



CLINICAL PRACTICE GUIDELINE

# Falls: Risk Assessment and Management of Patient Falls

This document should be read in conjunction with the [Disclaimer](#)

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This Guideline is to be read in conjunction with the Australian Commission on Safety and Quality in Healthcare: [Preventing Falls and Harm From Falls in Older People \(2009\)](#) and the Health Service policy on Fall Prevention and Management. <http://www.health.wa.gov.au/circularsnew/pdfs/12981.pdf>

## Aim

Falls Risk Assessment tools and interventions are used collaboratively and can reduce the risk of falls and fall related injuries occurring at King Edward Memorial Hospital (KEMH).

## Key Points

1. All maternity and gynaecology inpatients at King Edward Memorial Hospital shall have the Minimum Standards for Fall Prevention implemented and adhered to at all times.
2. Initial falls risk screen and implementation of strategies must be performed as soon as practicable or within a maximum of 10 hours on all patients whom are confirmed for admission.
3. All patients admitted to the gynaecology and obstetric areas, including Day of Surgery Admission (DOSAs) patients shall be assessed for risk of falls. If Minimum Standards for Fall Prevention are not adequate, the Fall Risk Management Tool appropriate to the area is to be used. (Gynaecology: Falls Risk Assessment and Management Plan (FRAMP MR 260.04) and the Obstetric setting (The Maternity Inpatient Falls/Pressure Injury Risk Assessment MR 260.02 is used)).
4. Patients are at risk for a variety of reasons, and this risk is not limited to inpatients or the elderly but can include mobility/functional ability, medications/medical conditions, continence/elimination needs and cognitive state.
5. A person's risk of falling increases as their number of risk factors accumulates.
6. For each patient assessed as being at a high risk of falling, a fall prevention plan must be prepared and individually tailored to the patient's specific set of risk factors.
7. All patients identified as at risk of falls are to be handed over and the falls risk included in iSoBAR handover.

## Procedure for falls risk management at KEMH

### **Gynaecological Areas (Ward 6, Adult Special Care Unit (ASCU), Day Surgery Unit (DSU), Emergency Centre (EC)):**

All gynaecological patients admitted to WHNS will be assessed using the FRAMP, where used, and managed according to Department of Health FRAMP policy, with a multidisciplinary approach, to minimise the risk of falls.

- The Fall Risk Management Tool (FRMT) MR260.02 shall be completed on all women on admission to Ward 6, ASCU, or the DSU (DOSA Gynaecology patients only).
- If the patient meets **any** of the screening criteria on the FRAMP, a full assessment of each of the components (in the shaded boxes on the second page) shall be performed and documented.
- A full assessment shall occur if a patient meets any of the following criteria:
  - Has had a slip, trip or fall in the past 6 months.
  - Is unsafe when walking or transferring
  - Is confused
  - Has urinary or faecal frequency/urgency or nocturia
- Identify the appropriate interventions required to prevent falls and transfer to the Nursing Care Plan.
- Identify each patient's individual risks for falling and the strategies that have been put in place as per FRAMP are included in iSOBAR handover.
- If no criteria are met, ensure minimum standards are in place, but do not complete the assessment interventions.
- A full re-assessment shall be repeated in the following circumstances:
  - Following a fall
  - Where there is a change in the patient's condition (cognitive, functional or environmental)
  - On any ward transfer

### **Obstetric areas (Ward 3,4,5,Labour and Birth Suite, DSU, ASCU and EC)**

- The Maternity Inpatient Falls/Pressure Injury Risk Assessment MR260.02 shall be completed on all obstetric women who present for admission to ASCU, Obstetric Wards 3, 4, 5, Maternal Fetal Assessment Unit (MFAU), and Labour and Birth Suite.
- A full assessment shall occur if a patient meets any of the following criteria:
  - Mobility impairment (including epidural/spinal analgesia)
  - Postpartum haemorrhage 1000mls and or symptomatic and /or anaemic <90g/L
  - Significant medical co-morbidities
  - You, or the woman, have any other concerns e.g. low blood pressure, drowsy, dizzy, feels faint, extreme fatigue etc.
  - Regular systemic opioid analgesia/sedatives
  - Altered cognitive status
  - Visual impairment
  - Continence issues- incontinence, frequency, nocturia

- If the patient meets any of the above criteria complete the appropriate falls prevention and intervention care plan on page 3 of 3 on the Maternity Inpatient Falls/Pressure Injury Risk Assessment MR 260.02.
- Identify the appropriate interventions required to prevent falls and transfer to the Obstetric Clinical Pathway.
- Identify each patient's individual risks for falling and the strategies that have been put in place as per the risk assessment tool are included in iSOBAR handover.
- A full risk rescreen should be performed post birth (prior to transfer) and before discharge home.
- For Obstetric patients with a Neuraxial catheter, please refer to Clinical Guideline, Anaesthetics: Labour Analgesia: [Epidural Analgesia in Labour](#).

