

Policy Directive: compliance is mandatory

Fall and Fall Injury Prevention and Management Policy Directive

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Summary The purpose of the Fall and Fall Injury Prevention and Management Policy Directive is to establish a uniform approach to falls and fall injury prevention and management that is consistent with Australian best practice guidelines and the requirements of the National Safety and Quality Health Service Standards. The Directive clearly outlines governance and the responsibilities of individuals and health service organisations in relation to falls and fall injury prevention, and management after a fall event.

Keywords Fall, falls prevention, fall injury, safety and quality, policy, directive, Standard 10, patient safety, prevention of falls and harm from falls

Policy history Is this a new policy? *N*
 Does this policy amend or update an existing policy? *Y*
 Does this policy replace an existing policy? *Y*
 If so, which policies? This policy Directive subsumes the previous Fall and Fall Injury Prevention Guideline (GO100, eA482359).

Applies to *All Health Networks*

Staff impacted *All Staff, Management, Admin, Students; Volunteers*

EPAS compatible *Yes*

Registered with Divisional Policy *Yes*

Contact Officer

Policy doc reference no. D0218

Version control and change history

Version	Date from	Date to	Amendment
1.0	02/12/2010	16/09/2012	Original version
1.1	17/09/2012	18/06/2013	Update to reflect the restructures within the portfolio and are not material in nature.
2.0	19/06/2013	31/12/2015	Revision following consultation process
3.0	15/01/2016	30/06/2018	Scheduled review and consultation process. Accompanying policy guideline G0100 rescinded and replaced by revised toolkit.



Fall and Fall Injury Prevention and Management Policy Directive

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of South Australia

SA Health

Document control information

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15/01/2016	V3	Portfolio Executive	Formally reviewed in line with 1-5 year scheduled timeline for review. Accompanying policy guideline (GO100) rescinded and replaced by revised toolkit.
19/06/2013	V2	Portfolio Executive	Formally reviewed in line with 1-5 year scheduled timeline for review.
17/09/2012	V1.1	Portfolio Executive	Update to reflect the restructures within the portfolio and are not material in nature.
02/12/2010	V.1	Portfolio Executive	PE Approved original version.

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Fall and fall injury prevention and management Policy Directive

1. Objective

The purpose of this policy is to:

- establish a consistent, embedded approach to the prevention and management of falls across SA Health services that is:
 - in accord with the national guidelines
 - supports services to meet accreditation requirements
 - supports least restrictive care.
- increase the awareness among clinical and non-clinical workers, consumers and the public of the importance of being proactive in the prevention of falls, and the risk to consumer safety, and to the organisation, when this is not achieved
- describe governance and clearly outline workers' and health services' responsibilities in relation to the prevention and management of falls.

This policy directive is to be read / administered in conjunction with the [Fall and Fall Injury Prevention and Management toolkit](#).

2. Scope

All SA Health employees, and persons who provide services on behalf of SA Health, directly or indirectly to consumers, must adhere to this policy.

This policy directive and the accompanying tools apply only to consumer falls.

This policy directive and the accompanying tools do not:

- apply to workers, including employees, occupiers, volunteers, contractors, labour hire workers, students and other people, who are covered by [Prevention of Slips, Trips & Falls Policy Directive](#)
- provide advice on individual clinical issues, but refer to such guidelines where relevant.

3. Principles

3.1 Injurious falls are a major threat to a person's independence, and can result in disability, increased length of stay and need for supported care.

3.2 Although falls are more common among older people, younger people and children with health conditions or a disability, and any consumer undergoing particular treatments such as surgical procedures or dialysis can be at elevated risk of falling and injury in the short or long term.

3.3 Engaging consumers and their carers in care planning and decision-making is an integral part of preventing falls, minimising harm from falls, and the fear of falling.

3.4 SA Health seeks to reduce the falls and harm from falls that occur during care. SA Health inpatient services and residential care facilities will respond to risk of falls and harm from falls in ways that respect the individual's rights, dignity, autonomy and decision-making capacity and use evidence-based, multidisciplinary team care.

3.5 Care is provided in a way that minimises the use of restrictive practices, while effectively managing risk to the consumer.

3.6 SA Health seeks to reduce the demand on emergency and treatment services that is generated by falls in the community, by:

- systematic and proactive risk identification across health care settings
- using primary, secondary and tertiary prevention in community-based services
- using population health, and health promotion approaches in community-based services.

3.7 Managing the risk factors for falls supports healthy ageing principles and has benefits beyond reduction of falls and fall injury, for example management of delirium, vision or balance problems and bone health.

4. Detail

4.1 Governance

With the implementation of this policy, all SA Health organisations and services will meet the requirements of accreditation against national standards (1) and ensure that:

- governance structures and systems with management, clinical, and procurement representation are in place
- health workers have access to policies and procedures, education and training; referral information and other relevant resources.

Clinical governance will provide:

- development, implementation and monitoring of organisation-wide falls and fall injury prevention systems of care, that are based on local needs and include internal procedures, equipment provision and referral pathways
- advice to management and clinical governance committees around service design, staff training needs, environment, equipment and relevant resources
- leadership of quality improvement activities and use of administrative data (incident reports and coded data), clinical data (audits) and research evidence to plan, measure, monitor and improve the effectiveness of systems of care and clinical practice in reducing falls incidents and rates of harm.

Further information: Tool 1 [Example Terms of Reference \(TOR\)](#) for a health service's Fall Prevention Committee.

4.2 Prevention of falls and harm from falls

4.2.1 Identifying consumers at risk of falling and injury (screening and assessment protocols)

A current knowledge of the consumer's risk factors for falls and for injury in the event of a fall is critical in implementing an effective care plan, and for communicating that with other health professionals.

Screening, assessment and review or reassessment to identify the individual's fall and fall injury risk factors is conducted in accord with the Australian Best Practice Guidelines (2) and accreditation standards (1).

Recommended screening, assessment and review or reassessment for a variety of healthcare settings is outlined in Tool 2 [When and how to do Fall risk screening, assessment, care planning and discharge planning](#) and also in the online eLearning course – [Falls Prevention](#).

4.2.2 Management of consumers who are at risk

The care provided by SA Health services is informed by best available evidence, and individual assessment (2).

Falls and injury risk factors, and therefore the interventions required, differs between consumers in community, residential care and hospital settings; and between individuals who are relatively well, frail, or cognitively impaired, younger or older, disabled, and their current health care.

While there are general falls prevention strategies, for example removal of tripping hazards, that should always be applied, the most effective approach for those at risk in any setting is an individualised multifactorial, multidisciplinary falls prevention program. There is also evidence for some single interventions, such as cataract removal.

Multifactorial interventions for those at risk are aimed at:

- reducing the burden of intrinsic and extrinsic risk factors
- providing a safe physical environment and appropriate equipment
- using systems of care that reduce risk of fall and fall injury, for example rounding
- providing seamless care transitions and longer term risk reduction through handover and/or referral to appropriate service providers after hospital-based and other services for follow-up.

Falls prevention and harm minimisation strategies should be offered to consumers with cognitive impairment, but strategies may need to be modified to suit the individual.

