**Falls prevention and management for people admitted to acute and sub-acute care**

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<th><strong>NAME OF DOCUMENT</strong></th>
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<td>Directorate of Planning, Population Health and Equity</td>
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<tr>
<td><strong>KEY TERMS</strong></td>
<td>Falls, prevention, patients, falls risk screen/assessment, management plan, intervention, post fall guidelines</td>
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<td><strong>SUMMARY</strong></td>
<td>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 South Eastern Sydney Local Health District (SESLHD). It details recommendations for all adults, children and women receiving maternity care and is no longer limited to those aged over 65. 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.</td>
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**COMPLIANCE WITH THIS DOCUMENT IS MANDATORY**

Feedback about this document can be sent to SESLHD-ExecutiveServices@health.nsw.gov.au
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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) Standard 10 - Preventing Falls and Harm from Falls
- 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 which 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.

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 65². While older people are at highest risk, falls and injury from falls can occur at any age. Guidelines are needed 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 reported³. Inpatient falls therefore result in substantial morbidity and additional healthcare costs.

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 regularly².

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
- NSW Policy Directive PD2011_029
- National Safety and Quality Health Service (NSQHS) Standard 10 - Preventing Falls and Harm from Falls
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
- Ensure that the falls risk alert sticker is available for use
- 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
- Maintain an equipment log to register and record available equipment, identify equipment needs and record equipment maintenance as it occurs
- Investigate all patient falls in the unit in accordance with NSW 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
- Attend or nominate a representative to attend the facility falls committee and/or relevant quality and safety meeting as required
- Ensure relevant information and actions arising from falls committee and/or quality and safety meetings is communicated to staff on a regular basis

3.2 **Nursing staff will:**
- Complete the relevant falls risk screen within 24 hours of admission to the ward
- Identify high falls risk status by placing a falls risk alert sticker on the Care Plan. For paperless units that document the patient episode of care electronically, falls risk should be flagged through eMR or via the electronic journey board
- Complete a 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
- 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
• 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 Nursing 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

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
• Record fall incidents in IIMS
• Complete post fall observations and interventions as per this Procedure
• Report any identified hazards or equipment needs to the Unit Manager
• Complete any relevant training in falls prevention

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
• 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 staff 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
3.6 **Allied Health clinicians will:**
- Conduct discipline-specific assessment and interventions
- Document high falls risk in clinical record as part of initial assessment where appropriate (e.g. physiotherapy and occupational therapy)
- Communicate 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
- 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
- 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
- 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
- Consider referral to appropriate services on discharge. Communicate any referrals made to the medical team for inclusion in the discharge summary
- 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
- 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

3.7 **CGU/CPIU Managers will:**
- Provide SESLHD and facility falls data to District Steering Committee for Falls Injury Prevention in Health Facilities and facility falls committees
- Assist with the analysis and interpretation of patient falls data
- Monitor Procedure compliance through assisting with the audit process, including compilation and distribution of audit reports
- Assist with the investigation of SAC1 and SAC 2 fall incidents
- Monitor the implementation of the NSW Health PD 2011_029

3.8 **The 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

3.9 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 policies and procedures across SESLHD
• Support the implementation of this Procedure across SESLHD and undertake periodic review to ensure it reflects best practice recommendations

3.10 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 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 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. 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 (Sydney Scoring) falls risk screen. This is currently included on the Admission and Discharge Risk Assessment Tool (ADRAT - District Form Ref No: S0142SES) or separately as State Form SMR060911. The completed screen should be placed in the bedside chart. Refer to Appendix 1 for a copy of the risk screen.

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

It is anticipated that the screening tool will also be available through eMR in 2015. Use of the electronic version of the screening tool, when available, should occur in line with broader unit/facility implementation of the electronic medical record for documentation purposes.

**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**

<table>
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<tr>
<th>When</th>
<th>Procedure</th>
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</table>
| Emergency Department   | People over the age of 65 who present to the Emergency Department and are not admitted to hospital are screened for future falls risk using a screening tool approved by the District Steering Committee for Falls Injury Prevention in Health Facilities  
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 |
On admission to acute, sub-acute or rehabilitation services

<table>
<thead>
<tr>
<th>On admission to acute, sub-acute or rehabilitation services</th>
<th>All adults who are admitted to hospital will be screened for falls risk using the Ontario Modified Stratify (Sydney Scoring) within the first 24 hours of their admission to a ward. Risk assessment must be repeated when transferring the patient to another ward/unit</th>
</tr>
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</table>

Following a fall

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<tr>
<th>Following a fall</th>
<th>All patients who fall in hospital must have a repeat falls risk screen</th>
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Change in the patient’s condition (Physical and/or Mental)

| Change in the patient’s condition (Physical and/or Mental) | A repeat falls risk screen 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

<table>
<thead>
<tr>
<th>Post-operative patients</th>
<th>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</th>
</tr>
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</table>

Standard care actions apply to all patients regardless of risk status. These are outlined on Page 2 of the Ontario Modified Stratify (Sydney Scoring) screening tool (see Appendix 1).
4.1.3 Identifying high risk patients
High risk status must be documented in the medical record and communicated to relevant clinical staff as a routine part of clinical handover. An orange fall risk sticker (Stream Solutions stock code number NH600955) should be placed on the front of the Nursing Care Plan.

Local procedures may vary but high falls risk status should be noted on the electronic journey board if in use and can also be flagged via falls risk signs or magnet alerts on whiteboards.

For paperless units that document the patient episode of care electronically, such as SESLHD Mental Health units, use of the falls risk sticker may not be appropriate. In this case, falls risk should be flagged to staff through eMR or via the electronic journey board.

