



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 Department of Health WA [Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018](#)

## 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 (DOSA) 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 patients 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 and Postoperative Analgesia \(including epidural management\)](#): 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.

## Post fall management

Please refer to the Department of Health WA: [Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018](#)

### Post fall process

NURSING GUIDELINE AND 48 HOUR POST FALL PROCESS	
<b>Stop and Consider:</b> Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy (e.g. alcohol dependent persons) are at an increased risk of intracranial, intrathoracic, intra-abdominal haemorrhage	
<b>DATE AND TIME OF FALL:</b>	
IMMEDIATE POST FALL PROCEDURE	
DRSABCDE	
<ul style="list-style-type: none"> <li>• Provide patient reassurance and comfort and call for assistance</li> <li>• Patient not to be moved if any physical injuries identified (unless airway is compromised)</li> <li>• Activate Medical Emergency Team (or local process) if patient meets criteria</li> <li>• If significant physical injuries identified, fast track Medical Officer review within 30 minutes</li> <li>• Immobilise cervical spine if patient is unconscious or reports head or neck pain</li> <li>• Patient movement to be guided by local policy and clinical assessment</li> <li>• Commence neurological and baseline physical observations</li> <li>• Minimum investigations include blood glucose level, ECG cognitive impairment screening using the AMT4/4AT/CAM (as per local policy). Identify immediate pre-fall symptoms e.g., dizzy, feeling unsteady, etc. and consider other investigations as indicated by the pre-fall symptoms, contributing factors to the fall and the patient's condition</li> <li>• Notify Medical Officer of patient fall and request review. (If no apparent injury, this can occur within 4 hours or as per local policy)</li> <li>• Notify Ward/Area/ Facility/ Senior Registered Nurse (SRN)/After Hours Clinical Nurse Specialist</li> </ul>	
↓ TYPE OF FALL AND ONGOING OBSERVATIONS AND CARE DELIVERY ↓	
<b>WITNESSED FALL – DID NOT HIT HEAD</b>	<b>PATIENTS ON ANTICOAGULANTS/ANTIPLATELETS AND/OR WITNESSED FALL – HIT HEAD, UNWITNESSED FALL</b>
<ul style="list-style-type: none"> <li>• Medical/SRN's clinical judgment for observations.</li> <li>• Documentation of rationale required.</li> </ul> <p>Continue with instructions below.</p>	<p>Neurological observations:</p> <ul style="list-style-type: none"> <li>• Half-hourly for a minimum of 2 hours until GCS of 15 or patient considered back to their normal level of cognition achieved.</li> <li>• Continue if GCS remains &lt; 15 or patient not considered at normal level of cognition. Report to MO and continue as per instructions.</li> </ul> <p>If patient has GCS of 15 or patient considered back to their normal level of cognition then continue:</p> <ul style="list-style-type: none"> <li>• Hourly for 4 hours.</li> <li>• Two-hourly 4 hours.</li> <li>• Four-hourly for 40 hours (to make total of 48 hours from time of fall).</li> <li>• If clinically assessed as stable, no deterioration, return to observations pre-fall.</li> </ul>
↓ RECOMMENDED ACTIONS WITHIN 4 HOURS OF THE FALL ↓	
<ul style="list-style-type: none"> <li>• Next of Kin (NOK) notification</li> <li>• Physical, behavioural, and cognitive injury care as indicated</li> <li>• Continue to identify and report clinical deterioration</li> <li>• Rescreen using FRAMP (or local endorsed falls risk assessment tool) and implement interventions</li> <li>• Medical review (if not fast tracked)</li> <li>• Documentation and reporting of the fall</li> <li>• For an injurious fall that may be considered a SAC 1 injury – complete notification as per local clinical incident management policy</li> </ul>	

