood Pressure (BP)
  - Temperature
  - Scalp check.
- 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 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

  - 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 NSW Ministry of Health Policy - PD2014_028 Open Disclosure Policy
- If any signs of deterioration are noted as per SESLHDPR/340 Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating NEONATAL Inpatient in Maternity Services and nurseries, follow SESLHDPR/283 Patient with Acute Condition for Escalation (PACE): Management of Deteriorating ADULT and MATERNITY 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 incident management system i.e. IIMS and document the Incident ID in the medical record. All fall incidents should be allocated a minimum SAC 3 rating
- SAC 2 fall events must be reviewed using the approved SESLHD SAC 2 review template. Refer to Appendix 6 for a copy of the template.

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 Committee or CPIU for information on current audit content. The results will be reported to Facility Falls Committee and to the District Steering Committee for Falls Injury Prevention in Health Facilities. The facility CPIU's 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 CPIU's and falls committees.

Quality Informatics are available on eMR2, which allows clinicians to generate reports on the completion rates of the Ontario Modify Stratify. 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 Committee Chairs and CPIU's will be responsible for determining how best to complete this audit.

6. RESOURCES

NSW Ministry of Health

NSW Ministry of Health Policy - PD2012_013 Initial Management of Closed Head Injury in Adults

NSW Ministry of Health Policy - PD2011_024 Children and Infants - Acute Management of Head Injury
NSW Ministry of Health Policy - PD2012_013 Closed Head Injury in Adults - Initial Management
NSW Ministry of Health Policy - PD2014_028 Open Disclosure Policy
NSW Ministry of Health Policy - PD2014_004 Incident Management Policy
NSW Ministry of Health Policy - PD2017_044 Interpreters - Standard Procedures for Working with Health Care Interpreters
NSW Ministry of Health Policy - PD2012_062 Maternity - Safer Sleeping Practices for Babies in NSW Public Health Organisations
NSW Heath Interpreters

South Eastern Sydney Local Health District (SESLHD)
Falls Prevention Program Intranet site
SESLHDPR/421 Bed rails - Adult Inpatient use
SESLHDPR/483 Restraint use with adult patients
SESLHDPR/345 Delirium - Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub-Acute Care
SESLHDPR/283 Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating ADULT and MATERNITY Inpatient
SESLHDPR/284 Clinical Emergency Response System (CERS) for Paediatric Inpatients: Management of the Deteriorating PAEDIATRIC Inpatient
SESLHDPR/303 Clinical Handover: Implementation of ISBAR Framework and Key Standard Principles
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
SESLHDGL/058 Open Disclosure
SESLHDPR/340 Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating NEONATAL Inpatient in Maternity Services

Clinical Excellence Commission (CEC)
Falls Prevention Program
CEC Post Fall Guide
CEC Post Fall Huddle Information

Australian Commission on Safety and Quality in Healthcare
Preventing Falls and Harm from Falls in Older People - Best Practice Guidelines for Australian Hospitals 2009
Standard 10 - Preventing Falls and Harm from Falls
Standard 6 Clinical Handover
Hip fracture clinical care standard

NSW Falls Prevention Network
Resources

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

7. REFERENCES

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3. Oliver D, Healey F, Haines, TP. Preventing falls and fall-related injuries in hospitals. Clin Geriatr Med 26 (2010) 645–692
4. Cameron ID, Gillespie LD, Robertson MC, Murray GR, Hill KD, Cumming RG, Kerse N. Interventions for preventing falls in older people in care facilities and hospitals. *Cochrane Database of Systematic Reviews* 2012, Issue 12, Art. No.: CD005465.
5. Australian Commission on Safety and Quality in Health Care. Preventing Falls and Harm from falls in Older People: Best Practice Guidelines for Australian Hospitals. 2009
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7. O'Riordan S, Vasilakis N, Hussain L et al (2017) Measurement of lying and standing blood pressure in hospital. Nursing Older People. 29, 8, 20-26.
8. World Health Organisation. World report on child injury prevention [Internet]. 2008 cited March 2018. Available from http://www.who.int/violence_injury_prevention/child/injury/world_report/Falls_english.pdf
9. The Sydney Children's Hospital Network. Falls Prevention Policy (Policy No: 1/C/14:9062-01:00) [Internet]. cited March 2018. Available from http://www.schn.health.nsw.gov.au/_policies/pdf/2014-9062.pdf

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 2020	4	Update to Executive Sponsor. Published by Executive Services.

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 Management Guide for Adults

Appendix 4 – Initial Management of Adult Mild Closed Head Injury

Appendix 5 – Memo: Severity Assessment Code Rating for SESLHD Falls Incidents

Appendix 6 – SESLHD SAC 2 Review Template

Appendix 7 – CEC Post Fall Guide for Paediatric Patients

Appendix 8 – SESLHD Post Fall Guide for Newborns

Appendix 5 – Memo: Severity Assessment Code Rating for SESLHD Falls Incidents

Health
South Eastern Sydney
Local Health District

memo

Planning and Population Health

T13/43485

TO:	Cath Whitehurst; Director of Operations, St George/Sutherland Hospitals Jon Roberts; Director of Operations, Prince of Wales & Sydney/Sydney Eye Hospitals Leisa Rathborne, Director of Operations, Royal Hospital for Women Murray Wright, Director Mental Health Gerard Hyde; Executive Manager | War Memorial Hospital
CC:	George Rubin, Director Clinical Governance; Luckman Hlambelo, Clinical Governance, Calvary Hospital
FROM:	Julie Dixon, Director Planning and Population Health Chair, District Steering Committee for Falls Injury Prevention in Health Facilities
DATE:	26 November 2013
SUBJECT:	Severity Assessment Codes (SAC) for Falls Incidents

It has been identified that there is inaccurate and inconsistent reporting of the Severity Assessment Code (SAC) score for Falls Incidents across SESLHD facilities.

When applying a SAC score using the matrix generated in the IIMs system (see attached link), it is important to consider the ***consequence*** in the first instance. The minimum consequence for all falls incidents is **minor** because every fall requires a review and evaluation i.e. a repeat falls risk assessment. The next step is to consider the ***likelihood*** of a fall occurring in the area the fall has occurred. It is **possible** that a fall could occur in any area. Based on this, the minimum SAC rating for all Falls Incidents should be classified as a 3.

To ensure consistent reporting across the SESLHD, please disseminate this information to all staff.

For further information on the Severity Assessment Code:
http://www0.health.nsw.gov.au/pubs/2005/pdf/sac_matrix.pdf

Thanks,

Julie Dixon

South Eastern Sydney Local Health District

Appendix 8 – SESLHD Post Fall 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 (Activate Code Blue –dial 777), Airway, Breathing, CPR (DRSABC)
Follow Local Clinical Emergency Response System (CERS) & SESLHDPR/340

If BLS is not required, activate a PACE TIER 2 call

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 TIER 2 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. IIMS and document the Incident ID in the medical record. All fall incidents should be allocated a minimum SAC 3 rating
- SAC 2 events must be reviewed using the approved SESLHD SAC 2 review template

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