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 provide information to high risk patients (and carers/families) from CALD backgrounds.

4.1.4 Falls risk assessment and management
All adults who score greater than or equal to 9 (i.e. at high risk of falls) on the Ontario Modified Stratify (Sydney Scoring) falls risk screen 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 2 for a copy of the FRAMP.

It is expected that the FRAMP will not be made available through eMR in its current format. Cessation of the paper-based FRAMP and electronic documentation of a falls risk assessment and management plan should occur in line with broader unit/facility implementation of the electronic medical record.

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 judgement always overrules an individual score.

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. Use Health Care Interpreters (face to face or telephone) 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.

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Role/s</th>
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<tbody>
<tr>
<td>Dietitian</td>
<td>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</td>
</tr>
<tr>
<td>Medical officers</td>
<td>Review patients with identified falls risk factors including history of falls and delirium/altered mental status</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Consider postural hypotension as a potential contributor to fall risk and put in place a management plan if identified</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td>Nursing</td>
<td>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</td>
</tr>
<tr>
<td>Occupational Therapist (OT)</td>
<td>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</td>
</tr>
<tr>
<td>Optometrist/Ophthalmologist</td>
<td>People with an increased risk of falling due to visual impairment who have not had an eye examination for two years</td>
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</table>
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, antidepressants, 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 1 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, hi lo beds, non-slip socks, protective headwear and hip protectors.

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 the intranet 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.

### 4.1.5 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)
- Immediate response must assess the need for Basic Life Support. [Local Clinical Emergency Response System](#) 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, blood sugar level, and pain score). Repeat **hourly for 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 **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.

**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.

Refer to NSW Health PD2012_013: Initial management of closed head injury in adults. Algorithm 2: Initial management of adult mild closed head injury (Click [here](#) to view the algorithm or refer to Appendix 4).

**Strong indication for a CT scan if:**
- GCS <15 at 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 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 NSW Health PD2014_028 Open Disclosure

• A SESLHD post fall management sticker must be completed and placed in the clinical record. This is also available as an Ad Hoc form in eMR for paperless units

• Repeat the fall risk screen using the Ontario Modified Stratify (Sydney Scoring) tool (see Appendix 1)

• Document the risk status in the health care record, flagging high falls risk with an orange alert sticker, as outlined in 4.1.3

• The Falls Risk Assessment and Management Plan (FRAMP) must be completed or revised post fall incident. 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.

• 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: Memo on Severity Assessment Code ratings in SESLHD Falls Incidents

• Inform the Nursing Unit Manager 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.

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
- 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.

Communicate inpatient fall incidents and any ongoing falls risk factors to the patient’s GP and refer to appropriate services.

Discharge referrals 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 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. 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.

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 (State form SMR060020). Refer to Appendix 7 for a copy of the risk assessment.

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

<table>
<thead>
<tr>
<th>When</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission to acute or sub-acute facility</td>
<td>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</td>
</tr>
<tr>
<td>Following a fall</td>
<td>All children who fall in hospital must have a repeat falls risk screen</td>
</tr>
<tr>
<td>Change in the child’s condition (Physical and/or mental)</td>
<td>A repeat falls risk assessment must be completed if there is any change to the child’s physical and/or mental condition e.g. post-operative</td>
</tr>
</tbody>
</table>

4.2.4 Guide to completion of the Paediatric Falls Risk Assessment tool

- 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.

Parents/carers of the child should be informed of the high falls risk. Use interpreters (face to face or telephone) if necessary for people of CALD backgrounds.

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. See page 2 of the Paediatric Falls Risk Assessment (see Appendix 7) for Care Actions on Admission
and Routine Care. On admission, completed actions on should be signed and the date/time noted.

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. Refer to Page 2 Paediatric Falls Risk Assessment for suggested strategies to manage children at high risk of a fall. 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 (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

- 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
- Notify the Nursing Unit Manager in charge
- Take baseline vital signs, including neurological observations
- The frequency and type of observations required on an ongoing basis will be determined by the medical officer after review. However, if the child hit their head, neurological observations are mandatory hourly for four (4) hours post fall and then as clinically indicated
- 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: 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 PD2014_028 Open Disclosure
- Repeat the Paediatric Falls Risk Assessment and update the management plan
- Communicate the fall incident and post fall management during bedside clinical handover

4.2.8 Resources

Refer to the Clinical Excellence Commission website for further information and resources about preventing falls in children
4.3 MATUREITY 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: Clinical Excellence Commission Falls Prevention for Maternity Services 1 page flyer. Use interpreters (face to face and telephone) if necessary for women of CALD backgrounds
- 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
• Alert 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 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, blood sugar level, pain score, neurological observations)
• If the woman is post birth, check fundus and blood loss
• If applicable, refer to NSW Health PD2012_013: Initial management of closed head injury in adults. Algorithm 2: Initial management of adult mild closed head injury (Click here to view the algorithm or refer to Appendix 4)
• 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: Memo on Severity Assessment Code ratings in SESLHD Falls Incidents
• Inform the Team Leader and/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 Health PD2012_062 Maternity - Safer Sleeping Practices for Babies in NSW Public Health Organisations

SESIAHS PD 293 Safe Bed Sharing for Feeding and Settling babies under 28 days

Clinical Excellence Commission Falls prevention information for women and their families
4.3.7 Post fall management for newborns

- Immediate response must assess the need for Basic Life Support. 
  SESLHDPR/340 Patient with Acute Condition for Escalation (PACE): Management of the Deteriorating NEONATAL Inpatient in Maternity Services and Nurseries outlines the Local Clinical Emergency Response System and 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)

  These should be documented on the Standard Newborn Observation Chart (SNOC).