In acute settings, a multifactorial approach, and involvement of interdisciplinary team is recommended. Recommended actions to address the risk factors identified are listed on the Fall and fall injury risk assessment and care planning form (MR58 or equivalent) and also in the online eLearning course – [Falls Prevention](#).

For community settings, there is good evidence for systematic and proactive risk identification and strategies such as tailored balance and strengthening exercises that can take time to reduce the risk factors (2). Community-based services, including but not limited to Falls Prevention Clinics, and community geriatric services can use:

- primary, secondary and tertiary prevention
- population health, and health promotion approaches (3) including awareness raising, for example service directories and April Falls Awareness Month.

In all settings, care is provided in a way that minimises the use of restrictive practices, that is, least restrictive care. For a consumer who is without decision-making capacity, the use of restraint may be considered as a last resort and only when alternative strategies have failed, and an imminent risk of harm from falling is still present. The application of restrictive practices will be guided by the [Minimising Restrictive Practices Policy Directive](#), and Tool 3 [Safe use of bedrails](#).

4.2.3 Falls and fall injury prevention equipment and environmental considerations

All health services should ensure that appropriate aids, equipment, devices are available for safe consumer mobility, transfers and injury reduction, and that staff training and procurement processes support their effective and safe use. This includes items for consumer use such as walking aides, bed mobility aides, hip protectors and grip socks; and shock absorbing bedside mats, surveillance or alert systems for staff use.

A safe environment for an unsteady consumer is one where both general and specific risks or hazards are identified and eliminated or modified. General hazards such as slippery floors present risk to all persons. Specific hazards relate to an individual and should be addressed as far as practicable. Examples of specific hazards include modifications of lighting for a consumer with visual impairment, or grab rails for ADL transfers for a consumer with severe arthritis. Further information is provided in the online eLearning course – [Falls Prevention](#).

All health services should ensure that a safe environment in facilities is provided through service design and planning and regular review/audit of the environment.

Where services are provided in the consumer's home by community-based services, intervention includes assessment and modification of the environment, and use of equipment/devices as agreed with consumer and carer.

4.2.4 Care planning

SA Health staff should discuss the findings from assessment with the consumer and/or carer to develop a care plan to manage risks, irrespective of their diagnosis, and ensuring continuity of care between settings.

The multifactorial care plan focusses on a consumer's individual risk factors for both falling and sustaining injury from falls, and the risk posed by the surrounding environment on that individual.

This will include provision of a safe environment, clinical care and referral to appropriate multidisciplinary team members, and recommended interventions, including equipment, based on their assessment.

Recommendations for care planning and review of care plans for a variety of health settings is outlined in [Tool 2 When and how to do Fall risk screening, assessment, care planning and discharge planning](#) and also in the online eLearning course – [Falls Prevention](#).

4.2.5 Engaging the consumer and carers

The consumer and carers are made aware of the outcome of the assessment and participate where possible in the planning of interventions, in accord with requirements of the [National Safety and Quality Health Service Standards](#) and consumer-centred care principles.

Consumers are supported to partner with clinical staff in the development of their falls prevention care plan and also the discharge plan.

The clinical team provides support and care coordination to consumers and carers to facilitate their engagement with their care, with consideration of health literacy and cultural and language requirements.

Written and verbal information can assist, but not replace this process. A variety of [consumer information](#) is available on the Safety and Quality webpages.

4.2.6 Documentation, teamwork and communication

Systematic verbal and written communication methods will be used to ensure that all healthcare workers providing direct and non-direct care are aware of the identified risk factors and planned interventions and precautions for the consumer. Consideration of an agreed visible flagging system to support these other methods can be considered.

Communication includes documentation in medical record or EPAS, and clinical handover as per the [Clinical handover policy](#) and also in the online eLearning course – [Falls Prevention](#).

4.2.7 Discharge planning

Where there is ongoing risk of falling, an assessment of the safety of the home environment for the consumer may need to be arranged.

Prior to discharge from hospital or respite, patients with modifiable risk factors still present are referred with appropriate information to appropriate community services for follow-up risk reduction interventions as per [Tool 2 When and how to do Fall risk screening, assessment, care planning and discharge planning](#).

Encourage supplementation with Vitamin D and calcium for all aged care residents and those in respite, unless medical advice recommends to the contrary.

Similarly, other health services will provide appropriate referral, and handover prior to discharge.

Discussion and consent from consumers and carers is required and further information is available in the online eLearning course – [Falls Prevention](#).

4.3 Management of Consumers who have fallen

4.3.1 Immediate care and management

Immediate care and management, in accord with local Post Fall Management Protocol will be provided to any consumer who falls. As well as diagnosis and treatment of injuries, more frequent physiological and behavioural observations over longer time frames (at least 48 hours) is recommended for consumers who may have hit their head and/or are taking anticoagulation therapy and/or are over 80 years old, to mitigate the risk of un-noticed development of intracerebral bleeding.

4.3.2 Revision of the care plan

A re-assessment of fall and fall injury risk will be completed using the Falls and fall injury risk assessment and care planning form or equivalent, within the same shift, and as soon as practicable as per Tool 2 [When and how to do Fall risk screening, assessment, care planning and discharge planning](#). Changes to the care plan are communicated to the care team and implemented. This is demonstrated in the online e-learning course – [Falls Prevention](#).

4.3.3 Incident reporting

Within the same shift, falls are reported to the incident reporting and management system (Safety Learning System). Further information is available in the [tools](#) Reporting a patient fall incident into Safety Learning System – a SLS Topic guide (Tool 4), and Reporting a patient fall incident – Frequently Asked Questions (Tool 5), and in section 6.

4.3.4 Post fall team review

In the event of a repeat fall or serious fall (SAC 1 or SAC 2, or other as deemed by senior staff) the clinical team will participate in a brief [Post Fall Team Review](#) (Tool 6) within 48 hours. This is aimed at reducing further falls, improving consumer and service safety, quality improvement.

This process is demonstrated in the online eLearning course – [Falls Prevention](#).

A post fall team review forms part of the incident review and analysis phase of the patient incident (*Health Care Act 2008* (SA) Part 7 and 8 s72(1)(b)). As such, any documents developed:

- are to be used for quality improvement purposes
- are to be uploaded into the managers section of the SLS incident
- are not to be released publicly
- do not form part of the medical record.

The process results in:

- recommendations for changes to the care plan for the fallen consumer to reduce the likelihood of further falls
- recommendations for area or service-wide practice changes.

The recommendations arising from the post fall team review can be used to:

- inform changes to the consumer's care plan, which are documented in the medical record
- support shared team learning and quality improvement
- inform consideration of area or service-wide practice changes.

Information is provided to patients and family in accord with [Open disclosure policy directive](#) and practices.

For consumers of community services, the fall reported is to the General Practitioner. If the fall was related to the health services provided, a risk reassessment including the home environment is performed, the care plan modified; and the fall notified into SLS.

4.4 Education and training

To build skills and knowledge to support falls prevention and management systems, orientation and regular education programs:

- are based on Australian best practice guidelines (2)
- are provided regularly to the clinical and nonclinical workforce and are multidisciplinary
- consider the individual's place of work and are tailored to individual roles and responsibilities.