<p><b>RECOMMENDED ACTIONS WITHIN 6 HOURS: CONTINUE OBSERVATIONS AS INDICATE BY FALL TYPE</b></p>
<ul style="list-style-type: none"> <li>• Continue to monitor for physical, behavioural, cognitive clinical deterioration. Report to MO if this occurs.</li> <li>• Notification of fall to Occupational Therapist or Physiotherapist.</li> <li>• Notify the Pharmacist when possible.</li> <li>• Referral to other health professionals as per clinical assessment (and as per local policy).</li> </ul>
<p><b>RECOMMENDED ACTIONS WITHIN 24 HOURS: CONTINUE OBSERVATIONS AS INDICATED BY TYPE OF FALL</b></p>
<ul style="list-style-type: none"> <li>• Patient and family/carer to receive information and education. Ongoing falls management care developed in partnership with patient and family/carer.</li> <li>• Review of results of bloods, imaging, microbiology, and observations has occurred and been actioned.</li> <li>• The multidisciplinary team members have collaboratively discussed the fall and identified any further risks and interventions required.</li> <li>• Consider a structured multidisciplinary Post Fall Safety Discussion.</li> </ul>
<p><b>RECOMMENDED ACTIONS AT 48 HOURS:</b></p>
<ul style="list-style-type: none"> <li>• Review of observations and if no clinical deterioration, return to appropriate observations.</li> <li>• Completion of all actions within the guidelines.</li> <li>• Comprehensive care plan review.</li> <li>• Document and communicate to the appropriate person any outstanding actions and date/time completion required.</li> </ul>
<p><b>COMMUNICATION:</b></p>
<ul style="list-style-type: none"> <li>• Ensure patient consents to discussion of care with family/carer (where clinically appropriate).</li> <li>• Interpreter is always to be utilised where appropriate (and as per local policy).</li> <li>• Primary nurse to ensure documentation in patient's health care record and local reporting database.</li> <li>• Medical and allied health reviews documented in the patient's health care record.</li> <li>• Patient and family/carer to receive information/education about the fall and ongoing instructions if discharged within 48 hours of the fall.</li> <li>• All disciplines involved are to partner with the patient and family and share decisions to develop ongoing plan of care.</li> <li>• Communication may require different approaches depending on disability/cultural requirements.</li> <li>• Documentation of the fall to occur on nursing, medical, allied health handover sheets, and all transfer and discharge documentation.</li> <li>• Inclusion of the fall in verbal handovers: nursing, medical, allied health.</li> <li>• All staff involved in the care of the patient to be informed of incident outcome and revised care plan.</li> <li>• Visual flagging that the patient is at high risk of falls (and as per local policy).</li> <li>• Contact Ward/Area/Facility/SRN/After Hours Clinical Nurse Specialist (and as per local policy)</li> </ul>
<p><b>ALLIED HEALTH ASSESSMENT: OT, PHYSIOTHERAPY, PHARMACY</b></p>
<ul style="list-style-type: none"> <li>• Complete assessments as per specific discipline guidelines within 2 working days of the fall (and as per local policy).</li> <li>• Work collaboratively with the wider multidisciplinary team.</li> </ul>

**Acknowledgment:** Western Australian Department of Health. WA Multidisciplinary Post Fall Management Guidelines 2018. Perth: Post Fall Working Group Western Australia; 2018

## 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.

## Neonates: 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 \(PDF, 5.93MB\)](#)', 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

1. Australian Commission on Safety and Quality in Health Care. Falls Prevention 2014. Available from: <https://www.safetyandquality.gov.au/our-work/comprehensive-care/related-topics/falls-prevention>
2. Department of Health Western Australia. Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018. Perth: Post Fall Working Group Western Australia. 2018. Available from: [https://ww2.health.wa.gov.au/~/\\_media/Files/Corporate/general%20documents/Health%20Networks/Falls%20prevention/WA%20Post%20Fall%20Guidelines\\_Final\\_2018\\_PDF.pdf](https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Health%20Networks/Falls%20prevention/WA%20Post%20Fall%20Guidelines_Final_2018_PDF.pdf)

## Related standards, policies and guidelines

- Australian Commission on Safety and Quality in Health Care: [Comprehensive Care Standard](#) (Minimising patient harm- actions 5.24-5.26): [Falls Prevention](#) (external site)
- Department of Health WA: [Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018](#)
- NMHS: [Falls Risk Management Policy](#)
- SCGH: [Nursing Practice Guideline No 9: Falls Prevention and Management](#)
- PCH Neonatology Guideline: [Falls: Care of a Newborn Following a Drop/Fall](#)

## Resources

- [Stay On Your Feet WA](#)
- Falls Prevention Health Network

Keywords:	In-hospital fall, falls, falls risk, fall, falls management, after fall		
Document owner:	Obstetrics and Gynaecology Directorate (OGD)		
Author / Reviewer:	Pod lead: SQP CPI Coordinator (standard 5) / CNC Ward 6		
Date first issued:	07/2007	Version:	6.0
Reviewed dates:	June 2009; Sept 2010; Aug 2014; Feb 2018; Mar 2020- links updated & added post-fall process chart	Next review date:	Mar 2023
Supersedes:	This March 2020 version (v6.0) supersedes the Feb 2018 version		
Endorsed by:	Standard 5 Minimising Harm Subcommittee Obstetrics & Gynaecology Directorate Management Committee [OOS approved with Medical and Midwifery Co-directors]	Date:	10/2/2020
		Date:	03/03/2020
NSQHS Standards (v2) applicable:	1  Governance, 2  Partnering Consumer, 5  Comprehensive Care (incl  ), 8  Recognising & Responding to Acute Deterioration		

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