- Transfer to the Special Care Nursery (SCN) for a minimum of 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 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 Health PD2014_028 Open Disclosure

• 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 the Local Clinical Emergency Response 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

• 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 8 for a copy of the Post fall guide for newborns
5. DOCUMENTATION

- Ontario Modified Stratify (Sydney Scoring) screening tool
- Falls Risk Assessment and Management Plan (FRAMP)
- Paediatric Falls Risk Assessment tool
- SESLHD Post fall management sticker
- SESLHD SAC 2 review template

6. 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. 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 audit in a one year period as evidence of clinical practice improvement. This will be determined by the facility CPIU’s and falls committees.

In addition, a higher level audit will 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.

Refer to Appendices 8-11 for a copy of the SESLHD audits for adults, paediatrics and maternity.

7. RESOURCES

- SESLHD Falls Prevention Program Coordination Intranet site
- NSW Health PD2011 029
- Australian Commission on Safety and Quality in HealthCare: Preventing Falls and Harm from falls in Older People- Best Practice Guidelines for Australian Hospitals 2009
- National Safety and Quality Health Service (NSQHS) Standard 10 - Preventing Falls and Harm from Falls
- Closed Head Injury in adults – Initial Management_PD2012_013
- Children and Infants - Acute Management of Head Injury
- NSW Health Incident Management Policy PD2014_004
- SESLHDPR/483 ‘Restraint use with adult patients’
- SESLHDPR/421 Bed rails – Adult Inpatient use
- SESLHDPR/345 Prevention, Diagnosis and Management of Delirium in Older People in Acute and Sub Acute Care
- NSW Agency for Clinical Innovation Care of Confused Hospitalised Older Persons
- Australian Commission on Safety and Quality in HealthCare Hip fracture clinical care standard
- Clinical Excellence Commission Falls Prevention Program
- NSW Falls Prevention Network Resources for Acute Care Setting
8. REFERENCES


9. REVISION AND APPROVAL HISTORY

(State the author of the document, the date it was written, its revision number and approval history)

<table>
<thead>
<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2014</td>
<td>0</td>
<td>Jamie Hallen, Falls Prevention Program Coordinator</td>
</tr>
<tr>
<td>December 2014</td>
<td>1</td>
<td>Endorsed by Clinical and Quality Council</td>
</tr>
<tr>
<td>October 2016</td>
<td>2</td>
<td>Jamie Hallen, Falls Prevention Program Coordinator. Addition of post fall management and guide for newborns. Review tool approved by Julie Dixon, Executive Sponsor</td>
</tr>
<tr>
<td>November 2016</td>
<td>2</td>
<td>Endorsed by SESLHD Clinical and Quality Council</td>
</tr>
</tbody>
</table>
Appendix 1: Ontario Modified Stratify (Sydney Scoring) screening tool
## ONTARIO MODIFIED STRATIFY (SYDNEY SCORING)
### FALLS RISK SCREEN

**Complete All Details or Affix Patient Label Here**

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Score</td>
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</table>

### 1. History of Falls
- Did the patient present to hospital with a fall or have they had a fall since admission?
  - Yes to any = 6
- If not, has the patient fallen within the last 2 months?

### 2. Mental Status
- Is the patient confused? (i.e. unable to make purposeful decisions, disorganised thinking and/or memory impairment)
  - Yes to any = 14
- Is the patient disoriented? (i.e. lacking awareness, being mistaken about time, place or person)
- Is the patient agitated? (i.e. fearful affect, frequent movements and/or anxious)

### 3. Vision
- Does the patient require eyeglasses continually?
  - Yes to any = 1
- Does the patient report blurred vision?
- Does the patient have glaucoma, cataracts or macular degeneration?

### 4. Toileting
- Are there any alterations in urination? (i.e. frequency, urgency, incontinence, nocturia)
  - Yes = 2

### 5. Transfer Score (TS) [means from bed to chair and back]

- Independent - use of aids to be independent is allowed
- Minor help - one person easily or needs supervision for safety
- Major help - one strong skilled helper or two normal people; physically can sit
- Unable - no sitting balance, mechanical lift

### 6. Mobility Score (MS)

- Independent (but may use any aid, e.g. walking stick)
- Walks with help of one person (verbal or physical)
- Wheelchair independent including corners, etc
- Immobile

≥9 = HIGH RISK OF FALLS

**Total Score**

**Name:** ___________________
**Designation:** ___________________
**Signature:** ___________________

**Name:** ___________________
**Designation:** ___________________
**Signature:** ___________________

**Name:** ___________________
**Designation:** ___________________
**Signature:** ___________________


MEDICATIONS: Is the patient on antipsychotics, antidepressants, sedatives/hypnotics, or opioids?

YES □ Complete medication section on Falls Risk Assessment and Management Plan.