Content of learning and teaching activities will include:

- screening, assessment, care planning, intervention, referral, review and handover/discharge to reduce risk in the short and longer term
- care of the fallen person to minimise harm, promote recovery and facilitate open disclosure and complaint management
- teamwork, shared learning and structured clinical communication
- partnering with consumers and consumer centred care.

Delivery and attendance at education programs is supported by allocated time and resources and is reported within organisational structures.

5. Roles and Responsibilities

5.1 SA Health Chief Executive (CE) will:

- ensure that the management of the risk of falls and harm from falls across SA Health is in accordance with this policy.

5.2 Director of Safety and Quality – System Performance and Service Delivery will:

- establish, maintain and review the effectiveness of the Fall and fall injury prevention and management Policy Directive
- support the implementation of the national guidelines through facilitating the development, dissemination and implementation of training, tools, resource materials and evaluation of these
- support the development of a suite of data indicators relating to falls and fall injury that will be used to monitor trends and inform planning. This will include, but not be limited to incident data, hospital, ambulance, and emergency department data
- review reported falls incidents and investigation reports, conducting trend analysis and develop and disseminate statewide strategies for system improvement
- provide advice to health services in response to specific queries about falls prevention and management.

5.3 Local Health Network Chief Executive Officers will:

- allocate sufficient human and material resources to enable effective falls prevention and management programs to operate across all areas within their area of control, and appropriate data is gathered and analysed to inform planning and evaluation
- delegate the day-to-day responsibility for establishing and monitoring the implementation of this policy to the relevant senior managers
- ensure that services delivered to SA Health consumers, and purchased from providers other than SA Health, are in accord with this policy

- ensure that available evidence and expertise is included in the design and planning of service delivery, to maximise cost effectiveness and impact on the population served
- use available best evidence in falls prevention for new service developments, structural design, changes in work practices and purchase of new equipment and conduct environmental hazard assessments in existing facilities and managed the identified risk
- ensure the health services within their area of control have systems in place which facilitate the effective management and notification of fall incidents (in accordance with the SA Health incident management policy and guideline)
- ensure that all fall related incidents that have the potential to result in substantial liability and/or have the potential to attract significant media attention are immediately escalated to the Chief Executive – SA Health.

5.4 General Managers, Directors, heads of service/departments and other senior managers will:

- develop, implement and monitor local systems and procedures, including staff training and governance structures, that support employees and other persons providing health services on behalf of SA Health to achieve effective management of risk of falls and harm from falls. This includes embedding the identification and management of falls and fall injury risk factors in practice
- create an environment where any incident related to a fall is notified and active management of the consumer and the incident is fostered, ensuring the learning gained from any investigation process is fully implemented and monitored. This includes:
 - investigation of falls and near misses
 - implementation of the actions necessary to reduce the likelihood of recurrence of a similar incident, and evaluation of the effectiveness of those actions taken
- create an environment where the involvement of patients/carers in falls prevention and management processes is actively supported by clinical and non-clinical staff.

5.5 Patient/Client Safety and Quality Risk Managers will:

- promote this falls prevention policy and accompanying guidelines
- assist others to ensure that the health service meets its obligations under this policy
- ensure that an evaluation strategy is in place to assess compliance with this policy and falls prevention and management principles
- ensure that they have sufficient expertise to be able to provide support and advice to staff in relation to falls related issues
- establish mechanisms to support implementation of this policy, including participating in a collaborative, multidisciplinary working group to plan and implement local initiatives, working towards achieving compliance with national guidelines and accreditation
- develop expertise in presenting data to support continuous practice improvement.

5.6 Clinical Educators will:

- ensure that workers are enabled to deliver effective fall and fall injury prevention and management by providing an education program in collaboration with trained Falls Prevention Leaders and the relevant governance committee that includes
 - annual analysis of training needs, to determine which workers require training and education, and what skills, knowledge, attitudes, values and abilities they require
 - delivery of learning programs, including the frequency of refreshers or updates, to meet training needs

- development of learning programs that will support workers to effectively contribute to a reduction in falls and fall-related injury
- evaluation of the learning programs in enabling desired outcomes

5.7 All SA Health employees will:

- adhere to the principles and aims of this policy and ensure that they provide care in accordance with its associated guidelines
- ensure that all fall incidents are reported the Safety Learning System in accord with the [SA Health Incident Management Policy](#).
- participate in education or training to ensure that they have knowledge and skills relevant to their role in preventing falls and harm from falls.

6. Reporting

6.1 All incidents involving a fall or a near miss in an acute or other inpatient service, or centre-based service, or residential facility are to be reported into the 'patient incident' section of Safety Learning System (SLS), and noted in the medical record. Documentation in the medical record should include a factual summary of events, any injuries and their treatment and resultant interventions and actions.

6.2 For community care, all falls or near misses that occur during the period covering the episode of care that are related to any aspect of the provision of care, are to be reported into SLS, and also noted in case records.

6.3 There are requirements for reporting health service area data to the relevant committee and clinical governance system.

6.4 All fall events must be investigated to the level required by the SA Health Incident Management Policy and Guideline.

6.5 Any fall incident which is categorised as SAC 1 (Safety Assessment Code 1) must be reported to the Department for Health and Ageing in accordance with SA Health Incident Management Policy and Guidelines.

6.6 Progress on the implementation of all recommendations generated by the Post fall team reviews, Root Cause Analyses and other investigations must be reported and monitored in accordance with the SA Health Incident Management Policy and Guidelines. SLS includes provision for recording the post fall team review and the actions arising.

For further information, there are three relevant [tools](#):

- Reporting a patient fall incident into Safety Learning System – an SLS Topic guide (Tool 4).
- Reporting a patient fall incident – Frequently Asked Questions FAQs (Tool 5).
- The post fall team review (Tool 6).

7. EPAS











The documentation of the fall risk screening, assessment and care plan, and the clinical management of the person before, during and after a fall will be recorded as part of the medical record in relevant sections of EPAS. This will include the use of alerts, recording of relevant treatment or other orders. These sections have been aligned with current medical records forms, namely:

- Fall and fall injury risk assessment and care planning form (MR58 or MR24.0 at RAH, or equivalent)
- Fall and fall injury risk review form (MR 58a or MR 24.1 or equivalent)
- Fall risk screen (MR 58b or MR 24.2 or equivalent, that includes the FROP-Com screening tool, NARI).

8. Exemption

No exemption allowed for this policy directive

9. National Safety and Quality Health Service Standards

									
National Standard 1	National Standard 2	National Standard 3	National Standard 4	National Standard 5	National Standard 6	National Standard 7	National Standard 8	National Standard 9	National Standard 10
Governance for Safety and Quality in Health Care	Partnering with Consumers	Preventing & Controlling Healthcare associated infections	Medication Safety	Patient Identification & Procedure Matching	Clinical Handover	Blood and Blood Products	Preventing & Managing Pressure Injuries	Recognising & Responding to Clinical Deterioration	Preventing Falls & Harm from Falls
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This policy directive formally aligns with Standard 10, and with relevant sections of Standards 1 and 2.