## Minimum standards: Implemented for ALL patients

- Orientate the patient to the bed area, toilet facilities and ward.
- Educate the patient and family and provide information about the risk of falls and safety issues.
- Demonstrate the use of the call bell to the patient and ensure it is in reach of the patient.
- Ensure frequently used items including mobility aids are within easy reach of the patient.
- Provide appropriate mobility assistance.
- Ensure the bed and chairs are at an appropriate height for the patient.
- Ensure bed brakes are employed at all times when the bed is stationary.
- Position the over-bed table on the non-exit side of the bed when possible, taking into consideration the siting of IV cannulas and wound drains.
- Place the IV pole and all other devices/attachments (as appropriate) on the exit side of the bed when possible.
- Remove clutter and obstacles from the room.
- Ensure the patient is using appropriate aids such as glasses or a hearing aid.
- Ensure the patient wears appropriate footwear if ambulant especially if wearing graduated compression stockings (TEDS)
- Use bed rails as appropriate. When bed rails are used, the reason for this choice shall be documented in the patient's notes.

## Falls management

See WNHS Policy [Falls Prevention and Falls Management](#)

## Post fall management

Please refer to the Post-Fall Management Guidelines in WA Healthcare Settings Guideline (2015)

**An immediate decision should be made for patients with a high risk of bleeding post fall.**

- Patients on an anticoagulant ( including but not limited to warfarin, heparin or enoxaparin), anti-platelet therapy( including but not limited to aspirin, aspirin plus dipyridamole or clopidogrel) and / or patients with a known coagulopathy (alcohol dependent persons, persons with liver disease and people with bleeding disorders ) are considered at an increased risk of intracranial, intrathoracic or intra-abdominal haemorrhage.
- The risk versus harm of continuing anticoagulant therapy post fall should be considered by the treating medical team.
- There may be late manifestations of **head injury up to 72 hours.**
- Consider that patients may present with subtle symptoms/signs of fractures and closed head injuries.
- A full physical examination of the patient should be undertaken by the medical team to assess if intracranial, intrathoracic or intra-abdominal bleeding has occurred
- Fall incidents resulting in surgical intervention are assessed as Datix CIMS SAC 1 (Severity Assessment Code) and are to be reviewed within 24 hours.

## **Recommended actions post-fall**

### **Immediate post fall**

**Activate a Code Blue Medical if the patient meets the criteria for prompt care.**

- Do not move the patient initially but reassure. Look for danger
- Call for assistance.
- Immobilise the cervical spine if head and / or neck pain is reported or suspected.
- Check for other potential injuries.
- Perform vital signs observations – blood pressure, pulse, respiration rate, oxygen saturation, blood sugar level (if applicable), temperature and pain score.
- Perform **neurological observations and assessments**, including Glasgow Coma Scale, speech, eye movements and pupil abnormalities, facial asymmetry, power, reflexes and plantar responses.
- If there are any doubts about the appropriate investigations and management contact the Senior Registrar for prompt care and review.
- Observe for delirium and new or worsening confusion, headaches, amnesia, vomiting or change in the level of consciousness.
- Clean and dress any wounds – consider immunisation status for tetanus.
- Notify the medical team and request a review.
- Notify the Unit Manager /Clinical Nurse/Midwife Consultant Specialist/ After Hours Hospital Clinical Manager as appropriate.

- Consider the need for analgesia as indicated.
- Conduct relevant investigations as required. Consider blood tests, ECG, x-rays, CT head scan
- Report the fall on the Datix CIMS database.