**Provide patient/family/carers with information about Falls Prevention**
<table>
<thead>
<tr>
<th>Facility:</th>
<th>Ontario Modified Stratify (Sydney Scoring) Falls Risk Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE</td>
</tr>
</tbody>
</table>

**Care actions for all patients**

*These care actions are relevant for all patients and are a component of ongoing clinical care at all times.*

- Orientate patient to bed area, toilet and ward
- Educate patient and family, providing culturally appropriate information about the risk of falling and safety issues
- Instruct patient on the use of the call bell, ensure it is within reach and advise to call for assistance if required
- Ensure frequently used items (including mobility aids) are within easy reach, on appropriate side of the bed, in good working order and are adjusted for the patient
- Bed and chair are at appropriate height for the patient – instruct patient on use of bed control (if appropriate)
- Ensure bed brakes are on at all times and chair brakes are on when not mobilising
- Position over-bed table on the non exit side of the bed
- Place IV pole and all other devices/attachments (as appropriate) on the exit side of bed
- Ensure attachments (such as catheters, wound drainage, IVs) are secured
- Remove clutter and obstacles from room
- Ensure patient is using appropriate personal aids such as eyeglasses (that are clean) and/or working hearing aid
- Ensure patient wears appropriate footwear when ambulant
- Establish patient’s level of personal care need
- Ensure adequate night lighting

**Provide patient/family/carers with falls prevention information.**


For further information scan this with your smart phone ➔
Appendix 2:
Fall Risk Assessment and Management Plan (FRAMP)
### FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

Following completion of the Falls Risk Screen, implement the appropriate action/s for the identified falls risk factors

<table>
<thead>
<tr>
<th>Risk factors and actions implemented</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. History of Falls</strong>&lt;br&gt;Obtain details about previous fall in the last 2-6 months (medical record, family/carer)<strong>&lt;br&gt;ACTION:</strong>&lt;br&gt;Refer for medical review (loss of consciousness, syncope, blackout, seizures, osteoporosis (bone health))**&lt;br&gt;<strong>Additional Comments:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Mental Status</strong>&lt;br&gt;If this patient is confused, disoriented, agitated or depressed**&lt;br&gt;ACTION:<strong>&lt;br&gt;Conduct or refer for a cognitive screen (e.g. AMTS, SIS, MMSE, RUDAS)&lt;br&gt;Consider delirium. Complete or refer for a Confusion Assessment Method (CAM)&lt;br&gt;Consider causes for delirium e.g. sepsis, pain, constipation, urinary retention, medication related, or infection&lt;br&gt;Refer to medical staff for review&lt;br&gt;Implement a Delirium Care Pathway (as per LHD protocol)&lt;br&gt;Commence communication plan with family/carers (e.g. Top 5, C&amp;C Cues)&lt;br&gt;Patient requires increased observation <strong>(avoid use of bed rails)</strong>&lt;br&gt;Always supervise patient in the bathroom/toilet <strong>(not to be left alone)</strong>&lt;br&gt;Locate patient near nurses’ station if possible or co-locate to ‘high risk’ room&lt;br&gt;Consider behavioural chart if patient’s behaviour is disruptive/unsafe&lt;br&gt;Provide lo-lo bed or bed at lowest level (if available/appropriate)&lt;br&gt;Provide bed/chair alarm (if available/appropriate)&lt;br&gt;Refer to Allied Health for review (if available/appropriate)</strong>&lt;br&gt;<strong>Additional Comments:</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>3. Vision</strong>&lt;br&gt;If the patient has visual impairment (e.g. cataract, glaucoma, macular degeneration)<strong>&lt;br&gt;ACTION:</strong>&lt;br&gt;Ensure easy access to bathroom and toilet&lt;br&gt;Direct patient to seek assistance when mobilising&lt;br&gt;Provide patient/family/carer with CEC Falls Prevention – Eyesight flyer&lt;br&gt;Refer for allied health/medical review if appropriate/available**&lt;br&gt;<strong>Additional Comments:</strong></td>
<td></td>
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</tbody>
</table>
### Risk factors and actions implemented

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Initial and date action if patient has any of these risk factors</th>
<th>Date</th>
<th>Date</th>
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</tr>
</thead>
</table>

#### 4. Toileting
If the patient has confusion, urinary or faecal frequency, incontinence, urgency, nocturia or other toileting issues

**ACTION:**
- Provide patient with individualised (supervision/assistance) toileting plan (e.g. regular toileting, rounding) and document in care plan
- Patient to be always supervised when mobilising to the toilet/bathroom
- Patient not to be left alone in the toilet/bathroom
- Refer to Continence nurse and/or Allied Health review (if available)

**Additional Comments:**

#### 5. Transfer/Mobility
If the patient has issues that affect balance/mobility/transfer that require assistance/equipment or safe footwear

**ACTION:**
- Referral to Physiotherapist for mobility (if available)
- Referral to Occupational Therapist for self care assessment (if available)
- Provide patient with equipment to assist mobility/transfer/self care
- Provide patient with assistance to mobilise to the bathroom
- Provide patient with assistance for personal care
- Patient to be supervised in bathroom/toilet (not to be left alone)
- Ensure patient has access to non-slip footwear e.g. non-slip socks, ted stockings or shoes

**Additional Comments:**

#### 6. Medications
If the patient is taking antipsychotics, antidepressants, sedatives/hypnotics, or opioids

**ACTION:** Refer to treating Medical Officer for medication review

Does this patient have postural hypotension?

**ACTION:** Refer to treating Medical Officer for review

**Additional Comments:**

Placing Falls Sticker on Care Plan and patient health record to alert staff

Ensure all actions identified are noted in Care Plan

Falls risk discussed and intervention developed in partnership with patient/family/carer & resource information provided

Comments:

Staff member attending to the assessment/action plan

Other Comments:

---

Flag and communicate falls risk status and interventions in place at each clinical handover
Appendix 3:
CEC Post Fall Management Guide for Adults
CEC POST FALL GUIDE

Patients who fall require observation and ongoing monitoring. Staff are to follow local Clinical Emergency Response Systems and if at any time a staff member is concerned about a patient they can call for a Clinical Review.