Clinical handover (Standard 6) and Medication safety (Standard 4) are important for prevention of falls and harm from falls.

10. Risk Management

Risks relevant to falls and harm from falls include:

- harm or injury to consumer, death of a consumer
- inconsistent clinical management, unsuccessful or ineffective interdisciplinary practice and or poor teamwork
- poor or incomplete documentation in medical records
- poor consumer experience, consumer or carer complaints, failure of open disclosure requirements
- unreported incidents
- inappropriate, unlawful or unnecessary use of restraint
- failure to meet national Safety and Quality Health Service Standards
- increased manual handling, treatment and length of stay and documentation required for injured consumers
- adverse media and public perceptions regarding consumer safety.

Activities for SA Health services to reduce organisational risk include:

- ensure accountability and governance of fall prevention systems
- ensure adequate training of workers in relation to this policy and related policies and local procedures
- ensure adequate training of workers in principles and clinical practice of prevention and management of falls and fall injury, including interdisciplinary care
- complying with relevant legislation and being able to provide evidence that supports this

- ensure adequate training of managers in the actions required to support recovery of consumers, complaint and grievance handling, learning and practice improvement
- documentation of assessment of consumer's risk and the agreed care plan
- ensure effective planning and handover or referral on discharge for consumers with risk of falls
- meeting the requirements of relevant standards (NSQHSS) and being able to provide evidence that supports this
- responding to complaints, coronial requests, medico-legal, requests under the Freedom of Information legislation.

11. Evaluation

Demonstration of compliance with this policy directive by Local Health Networks and health services will include:

- achievement of accreditation against National Safety and Quality Health Service Standards
- evidence of clinical governance, quality improvement projects and clinical audit of practice against this policy
- evidence of change in clinical practice, for example assessment of risk of falls, appropriate interventions and participation in training and education relevant to roles
- monitoring and action in response to relevant consumer experience and consumer feedback
- evidence of consumer participation in service design, planning and evaluation relevant to falls prevention
- incident reporting, review and management (SLS).

The SA Health Safety and Quality Unit will report data and trends of falls and near misses through the annual Patient Safety Report; through reports to the Portfolio Performance Review committee; and displayed in Local Health Network Analytics and Reporting System (LARS).

Metrics include counts and rates of falls, and rates of harm from falls (SAC rating and consequences from SLS), including intracranial injury, hip and other fractures (ICD-10 codes).

The SA Health Safety and Quality Unit monitors consumer experience (SACESS) and complaints, feedback (SLS).

12. Definitions

In the context of this document:

- **admission assessment** means: a comprehensive assessment completed for each patient on admission, including an holistic assessment of risk, and designed to inform the development of an initial care plan
- **decision-making capacity** means: a person's decision-making capacity related to their ability to make a particular decision, and this can fluctuate over time. Decision-making capacity is required in order to provide informed consent to medical treatment. A person has decision-making capacity, in relation to a specific decision, if they can:
 - understand information about the decision
 - understand and appreciate the risks and benefits of the choices
 - remember the information for a short time
 - tell someone what the decision is and why they have made the decision.

- **fall** means: an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. If a consumer is found on the floor or lower level, it should be assumed that a fall has occurred unless there is reasonable evidence of a sudden onset of paralysis, epileptic seizure, loss of consciousness or overwhelming external force (being pushed).
- **fall and fall injury risk assessment** means: A detailed assessment that identifies the individual's risk factors for falling and for fall related injury. This will assist with clinical decision-making by indicating which interventions should be included in the care plan
- **fall risk screen**, or screening tool means: A brief test that gives an indication of the patient's overall level of risk of falling. This may indicate the need for more detailed assessment
- **incident** means: any event or circumstance which could have (near miss) or did lead to unintended and / or unnecessary psychological or physical harm to a person and / or to a complaint, loss or damage (SA Health Incident Management Policy)
- **interventions** means:
 - **single intervention** means: an intervention targeting one risk factor, such as a balance and strength exercise program, medication adjustment, vision improvement, home/environmental modification, footwear adjustment or educational program
 - **multifactorial intervention** means: an intervention made up of a set of interventions that are intended to address some or all of the specific risk factors that were identified through an individual's fall injury risk assessment. This is ideally provided by a multidisciplinary team
- **least restrictive** means an environment or intervention which places the least amount of restriction on freedom of movement while maintaining the safety of the person and others (*Mental Health Act, 2009*).
- **mobility or functional assessment** means: An assessment of the person's mobility and function – gait, balance, strength, transfers –which considers a subset of the factors included in a fall and fall injury risk assessment, but in more depth, for example an analysis of balance or transfers
- **near miss (for falls)** means: an incident where a fall was likely but averted through the action of staff or by the consumer themselves, or other
- **older person** means: a person 65 years of age or over, or 50 years and over for those of Aboriginal or Torres Strait Islander background.
- **restrictive practices** mean all the types of restraint, care and control, reasonable force, and seclusion.
- **risk factors for falling** means: factors that increase a person's probability of falling. Usually described as;
 - **intrinsic risk factors** means: these relate to a person's condition and can include, but are not limited to, poor vision, poor balance, incontinence and muscle weakness.
 - **extrinsic risk factors** means: these relate to a person's environment or their interaction with their environment and include, but are not limited to slipping or tripping hazards.
 - **medication risk factors** means: these relate to the medications that a person is taking that are known to be associated with increased falls risk, and includes the type, for example psychotropics, and the number prescribed, for example polypharmacy (five or more medication types).
 - **behavioural risk factors** means: these relate to a person's behaviour and include but are not limited to inattention, risk-taking and inability to follow instructions.

- **risk factors for injury** means: factors that increase a person's likelihood of injury as a result of the impact from a fall. These include, but are not limited to poor bone strength, poor skin health, low body mass index, anti-coagulant therapy
- **risk of a fall** means: the probability or likelihood of falling.
- **risk of injury** means: probability or likelihood that an injury will result from the impact sustained during a fall

13. Associated Policy Directives / Policy Guidelines

- [Advance Care Directives](#)
- [Clinical handover policy](#)
- [Consumer feedback management policy directive and guideline](#)
- [Framework for active partnership with consumers and the community](#)
- [Incident management policy directive](#)
- [Minimising Restrictive Practices in healthcare Policy Directive](#)
- [Manual Tasks at work policy](#)
- [Open disclosure policy directive](#)
- [Restraint and seclusion in mental health services policy guideline](#)
- [Work Health and Safety Duty of care to all persons policy directive](#)

14. References, Resources and Related Documents

Related documents

- Tool 1 Example Terms of Reference (TOR) for a health service's Fall Prevention Committee Toolkit
 - Tool 2 When and how to do Fall risk screening, assessment, care planning and discharge planning
 - Tool 3 Safe use of bedrails
 - Tool 4 Reporting a patient fall incident into Safety Learning System – an SLS Topic guide
 - Tool 5 Reporting a patient fall incident – Frequently Asked Questions
 - Tool 6 Post fall team review
 - SA Health Accreditation Resource Guide
 - the online eLearning course – [Falls Prevention](#)
- Medical Records forms
- Fall and fall injury risk assessment and care planning form (MR58 or equivalent)
 - Fall and fall injury risk review form (MR 58a or equivalent)
 - Fall risk screen (MR 58b or equivalent, including FROP-Com screening tool, NARI)