### **Within 6 hours post fall and ongoing care**

- Initially record vital signs and neurological observations every 30-60 minutes for 4 hours on the MR 337, and then review by the Medical Officer.
- Any observations that fall outside of the acceptable parameters on the observation chart should prompt escalation as per the Recognising and Responding to Clinical Deterioration guideline.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal- motor/ sensory changes.
- Continue the investigation and treatment of any injuries sustained.
- Notify the next of kin and carer (if applicable) subject to the patient's consent or condition if the patient is unable to give consent themselves. Document all attempts to make contact in the medical notes.
- If not already identified as at high risk of falls injury, flag on the Falls Risk Management Tool MR 260.02 and note on the Clinical Handover sheet in the 'situation' section. It should also be documented on the Nursing Care plan MR 286.02 on the 'mobility' section (Ward 6).
- Complete preliminary patient, family and carer education on falls risk management.
- The Medical Officer should complete a post fall review:
  - Talk to relevant staff and the patient about the nature of the fall, the symptoms arising from the fall and the Fall Management Plan
  - Document the fall in the medical record. Details should include:
    - The mechanisms of the fall
    - Location
    - Time and circumstances
    - Evidence of injury
    - Any loss of consciousness
    - Relevant environmental information
    - What falls risk strategies were in place at the time of the fall and actions taken
- Reassess the patient's fall risk, discuss the management plan with the patient and document the agreed actions.

### **6-12 hours post fall**

- If the fall was not witnessed and / or the patient hit their head or is on anticoagulants/ anti-platelet medication complete the following observations

- Continue neurological observations based on the patient's condition; 30-60 minutely as indicated by the parameters on the observation chart; 4 hourly if stable.
- Refer all variances to the Medical Officer for further review.
- If the fall was witnessed and the patient is not on anticoagulants / anti-platelet medication complete the following observations
  - Continue vital signs observations at least 4-6 hourly for 72 hours or until discharge from the time of the fall, then review by the Medical Officer.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal motor / sensory changes.
- Ensure strategies have been put in place to prevent further falls as far as is practicable.
- Review the results of blood tests and x –rays with the Medical Officer for treatment options. Ensure the Medical Officer is aware of any abnormalities in the results.
- Modify the environment to reduce further falls and ensure the continued safety of the patient, including safe and easy access to personal belongings and equipment.

## **12- 48 hours post fall**

- If the fall was not witnessed and / or the patient hit their head or is on anticoagulants/ anti-platelet medication complete the following observations
  - Continue neurological observations based on the patient's condition; 4 hourly if stable.
  - Refer all variances to the medical officer for further review.
- If the fall was witnessed and the patient is not on anticoagulants / anti-platelet medication complete the following observations
  - Continue vital signs observations at least 4-6 hourly for 72 hours or until discharge from the time of the fall, then review.
- Notify the Medical Officer of any change in observations including visual changes, speech disturbance and focal motor / sensory changes.
- Ensure all tests results have been reviewed by a Medical Officer and actioned as required.
- Continue the investigation and treatment of any injuries sustained.
- Ensure falls prevention strategies are appropriate for the patient's particular risk factors and documented in the care plan – if there are any concerns, reassess and implement strategies.
- A review by other relevant staff is recommended within the following timeframes post fall:
  - Physiotherapist within 36 hours
  - Occupational Therapist within 36 hours
  - Pharmacist review within 36 hours

- Dietician review if the patient is malnourished
- Specialist nurse (e.g. urology) if indicated.
- Continue patient, family and carer education on falls risk management.

### **48-72 hours post fall**

- If the patient is considered stable at 72 hours, return to the pre-fall level of observations.
- All specialist and allied health reviews must be completed and a plan of care/ treatment documented in the patient's notes for falls risk management

### **Further considerations within 72 Hours post fall**

- Optimise secondary prevention of further falls using the following strategies where applicable and age-appropriate:
  - Consider Vitamin D testing.
  - Consider a bone mineral density scan if the patient is at risk of osteoporosis and is deemed appropriate by the medical officer.
  - Continued patient, family and carer education on falls risk management.
  - If patient has developed a fear of falling, offer referral to a Social Worker or Clinical Psychologist.
  - Plan the discharge with consideration of the patient's ongoing fall risk and the need for home assessment and equipment.
  - The discharge documentation shall include information about the fall occurring.

See Department of Health WA Summary: Guidelines of Post-Fall Management that includes the below flowchart



**Within 6 hours post-fall**

- Record vital signs and neurological observations every 30-60 minutes for 4 hours then review.
- Promptly action any observations outside of acceptable parameters.
- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Continue investigation and treatment of injuries sustained.
- Notify Next of Kin and provide patient, family and carer falls risk management education.
- If not already identified as high risk of fall injury, flag as per local policy.
- Ensure minimum standards as per Falls Risk Assessment and Management Plan OD (FRAMP).
- Complete Clinical Incident Form.
- Consider need for transfer to tertiary health service if at secondary health service.