**Basic life support**
Danger, Responsive, Send for Help, Airway, Breathing, CPR, Defib (DRSABCD)

**Rapid assessment**
Pain, bleeding, injury, fracture
Do not move until assessed: examine cervical spine and immobilise if there is an indication of injury

**Observations**
BP, P, R, T, SpO2, Blood Glucose and Pain Score, Neuro Observations

BP, P, R, T, SpO2, Pain Score, Neuro Observations, BGL (if indicated)
- At least hourly for a minimum of 4 hours
- 4 hourly for the next 24 hours or as clinically indicated, then
- REVIEW - ongoing observations as required

**CHECK FOR SEPSIS**
- Does this patient have sepsis risk factors or signs & symptoms of infection?
- Does this patient have observations in the yellow zone?

**CHECK FOR DELIRIUM**
- Does this patient have fluctuating changes in cognition, changes in behaviour, increasing confusion?

**CHECK FOR HEAD INJURY**
Does this patient have a head injury?

Strong indicators for a CT Scan include (see algorithm for full list of risk factors):
- The patient is on anticoagulants, antiplatelets, or with a known coagulopathy, (check INR/APTT).
- Has an abnormal GCS or fluctuating changes in cognition, changes in behaviour, or increasing confusion.
- Has large facial or scalp bruising, nausea, vomiting or persistent severe headache.
- Age ≥ 65 years (clinical judgement required).

Refer to PD2012_013: Initial Management of Closed Head Injury in Adults. Algorithm: Initial Management of Adult Mild Closed Head Injury

Are you concerned about this patient and or family, carer has reported concerns?

**THERE MAY BE MANIFESTATIONS OF HEAD INJURY AFTER 24 HOURS**
- CONTINUE TO MONITOR -

**COMMUNICATE**
- Reassure the patient and explain all treatment and investigations.
- All patient falls are to be reported to medical officer for review.
- Notify the person responsible (family/carer/friend) with permission and inform them about the fall.
- If the person is not able to communicate effectively engage with the substitute decision maker.
- Discuss appropriate treatment options and clarify if there is an Advance Care Directive in place - symptom management is important.
- Implement plan of care and inform staff of care plan.
- Communicate at clinical handover - observations, falls risk and interventions in place.

**DOCUMENT**
- Treatment, palliation/escalation process and outcome documented in the clinical record.
- Change falls status to: HIGH RISK and record in clinical record and complete revised care plan.
- Complete IIMS report and note incident and IIMS number in the clinical record.
- Complete a review of fall event with ward clinical leadership team.
- Complete CEC Incident Review for any serious injury/outcome from fall.
Appendix 4:
Algorithm 2: Initial management of adult mild closed head injury
Initial Management of Adult Mild Closed Head Injury

Initial GCS 14-15 on arrival following blunt head trauma
Stabilise ABCDEs and assess clinical risk factors.
Commence minimum of hourly clinical observations of vital signs, GCS, pupils, PTA and clinical symptoms.

Low risk mild head injury

No indication for CT scan if all of...
- GCS 15 at 2 hours post injury.
- No focal neurological deficit.
- No clinical suspicion of skull fracture.
- No vomiting
- No known coagulopathy or bleeding disorder.
- Age <65 years.
- No seizure
- Brief loss of consciousness (<5 mins).
- Brief post traumatic amnesia (<30 mins)
- No severe headache.
- No large scalp haematoma or laceration
- Isolated head injury
- No dangerous mechanism.
- No known neurosurgery / neurological impairment.
- No delayed presentation or representation

NOTE:
Mild acute clinical symptoms such as lethargy, nausea, dizziness, mild headache, mild behavioural change, amnesia for event and mild disorientation are common and are not associated with increased risk of intracranial injury. These clinical symptoms usually start to improve within 2 to 4 hours of time of injury.

Clinical symptoms IMPROVING or remain normal during period of observation.

Clinical symptoms IMPROVING at 4-6 hours post time of injury.
Clinical symptoms NOT IMPROVING at 4-4 hours post time of injury.

Clinical symptoms IMPROVING remain normal during period of observation.

Clinical symptoms IMPROVING at 4-6 hours post time of injury.

Clinically safe for discharge for home observation if:
- GCS 15/15
- No persistent post traumatic amnesia (nb A-WPTAS >18/18)
- Alertness / behaviour / cognition returning to normal
- Clinically improving after observation.
- Normal CT scan or no indication for CT scan.
- Clinical judgment required regarding discharge and follow up of elderly patients or patients with known coagulopathy or bleeding disorder due to increased risk of delayed subdural haematoma.

Continue minimum of hourly clinical observations until at least four hours post time of injury.

High risk mild head injury

Strong indication for CT scan if...
- GCS <15 at 2 hours post injury.
- Deterioration in GCS.
- Focal neurological deficit.
- Clinical suspicion of skull fracture
- Vomiting (especially if recurrent)
- Known coagulopathy or bleeding disorder
- Age >65 years.
- Seizure
- Prolonged loss of consciousness (>5 mins).
- Persistent post traumatic amnesia (A-WPTAS <18/18 at 4hrs post injury)
- Persistent abnormal alertness / behaviour / cognition
- Persistent severe headache.

Relative indication for CT scan if...
- Large scalp haematoma or laceration
- Multi-system trauma
- Dangerous mechanism
- Known neurosurgery / neurological impairment.
- Delayed presentation or representation

Indication for CT scan. Continue clinical observations.