References

1. [National Safety and Quality Health Service Standards](#) Australian Commission for Safety and Quality in Health Care
2. Australian Best Practice [Guidelines](#) Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care and Community Care (2009) Australian Commission on Safety and Quality in Health Care.
3. Stay on Your Feet® [Community Good Practice guidelines](#) Queensland Health

Legislation

- *Advance Care Directives Act 2013 (SA)*
- *Aged Care Act 1997 (Commonwealth)*
- *Civil Liability Act 1936 (SA)*
- *Coroners Act 2003 (SA)*

- *Health Care Act 2008 (SA)* (Part 7 – Quality improvement and Research & Part 8 – Analysis of adverse incidents.) *Health Care Regulations 2008 (SA)*
- *Health Practitioners Regulation National Law Act 2009*
- *Mental Health Act 2009 (SA)*
- *Work Health and Safety Act 2012 (SA)* and *Work Health and Safety Regulations 2012 (SA)*
- *Commonwealth Aged Care Act 1997*

Relevant SA legislation can be accessed at www.legislation.sa.gov.au.

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A guide to using the policy directive and toolkit



<p>POLICY DIRECTIVE</p> <p>Fall and fall injury prevention and management</p>	<p>The purpose of this policy is to:</p> <ul style="list-style-type: none"> > establish a consistent, embedded approach to the prevention and management of falls across SA Health services that: <ul style="list-style-type: none"> • is in accord with the national guidelines • supports services to meet accreditation requirements • supports least restrictive care > increase the awareness among clinical and non-clinical workers, consumers and the public of the importance of being proactive in the prevention of falls, and the risk to consumer safety, and to the organisation, when this is not achieved > describe governance and clearly outline workers' and health services' responsibilities in relation to the prevention and management of falls.
<p>TOOL 1</p> <p>Example Terms of Reference (TOR) for a health service's Fall Prevention Committee</p>	<p>This tool illustrates how such a committee can lead activities to improve care, reduce risk and meet national safety and quality health services standard requirements.</p> <p>Intended readers include managers and committee members.</p>
<p>TOOL 2</p> <p>When and how to do fall risk screening, assessment, care-planning and discharge planning</p>	<p>This tool provides recommendations for:</p> <ul style="list-style-type: none"> > when and how to do screening and/or assessment of a consumer's risk of falls or harm from falls in a variety of settings across SA Health > the process of planning and reviewing care, and discharge, including consumer and carer input. <p>Intended readers include managers, service planners and clinicians.</p>
<p>TOOL 3</p> <p>Safe use of bed rails</p>	<p>This guide assists SA Health staff to:</p> <ul style="list-style-type: none"> > identify when the use of bed rails can be avoided > identify situations when the use of bed rails is the least restrictive and least harmful option for ensuring that a consumer and others are safe > implement risk control measures to minimise any potential harm > identify unsafe or inappropriate use of two full length bed rails on hospital beds, barouches, trolleys and similar > identify when the use of bedrails is restraint, and therefore requires reporting into Safety Learning System (SLS) as a patient safety incident. <p>Intended readers include clinicians and clinical managers.</p>

<p>TOOL 4</p> <p>Reporting a patient fall incident into Safety Learning System (SLS) –Topic guide</p>	<p>This tool is a one page quick guide. Together with Tool 5 it provides clear guidance on recording incidents into Safety Learning System after a patient fell, or had a near miss fall.</p> <p>Intended readers include staff providing direct care to patients/consumers, managers, clinical educators and safety and quality staff.</p>
<p>TOOL 5</p> <p>Reporting a patient fall incident – frequently asked questions (FAQs)</p>	<p>Tool 5 provides clear guidance on recording incidents into Safety Learning System after a patient fell, or had a near miss fall. It provides illustrative scenarios and examples to clarify when and how to report.</p> <p>Intended readers include staff providing direct care to patients/consumers, managers, clinical educators and safety and quality staff.</p>
<p>TOOL 6</p> <p>Post fall team review</p>	<p>Conducting a post fall team review is an important strategy to reduce the risk of the patient falling again, share interdisciplinary expertise, and systematically record the review of incidents. This tool centres around a flowchart to guide this process.</p> <p>Intended readers include staff providing direct care to patients/consumers, managers, clinical educators and safety and quality staff.</p>
<p>SA Health Accreditation Resource Guide</p>	<p>This guide support health services to meet the requirements of Standard 10 Preventing falls and Harm from Falls of the National Safety and Quality Health Service Standards. It identifies the resources that are available to support each accreditation criteria.</p>
<p>Consumer information</p>	<p>A range of posters, factsheets, checklists are all available at www.sahealth.sa.gov.au/falls</p>

For more information

SA Health
Safety and Quality Unit
Telephone: 08 8226 6539
www.sahealth.sa.gov.au/fallsprevention

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SA Health

2015 Revision of the SA Health Falls and fall injury prevention and management policy directive and guideline



This fact sheet is to inform SA Health clinical employees about amendments to the Falls and fall injury prevention and management policy documents as a result of a scheduled revision process in 2015.

The Policy Directive and Guideline are part of a suite of documents that guide actions to prevent and manage the risk of falls and harm from falls across SA Health services.

They were first developed in 2010 and have since been through several processes of review, seeking and collating feedback, and evaluating their implementation.

These are available on the Falls Prevention section of the SA Health website www.sahealth.sa.gov.au/fallsprevention

What has changed?

The Policy Directive is in the format now required by the Office of the Chief Executive.

The Guideline has been retired and relevant content is reflected in the Policy Directive, and in the new tools.

The Policy Directive and toolkit now comprises:

> **FALLS AND FALL INJURY PREVENTION AND MANAGEMENT POLICY DIRECTIVE**

- A new inclusion into the policy is the principle 3.5 'Care is provided in a way that minimises the use of restrictive practices, while effectively managing risk to the consumer'. This is reflected, where relevant, through the policy and tools, particularly Tool 3.
- Section 4.3.4 of the policy directive clarifies the status of documents produced as part of the incident review and analysis under the Health Care Act 2008 (SA Part 7 and Part8 s72(1)(b)). This is also included in Tool 6.

> **TOOL 1** - Example Terms of Reference (TOR) for a health service's Fall Prevention Committee. This has been revised with minimal change.

> **TOOL 2** - When and how to do fall risk screening, assessment, care-planning and discharge planning.

This new tool provides recommendations for:

- when and how to do screening and/or assessment of a consumer's risk of falls or harm from falls in a variety of settings across SA Health
- the process of planning and reviewing care, and discharge, including consumer and carer input.

> **TOOL 3** - Safe use of bed rails

This new guide assists SA Health staff to:

- identify when the use of bed rails can be avoided
- identify situations when the use of bed rails is the least restrictive and least harmful option for ensuring that a consumer and others are safe
- implement risk control measures to minimise any potential harm
- identify unsafe or inappropriate use of two full length bed rails on hospital beds, barouches, trolleys and similar
- identify when the use of bedrails is restraint, and therefore requires reporting into Safety Learning System (SLS) as a patient safety incident.