**Post-fall review**

- Document fall in medical record. Include mechanisms of fall, location, time, injury and actions taken.

**Reassess falls risk status**

- Complete FRAMP.
- Refer to relevant staff.
- Develop or update care plan.

**Communication**

- Communicate incident, outcomes and care plan to all relevant staff.

**6 to 12 hours post-fall**

**Unwitnessed fall and/or hits head OR is on anticoagulants/ antiplatelet medication**

- Continue neurological observations based on patient's condition; 30-60 minutely as indicated by parameters on the observational chart; 4 hourly if stable.

**Witnessed fall and did not hit head**

- Continue vital signs observations 4-6 hourly for 72 hours then review.

**For all patients**

- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Ensure care plan and FRAMP are in place, effective and updated as required.
- Review investigation results.
- Modify environment to reduce falls.
- Refer to relevant staff
- Continue patient, family and carer education on falls risk management.

**12 to 48 hours post-fall**

**Unwitnessed fall and/or hits head OR is on anticoagulants/ antiplatelet medication**

- Continue neurological observations based on patient's condition; 30-60 minutely as indicated by parameters on the observational chart; 4 hourly if stable.

**Witnessed fall and did not hit head**

- Continue vital signs observations 4-6 hourly for 72 hours then review.

**For all patients**

- Notify MO/NP of any visual or focal motor/ sensory changes or speech disturbance.
- Ensure all tests results have been reviewed by MO/ NP and actioned.
- Continue investigation and treatment of injuries sustained.
- Ensure FRAMP and care plan are in place, effective and updated as required.
- Review by other relevant staff is recommended. This includes physiotherapist, occupational therapist and pharmacist review within 48 hours post fall; Consider dietician (if patient is malnourished), podiatry and specialist nurse review.
- Continue patient, family and carer education on falls risk care.

**48 to 72 hours post-fall**

- if patient is considered stable at 72 hours, return to pre-fall level of observations.
- All specialist and allied health review must be completed and plan of care/ treatment documented in the patient's notes for falls risk management.

**Considerations within 72 hours post-fall**

Optimise secondary prevention of further falls by:

- Consider Vitamin D testing.
- Consider bone mineral density scan if patient is at risk of osteoporosis.
- Consider use of hip protectors.
- Continued patient, family and carer education on falls risk management.
- Consider Fear of Falling and refer to Social Worker or Clinical Psychologist.

Note: Clinical protocol does not replace clinical judgement. Care outlined in this clinical protocol must be altered if it is not clinically appropriate for the patient.

## Educate new parents for baby falls prevention

### Provide education on how to keep their baby safe from falling

- Refer parents to the Safe sleeping and Keeping your baby safe brochures and the safe sleeping section in the '[Pregnancy, birth and your baby](#)' patient information book.
- Address safety issues when changing nappies, bathing babies etc as these are potential fall risk situations
- Address the safety issues of placing the baby on the bed unattended as all babies have the potential to roll off the bed
- Highlight the importance of putting their baby to sleep on their back from birth in their own cot next to the adult bed.
- Provide verbal advice and patient information about the risk of a falling asleep while holding their baby.
- Highlight the risks of walking around the maternity units or hospital with their baby in their arms, and advise them to always place baby in cot to transport.

## References and resources






1. Australian Commission on Safety and Quality in Health Care. Falls Prevention 2014. Available from: <http://www.safetyandquality.gov.au/our-work/falls-prevention/>
2. Department of Health, Western Australia. Post-Fall Management Guidelines in WA Healthcare Settings. Perth: Health Networks Branch, Department of Health, Western Australia. 2015. Available from: <http://www.health.wa.gov.au/circularsnew/attachments/754.pdf>

## Related policies

- [Stay On Your Feet WA](#)
- [Falls Prevention Health Network](#)
- [OD 0442/13 Post-Fall Management Guidelines in Western Australian Healthcare Settings](#)
- [OD 0442/13 Post-Fall Management Guidelines in Western Australian Healthcare Settings](#)
- <http://www.health.wa.gov.au/circularsnew/pdfs/13180.pdf>
- <http://www.health.wa.gov.au/circularsnew/attachments/975.pdf>

## Related WNHS policies, procedures and guidelines

WNHS Policy [Falls Prevention and Falls Management](#)

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