Normal CT scan
Abnormal CT scan
CT scan unavailable

Consider transfer for CT scanning particularly if:
- Persistent GCS <15.
- Deterioration in GCS.
- Focal neurological deficit.
- Clinical suspicion of skull fracture
- Known coagulopathy (esp if INR>4)
- Persistent abnormal alertness, behaviour, cognition, PTA, vomiting or severe headache at 4 hours post injury

Consult senior clinician and network neurosurgical service regarding further management and disposition. Continue clinical observations in hospital.

Explanatory notes for risk factors
1. Using GCS<15 at 2 hours post injury allows clinical judgement for patients who present soon after injury or who have drug or alcohol intoxication. Drug or alcohol intoxication has not been shown to be an independent risk factor for intracranial injury but persistent GCS<15 is a major risk factor and mandates CT.
2. Clinical suspicion of skull fracture includes history of focal blunt assault or injury; palpable skull fracture; large scalp haematoma or laceration; signs of loss of skull fracture – haemotympanum / CSF leak / raccoon eyes / Battle’s sign. Serial observation such as abnormal alertness / behaviour / cognition, PTA, vomiting or decreasing level of consciousness may be an independent risk factor for intracranial injury but persistent GCS <15 is a major risk factor and mandates CT.
3. Focal neurological deficit may mandate CT for altered level of consciousness or focal neurological deficit and must be an independant risk factor for intracranial injury but persistent GCS <15 is a major risk factor and mandates CT.
4. Abnormal alertness/cognitive/behavioural changes detect subtle brain injury better than GCS and should be part of the bedside assessment. Other clinical signs should be included in the assessment such as retching, vomiting, EEG, CT scan and CSF analysis.\n5. Elderly patients have increasing risk of intracranial injury with increasing age; routine CT scanning is not indicated but individual cases should be considered.
6. Delayed presentation should be considered as failure to clinically improve during observation. For representation consider both intracranial injury and post concussion symptoms and have a low threshold for CT scanning if not done initially.

Clinical symptoms that are deteriorating or not improving by 4 hours post injury on serial observation such as abnormal alertness / behaviour / cognition, PTA, vomiting or severe headache are very concerning.

No vomiting
No clinical suspicion of skull fracture
No focal neurological deficit
No Deterioration in GCS.
No Multi-system trauma
No Dangerous mechanism
No Known neurosurgery / neurological impairment
No Delayed presentation or representation

No vomiting
No clinical suspicion of skull fracture
No focal neurological deficit
No Deterioration in GCS.
No Multi-system trauma
No Dangerous mechanism
No Known neurosurgery / neurological impairment
No Delayed presentation or representation
Appendix 5:
Memo: Severity Assessment Code Rating for SESLHD 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.


Thanks,
Appendix 6:
SESLHD SAC 2 review template
SESLHD SAC 2 Fall Incident Investigation Form

<table>
<thead>
<tr>
<th>Facility:</th>
<th>Ward and Specialty:</th>
<th>IIMS Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Time of Incident:</th>
<th>Location of fall: e.g. bathroom:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRIM Number:</th>
<th>Patient MRN:</th>
<th>Gender: M ☐ F ☑</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Age:</th>
<th>Preferred language</th>
<th>Aboriginal ☐ Torres Strait Islander ☑</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How long after admission to unit did the fall occur? Enter Length of time

Patient’s Admission Diagnosis:

Patient’s Co-morbidities:

What injuries did the patient sustain?

Synopsis of the incident: a concise description of incident

Enter description here using five to ten dot points in chronological order.

Environmental Factors

What was happening in the clinical unit at the time of the patient’s fall? Did any of these factors impact on the care and/or capacity to respond to the patient? Or directly to the patient’s fall?

Core Questions

<table>
<thead>
<tr>
<th>Issue / Consideration</th>
<th>Yes /No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were all expected falls risk screens undertaken at relevant points in his/her care? If no, please comment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Was a risk assessment and management plan completed? (e.g. FRAMP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Questions</td>
<td>Yes/No</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Issue / Consideration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Is there evidence of documentation regarding individual risk factors as appropriate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Investigation of confusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medication review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Continence/toileting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please comment on any gaps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is there evidence of implementation of strategies for management of individual risk factors (e.g. mobility, confusion, medications, continence)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please comment on any gaps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did non-compliance with policies/other safety mechanism/expected practice contribute to the incident (e.g. poor handover/communication, policy compliance, skill mix)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please comment on any gaps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Were all appropriate actions and patient care implemented after the patient’s fall?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please comment on any gaps</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Summary of contributing factors leading to this fall incident and corresponding recommendations

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Recommendation</th>
<th>Outcome Measure</th>
<th>Date Due</th>
<th>Staff designation responsible for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient given oxycodone and haloperidol for management of pain and confusion</td>
<td>This case to be discussed at M&amp;M meeting with a recommendation for medication review of patients at risk of a fall</td>
<td>Minutes of M&amp;M meeting reflect discussion of case.</td>
<td>One month</td>
<td>Department Head.</td>
</tr>
</tbody>
</table>

1
2
3
4
5
6
7
8
# Team Sign Off

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Team Member</th>
<th>Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Endorsed by CPIU Manager and Director of Operations if applicable

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Signature:</td>
</tr>
<tr>
<td>CPIU Manager</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

This report is to be tabled at the appropriate Falls Prevention Advisory Group / Executive Quality Committee

**Date Forwarded:**

**Date provided to Unit Manager for feedback to staff:**

**Date provided to relevant manager for feedback to family:**
Appendix 7:
Paediatric Falls Risk Assessment
### Fall Risk Assessment Tool