- > **TOOLS 4 and 5:** Tool 4 - Reporting a patient fall incident into Safety Learning System (SLS) – Topic guide, and Tool 5 - Reporting a patient fall incident – frequently asked questions (FAQs).

These new tools together provide clear guidance on reporting incidents into Safety Learning System after a patient fell, or had a near miss fall. Tool 4 is a one page quick guide and Tool 5 provides illustrative scenarios and examples to clarify when and how to report.

- > **TOOL 6** - Post fall team review

This tool has been revised and has minimal change. This tool centres around a flowchart to guide this process.

For a summary of the contents and purpose of the tools, refer to the Fact sheet - A guide to using the policy directive and toolkit.

For more information

SA Health
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TOOL 1

EXAMPLE

Terms of Reference (TOR) for a health service's Fall Prevention Committee

A Falls Prevention Committee can assist in demonstrating compliance with the requirements of accreditation.

Each site or cluster Falls Prevention Committee will keep minutes, agendas and reports that demonstrate that the committee has:

- > the overall aim of working towards implementing the national guidelines (Preventing Falls and Harm from Falls in Australian Hospitals, Community Care and Residential care, 2009 Australian Commission for Safety and Quality in Health Care ACSQHC)
- > designated responsibility for Falls Prevention activities
 - develops and works to TOR and an action plan approved annually by the Clinical Governance Committee
- > membership that includes management, clinical, clinical risk manager and procurement
- > regular meetings and keeps records of actions, business and progress.

Roles and Responsibilities for a health service's Fall Prevention Committee

The Committee should;

- > develop and implement an action plan to promote practice and delivery of services that are in accord with National Guidelines, SA Health Falls and Fall Prevention and Management Policy Directive, and National Safety and Quality Health Service Standard 10
- > use continuous practice improvement (CPI) or similar methodology to lead / undertake and document quality improvement activities to address safety risks and ensure the effectiveness of the falls-prevention system
 - develop, implement and monitor systems of care for falls and fall injury prevention that are based on local needs and actions arising from post fall team reviews, including:
 - internal procedures
 - safe environment and timely provision availability of equipment / devices
 - screening and assessment occurring right person, right time, right frequency
 - internal referral pathways
 - provision of interdisciplinary care and other intervention strategies as required
 - incident reporting, investigation and other data capture via the Safety Learning System (SLS)
 - discharge planning / handover / external referral to other services

- > receive and consider reports about falls incidents, data and actions arising from team reviews, and progress against the falls prevention action plan, from:
 - Safety and Quality Risk Manager
 - wards and units, health care teams
 - allied health
 - medical and pharmacy services
 - other relevant areas including, but not limited to workforce development, Work Health and Safety (WH&S), procurement
- > provide expert advice and reports to management, clinical governance committees and other staff;
 - participate in reporting, investigation and change management to respond to falls incidents.
 - assist with preparation and analysis of data and other information for reports to Committee responsible for Clinical Governance.
 - prepare reports and other presentations to executive as required.
 - assist with decision-making around procurement of equipment and relevant resources.
 - monitor the training conducted and maintain records on the numbers of sessions, topics, numbers and type of staff trained, proportion and spread of staff trained and effectiveness of training.
- > assist with planning and delivery (where possible) of workforce training, including determining staff training needs.
- > provide reports and evidence that assist the service to demonstrate compliance with accreditation requirements, and the requirements of the SA Health Falls and Fall Prevention and Management Policy Directive.

For more information

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TOOL 2

When and how to do fall risk screening, assessment, care planning and discharge planning

Purpose

This tool provides recommendations for when and how to do screening and/or assessment of a consumer's risk of falls or harm from falls in a variety of settings across SA Health.

It also includes recommendations about the process of planning care to reduce risk, including consumer and carer input.

Events and changes that trigger a review of the care plan and reassessment of the consumer are listed.

In order to be able to plan discharge, and provide current information to future care providers, there are recommendations for reassessment and additional actions.

SA Health screening and assessment tools

Recommendations for screening and assessment align with the national guidelines Best Practice for Preventing Falls and Harm from Falls in Australian Hospitals, Residential Care and Community Care services; and the Australian Commission on National Safety and Quality Health Service Standards (ACSQHC).

The online, interactive eLearning course – Falls Prevention includes videos and other resources to assist staff to become familiar with screening, assessment, planning for care and discharge in SA Health services.

Screening and assessment tools in use in SA Health services for falls prevention include the following.

- > **Fall and fall injury risk assessment** is designed to identify falls history, risk factors for falling and for injury. The form assists with development and documentation of a falls prevention care plan, and recording of consumer engagement, referrals, reassessments and discharge planning. The medical records form is numbered **MR58** (except for Royal Adelaide Hospital (RAH) where it is numbered 24.0). The equivalent of this form is available in Enterprise Patient Administration System (EPAS).
- > **Fall and fall injury risk review** is designed to record the frequent review of the care plan and actions taken for a consumer who has risk factors that can be rapidly changing, such as delirium. It is recommended that this review occur each shift where practicable. The medical records form is numbered **MR58a** (except for RAH where it is numbered 24.1). The equivalent of this form is available in EPAS.
- > **FROP-Com Fall risk assessment** is a longer assessment tool, covering a range of risk factors designed for use in community settings. The i-HOM-FRA is an equivalent assessment.
- > **FROP-Com screen** is a 3 item screening tool developed by National Ageing Research Institute that is designed to identify who is at a level of risk where a full assessment is warranted. In EPAS this tool is available in the Emergency Department (ED) section. The medical records form that includes this tool is numbered **MR58b** (except at RAH where it is numbered MR24.2). The paper form allows for documentation of the actions proposed (ie the care plan), engagement with consumer and carers and documentation of referrals and other actions as part of discharge planning.
- > **Self-screen questionnaire** is a checklist designed for consumers to complete themselves, then discuss with a health professional. It is for awareness-raising and does not indicate level of risk.
- > **Home safety assessment** is an assessment of the safety of the home and environs for the consumer, including their daily functional activities.

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Acute and post-acute inpatient settings

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<p>Is the consumer:</p> <ul style="list-style-type: none"> aged >65 years Aboriginal or Torres Strait Islander and aged >50 years younger, and <ul style="list-style-type: none"> - admitted as the result of a fall, or - unsteady, or - has a recent history of falls (2 or more falls in the previous 6 months), or - has a condition or disability that is associated with increased risk of falls or injury from falls? <p>If yes to any, this consumer requires fall and fall injury risk assessment.</p>	<p>Complete within 8 hours of admission, for all those who meet screening requirements.</p> <p>Use MR58, or EPAS fall risk assessment or equivalent.</p> <p>Additionally - any consumer who falls or becomes unsteady during an admission requires assessment</p>	<p>Development</p> <p>Consumer, carer and relevant members of the multidisciplinary care team should be involved in care planning.</p> <p>Document care plan within 24 hours (using MR 58 or 58a, or EPAS or equivalent).</p> <p>Review</p> <p>Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.</p>	<p>Re-assess using MR58 or equivalent if:</p> <ul style="list-style-type: none"> there is a fall or near miss this shift, or a significant change in the patient's <ul style="list-style-type: none"> - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation or general anaesthetic) environment. 	<p>Include falls risk information in all occasions of handover.</p> <p>Re-assess using MR58 or equivalent if discharge is planned within the next 24 hours.</p> <p>This enables effective handover, and referral to services for further falls risk reduction.</p> <p>Arrange devices, equipment and modifications to home with allied health assistance.</p>

Emergency Department (ED)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<p>Not required for consumer who is unconscious, or unable to move independently in bed or barouche.</p> <p>Is the consumer:</p> <ul style="list-style-type: none"> aged >65 years Aboriginal or Torres Strait Islander and >50 years younger, and <ul style="list-style-type: none"> - admitted as the result of a fall, or - has a condition or disability that is associated with increased risk of falls/fall injury? <p>If yes to any, within 2/24 of admission complete the 3 question FROP-Com screen (in MR58b or equivalent).</p>	<p>Risk assessment only recommended if consumer stays >12 hours in ED/short stay area.</p> <p>Use MR58b, or EPAS or equivalent.</p>	<p>If consumer is at high risk (on screen), ask consumer or carer "What assistance do we need to give you while you are here, when you are moving around?"</p> <p>Develop and document care plan within 2/24. Plan to maintain safety/ reduce risk during stay.</p> <p>Review care plan if:</p> <ul style="list-style-type: none"> there is a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation). 	<p>Only if risk assessment was completed using MR58 or equivalent.</p>	<p>Depending on next location:</p> <ul style="list-style-type: none"> Handover falls risk to ward. Handover falls risk to residential care staff and General Practitioner (GP). Discharge planning and referral for those at risk who are going home. Advise GP if high falls risk. <p>Community or aged care liaison, and/or allied health can be involved.</p>

Day patients, Day surgery

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<p>Use 3 question FROP-Com screen (in MR58b or equivalent).</p> <p>Complete at pre-admission or within 2/24 of admission for consumers who are:</p> <ul style="list-style-type: none"> aged >65 years, or Aboriginal or Torres Strait Islander and >50 years, or younger, and have a condition or disability associated with increased risk of falls/fall injury. 	N/A	<p>If consumer is at high risk, ask consumer or carer: "What assistance do we need to give you today when you are moving around?"</p> <p>Develop care plan</p> <p>After screening, plan care with consumer to provide necessary assistance to maintain safety during stay.</p> <p>Review care plan if:</p> <ul style="list-style-type: none"> there is a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation). 	<p>Re-assess mobility after procedure, or if the consumer falls, using question 3 of the FROP-Com screen (in MR58b or equivalent).</p>	<p>Depending on recovery, and mobility, there may be a need to arrange:</p> <ul style="list-style-type: none"> follow-up care until recovery complete risk assessment via GP.

Intensive care and high dependency units

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
All patients Is this consumer able to independently move within bed? If yes, fall risk assessment required.	Fall risk assessment using MR58 or equivalent is required if/as soon as the consumer is starting to move independently in bed.	Develop care plan Within 8 hours of assessment. Review care plan Any consumer with changeable fall risk factors, eg delirium should have care plan reviewed each shift using MR58a.	Re-assess using MR58 or equivalent if there is: <ul style="list-style-type: none"> • a fall or near miss this shift, or • a significant change in the patient's <ul style="list-style-type: none"> - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes, sedation or general anaesthetic) - environment. 	Handover and transfer includes: <ul style="list-style-type: none"> • assessment of falls and fall injury risk • current interventions in place • precautions that receiving ward team needs to be aware of.

Dialysis units *(Caring for a high risk group, over long term)*

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
All patients.	MR58 or equivalent, within 2 weeks of admission.	Develop care plan Within 1 week of assessment. Plan care to provide assistance to maintain safety: <ul style="list-style-type: none"> • during and after treatment • at home. Consider referral for allied health home safety assessment (*). Provide advice and/or written materials to consumer and carer eg Falls Prevention Fact Sheets.	Re-assess using MR58 or equivalent if there is: <ul style="list-style-type: none"> • a fall or near miss, or • a significant change in the patient's <ul style="list-style-type: none"> - physical health status and/or mobility - behaviour, cognition or mental status - medication (multiple changes) - environment. Otherwise, routine review 4 monthly.	Handover and transfer includes: <ul style="list-style-type: none"> • assessment of falls and fall injury risk • current interventions in place • precautions that receiving ward team needs to be aware of.

Outpatient clinics – caring for high risk groups. This includes but is not limited to clinics such as endocrine, fracture, neurological, geriatric, and also some diagnostic services for example Dual energy x-ray absorptiometry (DEXA) scanning.

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<ul style="list-style-type: none"> Ask the following consumers if they have had more than 1 fall in the past 6 months: all consumers aged >65 years Aboriginal or Torres Strait Islander people >50 years younger people, if they have a condition or disability that is associated with increased risk of falls or injury from falls. <p>OR Self-screen questionnaire with follow-up discussion of results with clinician.</p>	<p>If yes to screening questions, ask consumer or carer:</p> <p>“What assistance do we need to give you while you are here, when you are moving around?”.</p>	<p>Document actions required to provide assistance to maintain safety during visit.</p>	N/A	<p>Include level of falls risk in communication to GP.</p> <p>Consider referral via My Aged Care portal (*) or Falls Prevention services, or Falls Prevention Clinic, via Geriatric and Community Services, as per local procedures.</p> <p>Provide advice and/or written materials to consumer and carer about falls risk and local available services eg Falls Prevention Fact Sheets and directory of falls prevention services.</p>

Residential Care Facilities (SA Health)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
N/A	<p>All residents (permanent and respite).</p> <p>MR58 or equivalent within 24 hours of admission.</p> <p>Review any handover information eg from hospital.</p>	<p>Develop care plan</p> <p>Within 1 week.</p>	<p>Re-assess using MR58 or equivalent if there is:</p> <ul style="list-style-type: none"> a fall or near miss or a significant change in the resident’s <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes, sedation) environment. <p>Routine re-assessment monthly.</p>	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> assessment of falls and fall injury risk current interventions in place precautions that future care providers need to be aware of.

SA Ambulance Service (SAAS)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<p>All patients who are:</p> <ul style="list-style-type: none"> attended as a result of a fall >65 years (or <50 years for ATSI) <p>but not if unconscious, or unable to move independently.</p> <p>If treat not transport:</p> <ul style="list-style-type: none"> use 3 question FROP-Com screen (MR58b) assess ability to walk safely (if previously ambulant). 	<p>If transported:</p> <ul style="list-style-type: none"> assess ability to transfer safely onto barouche, as per procedure. 	<p>If transported:</p> <ul style="list-style-type: none"> document any actions precautions to reduce fall risk. 	N/A	<p>If transported:</p> <ul style="list-style-type: none"> handover mobility status and precautions to ED staff. <p>If treat not transport:</p> <p>For those at high risk:</p> <ul style="list-style-type: none"> Ensure consumer can mobilise, and can get help if required. Notify GP, and refer those at high risk, as per procedure to community-based services (*).