(Adapted from the Miami Children's Hospital Humpty Dumpty Falls Prevention Program)

**Date and Time of assessment must be recorded**

To be completed on admission and/or when condition changes

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 3 years old</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 years to &lt; 7 years old</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 years to &lt; 13 years old</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 years +</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Gender**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
</tr>
</tbody>
</table>

**Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological Diagnosis</td>
<td>4</td>
</tr>
<tr>
<td>De-conditioned/Alteration in oxygenation (e.g. Respiratory Diagnosis, Dehydration, Anaemia, Syncope/Dizziness Disorder)</td>
<td>3</td>
</tr>
<tr>
<td>Psych/Behavioural</td>
<td>2</td>
</tr>
<tr>
<td>Other Diagnosis</td>
<td>1</td>
</tr>
</tbody>
</table>

**Cognitive Impairment**

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not aware of limitations</td>
<td>3</td>
</tr>
<tr>
<td>Forgets Limitations</td>
<td>2</td>
</tr>
<tr>
<td>Oriented to own ability</td>
<td>1</td>
</tr>
</tbody>
</table>

**Environmental Factors**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of falls</td>
<td>4</td>
</tr>
<tr>
<td>Infant - Toddler placed in bed</td>
<td>3</td>
</tr>
<tr>
<td>Patient uses assistive devices</td>
<td>2</td>
</tr>
<tr>
<td>Infant - Toddler in cot</td>
<td>1</td>
</tr>
<tr>
<td>Patient placed in bed</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient area</td>
<td>1</td>
</tr>
</tbody>
</table>

**Patient has had Surgery/Deep Sedation**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 24 hours</td>
<td>3</td>
</tr>
<tr>
<td>Within 48 hours</td>
<td>2</td>
</tr>
<tr>
<td>More than 48 hours/None</td>
<td>1</td>
</tr>
</tbody>
</table>

**Medication Usage**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple usage of Sedatives (excluding ICU’s); Hypnotics; Barbiturates; Antidepressants; Laxatives; Diuretics; Narcotic</td>
<td>3</td>
</tr>
<tr>
<td>One of the medications listed above</td>
<td>2</td>
</tr>
<tr>
<td>Other medications/None</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total Score**

High fall risk = score ≥ 12
# Care Actions for all Paediatric Patients

## On Admission

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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 any gaps where a child could be injured or trapped; consider the use of additional safety precautions, such as bolster
- Place child in developmentally appropriate sized bed (may require low bed), brakes on
- Ensure child has non-skid footwear and appropriate clothing to prevent tripping

## Routine Care

- Assess toileting needs and assist as needed
- 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

## Additional Considerations for High Risk (Score of 12 or Above) Patients:

- 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 closer to nurses' station
- Assess need for 1:1 general observation
- Review medication administration times for children
- Engage child’s parents/carers in falls prevention interventions

---

**Acknowledgement to:**
Miami Children’s Hospital Humpty Dumpty Falls Prevention Program.
NSLHD and CCLHD Falls Prevention Program - Paediatrics Group.
The Children’s Hospital at Westmead

**For more information scan this with your smart phone**

**Email:** falls@cec.health.nsw.gov.au
**Web:** www.cec.health.nsw.gov.au
Appendix 8:
Post fall guide for 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.

**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)

**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, SpO2: 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

**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**
- 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.
Appendix 9 :
Adult documentation audit
[to be completed annually at unit level]
<table>
<thead>
<tr>
<th>Standard</th>
<th>10.5.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Screening and assessing risk of falls and harm from falling</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>The Ontario Modified Stratify (Sydney Scoring) screening tool is completed within 24 hours of admission to a new ward for all adult inpatients</td>
</tr>
<tr>
<td>Guideline</td>
<td>Randomly select 10 records of inpatients who have been admitted for more than 48 hours.</td>
</tr>
</tbody>
</table>

Criteria

1. **Was the Ontario Modified Stratify completed within one (1) calendar day of admission to this ward?** Select Yes / No

2. **Was the risk screen scored correctly** *(Yes response requires the patient was given a score of either zero (0) or seven (7) for the transfer and mobility item AND the total score is correct when the individual scores are added. Select Not applicable if the risk screen has not been completed).*
### PART 2: PREVENTING FALLS AND HARM FROM FALLS

<table>
<thead>
<tr>
<th>Standard</th>
<th>10.6.2, 10.7.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Preventing falls and harm from falls</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>Patients identified to be at high risk of falls (i.e. score ≥9 on the risk screen) have a documented Falls Risk Assessment and Management Plan (FRAMP)</td>
</tr>
<tr>
<td>Guideline</td>
<td>Use the same 10 records as above. Select Yes / No if the patient scored ≥9 on the Ontario Modified Stratify. Select Not applicable to all questions if the patient scored &lt;9 on the risk screen.</td>
</tr>
</tbody>
</table>

#### Criteria

1. **Was a Falls Risk Assessment and Management Plan (FRAMP) completed?**

2. **Refer to both the Ontario Modified Stratify and the FRAMP. For each risk factor identified on the Ontario Modified Stratify, was the corresponding section of the FRAMP completed?** For each item, answer Yes, No or Not applicable
   - a. History of falls
   - b. Mental status
   - c. Vision
   - d. Toileting
   - e. Transfers and mobility
   - f. Medications

3. **Is there documented evidence that the patient’s falls risk status was communicated as part of clinical handover?**

4. **Was a falls risk alert sticker placed on the patients care plan?**
   *for paperless units such as Mental Health, answer Yes if falls risk was flagged through eMR or via the electronic whiteboard?*
<table>
<thead>
<tr>
<th>Standard</th>
<th>10.10.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Communicating with patients and carers</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>Staff are required to inform patients and carers of the identified fall risk and involve them in the development of a falls prevention plan</td>
</tr>
<tr>
<td>Guideline</td>
<td>Use the same 10 records as in PART 2 above and refer to the item on the bottom of Page 2 of the FRAMP. Select Yes / No. If the FRAMP wasn’t completed, select Not Applicable.</td>
</tr>
</tbody>
</table>

**Criteria**

1. Is there documented evidence that falls risk was discussed and interventions developed in partnership with the patient/family/carer?
Appendix 10:
Adult high level audit
[to be completed annually at facility level]
## POST FALL MANAGEMENT

<table>
<thead>
<tr>
<th>Standard</th>
<th>10.2.4 + PD 248</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Post fall management</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>Action is taken to reduce the frequency and severity of falls in the health service organisation. Staff are required to adhere to SESLHD PD 248 following an inpatient fall incident.</td>
</tr>
<tr>
<td>Guideline</td>
<td>Identify 10 patients across the organisation who fell during their acute/sub-acute admission and review their clinical record. Select: Yes / No.</td>
</tr>
</tbody>
</table>

### Criteria

1. Were all items on the post fall management sticker completed?

2. Was the Ontario Modified Stratify risk screen repeated after the inpatient fall incident?

3. Is there documented evidence that the FRAMP was reviewed/completed post fall?

4. Refer to the SAGO chart. Was a full set of observations completed post fall [Blood pressure (BP), Heart rate (HR), Respiratory rate (RR), temperature, oxygen saturation, pain score, blood sugar level (BSL)]

5. Refer to the neurological observation chart. Were neurological observations completed hourly for a minimum of four (4) hours?

6. Is there documented evidence that the patient was reviewed by a medical officer after the fall?
<table>
<thead>
<tr>
<th>DISCHARGE PLANNING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
</tr>
<tr>
<td><strong>Process Indicator</strong></td>
</tr>
<tr>
<td><strong>Guideline</strong></td>
</tr>
<tr>
<td><strong>Criteria</strong></td>
</tr>
<tr>
<td>1. Is there documented evidence in the medical discharge summary that the patient was identified as a high risk of falls during their hospitalisation?</td>
</tr>
</tbody>
</table>
Appendix 11:
Paediatric documentation audit
[to be completed annually at unit level]
## PART 1: SCREENING AND ASSESSING RISK OF FALLS AND HARM FROM FALLING

<table>
<thead>
<tr>
<th>Standard</th>
<th>10.5.2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Screening and assessing risk of falls and harm from falling</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>The Paediatric Fall Risk Assessment tool is completed within 24 hours of admission to a new ward for all inpatients admitted to a Paediatric unit</td>
</tr>
<tr>
<td>Guideline</td>
<td>Randomly select 10 records of inpatients who have been admitted for more than 48 hours. Select Yes / No</td>
</tr>
</tbody>
</table>

### Criteria

1. Was the Paediatric Fall Risk Assessment tool completed within one (1) calendar day of admission to this ward?

## PART 2: PREVENTING FALLS AND HARM FROM FALLS

<table>
<thead>
<tr>
<th>Standard</th>
<th>10.6.2, 10.7.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Preventing falls and harm from falls</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>Children &gt;3 years who are identified to be at high risk of falls (i.e. score ≥12 on the risk screen) have documented evidence of interventions to reduce the risk of falls in place. Refer to the additional considerations on Page 2 of the Assessment tool for appropriate strategies</td>
</tr>
<tr>
<td>Guideline</td>
<td>Use the same 10 records as above. Select Yes / No if the child is &gt;3 years and scored ≥12 (high risk) on the risk assessment. Select Not applicable for both questions if the child is under 3 years or scored &lt;12 on the risk screen</td>
</tr>
</tbody>
</table>

### Criteria

1. Is there documented evidence of interventions to reduce the risk of falls in those identified at high risk of falling?

2. Is there documented evidence that the child’s high falls risk status was communicated as part of bedside clinical handover?
<table>
<thead>
<tr>
<th>Standard</th>
<th>10.10.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>Communicating with patients and carers</td>
</tr>
<tr>
<td>Process Indicator</td>
<td>Staff are required to inform parents / carers of the identified fall risk and involve them in the development of a falls prevention plan</td>
</tr>
<tr>
<td>Guideline</td>
<td>Using the same 10 records above, identify <strong>all the children who scored ≥12</strong> and select <strong>Yes / No</strong>. Select <strong>Not applicable</strong> if the child scored &lt;12 on the risk assessment or the parent/carer is unavailable at the time of the audit</td>
</tr>
</tbody>
</table>

**Criteria**

Ask the child’s parent/carer:

1. Were you told that your child is at high risk of falling in hospital?

2. Were you provided with written information about ways to help prevent your child falling in hospital?
Appendix 12:
Maternity audit
[to be completed annually at unit level]
<table>
<thead>
<tr>
<th>PREVENTING FALLS AND HARM FROM FALLS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
</tr>
<tr>
<td><strong>Domain</strong></td>
</tr>
<tr>
<td><strong>Process Indicator</strong></td>
</tr>
<tr>
<td><strong>Guideline</strong></td>
</tr>
</tbody>
</table>

**Criteria**

1. Is there documented evidence on the care plan that falls risk was discussed and information provided to the woman and her partner/family?

   **Ask each of the women:**

   2. Was the risk of falling discussed with you?

   3. Were you provided with written information on ways to prevent falls during your stay?