Care in the community

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge
<ul style="list-style-type: none"> Self-screen questionnaire 3 question FROP-Com screen (MR58b or equivalent). <p>Note that these may be used separately or combined – refer to local procedures.</p> <p>For community mental health services, add the following italicised words to the second question 'Prior to today, how much assistance was the individual requiring for Instrumental Activities of Daily Living (IADL)?' <i>because of physical limitations</i></p>	<p>For those at high risk on screening:</p> <p>Use FROP-Com assessment tool or equivalent.</p> <p>Conduct or arrange home safety assessment where indicated by Occupational Therapist and/or Physiotherapist where practicable.</p>	<p>Develop care plan</p> <p>Within 1-2 weeks of assessment (depending on frequency of appointments)</p> <p>Review care plan</p> <p>This will depend on the nature of the interventions, for example, an exercise program is reviewed frequently. Review implementation of all elements, including referral.</p>	<p>Re-assess using FROP-Com assessment tool or equivalent if:</p> <ul style="list-style-type: none"> there has been a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes) environment. <p>Routine re-screening six monthly.</p>	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> assessment of falls and fall injury risk current interventions in place precautions that future care providers need to be aware of.

Care in the community (Mental Health services)

Falls risk screening	Falls and injury risk assessment	Development and review of care plan for those at risk	Reassessment	Preparation for transfer or discharge for those with falls care plan
<ul style="list-style-type: none"> Does the person have a recent history of falls (2 or more falls in the previous 6 months), or When walking or turning, does the person appear unsteady or at risk of losing their balance? <p>If Yes to any, fall and fall injury risk assessment is required</p>	<p>Use FROP-Com assessment tool or equivalent.</p> <p>In addition, conduct, refer for or arrange home safety assessment by Occupational Therapist and/or Physiotherapist where practicable.</p>	<p>Develop care plan</p> <p>Within 1-2 weeks of assessment (depending on frequency of appointments)</p> <p>Review care plan</p> <p>This will depend on the nature of the interventions, for example, an exercise program is reviewed frequently. Review implementation of all elements, including referral.</p>	<p>Re-assess using FROP-Com assessment tool or equivalent if:</p> <ul style="list-style-type: none"> there has been a fall or near miss, or a significant change in the patient's <ul style="list-style-type: none"> physical health status and/or mobility behaviour, cognition or mental status medication (multiple changes) environment. <p>Routine re-screening six monthly.</p>	<p>Handover to acute services includes:</p> <ul style="list-style-type: none"> current assessment of falls and fall injury risk current interventions in place precautions that future care providers need to be aware of. <p>* Use LHN Falls prevention service directories</p>

* Accessing community services

Refer to Local Health Network (LHN) Falls Prevention Service Directories on the SA Health [Safety and Quality](#) web area.

1300 0 FALLS (1300 0 32557) reaches the SA Health Metropolitan Referral Unit, Falls Prevention Clinics and Community Geriatric teams.

Use [My Aged Care](#) web portal to find community-based services. Phone: 1800 200 422.

For more information

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TOOL 3

Safe use of bed rails

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Introduction

Bed rails were developed as a safety device and have been commonly and routinely used in Australia. However, in some circumstances bed rails:

- > can be a threat to consumer safety
- > are used as restraints.

Purpose

The following guide has been prepared to assist SA Health staff to:

- > identify when the use of bed rails can be avoided
- > identify situations when the use of bed rails is the least restrictive and least harmful option for ensuring that a consumer and others are safe
- > implement risk control measures to minimise any potential harm
- > identify unsafe or inappropriate use of two full length bed rails on hospital beds, barouches, trolleys and similar
- > identify when the use of bedrails is restraint, and therefore requires reporting into Safety Learning System (SLS) as a patient safety incident.

Intended readers include staff who are providing direct care to consumers, managers and staff involved with procurement and provision of equipment in inpatient facilities.

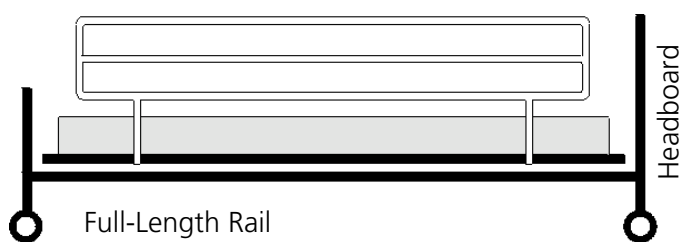
This should be read in conjunction with 'Safety with hospital and treatment beds' Safe Work Procedure 2014 (WFS SWP504) and relevant SA Health policies.

What are bed rails?

The recommendations in this document relate to the use of two full length bed rails that are attached to the frame of a bed, barouche, trolley, treatment table or similar, or one bed rail and the bed is in contact with a wall on the opposite side.

The term 'bed rail/s' refers to adjustable metal or rigid plastic bars that are available in a variety of shapes and sizes from full to half, one-quarter and one-eighth in lengths. They may also be called cot sides; side rails; side bars; grab bars; or safety rails. The use of part rails is not covered by this document.

A full length bed rail is a continuous rail that extends along the side of the bed from the head to the foot section and is fixed to the bed frame.



Example of a full length bed rail – design may vary.

Bed rails as a form of restraint

Bed rails are considered to be a restraint or restrictive practice when they are used primarily with the intention of limiting a consumer's freedom of movement. The application of any restrictive practice is an infringement of a person's right to free movement and decision-making.

Use of any restrictive practices, including restraint, is potentially harmful, and is not therapeutic. The use of any restraint is always a last resort after other strategies have been unsuccessful.

All restraint must be reported into Safety Learning System.

Restraint is the intentional restriction of an individual's voluntary movement or purposeful behaviour by physical, chemical, mechanical or other means.

If the risk to safety is immediate and serious, and alternative strategies have failed to maintain safety, bedrails may be the least restrictive way to maintain safety for the consumer and/or others. Bed rails may be a less restrictive form of restraint than, for example, a jacket type restraint.

Bed rails have more impact as a physical barrier or restraint for a person who has limited mobility. For some people they are a visual and emotional barrier.

In SA Health, restrictive practices should not be used as a punishment or for the convenience of others, or as an alternative to adequate surveillance, sufficient staff or resources to provide safe care, or an environment suitable for the individuals' appropriate care.

Bed rail use that is not restraint

During transport, bedrails are a safety measure.

It is not restraint when a consumer who has decision making capacity has requested that the bed rails are used, or consented to their use. However, in these situations the consumer must be able to call for and receive assistance if needed.

Risk assessment

The decision to use bed rails should be made as part of the consumer's assessment, and based on the principles of safe care and restraint minimisation, or least restrictive care.

Assessment by the consumer's health care team will identify:

- > the presenting problem (why bed rails may be considered), and alternative strategies
- > the potential risk(s) of harm to the individual consumer if a bed rail is used
- > the care required to reduce harm if a decision is made to use bed rails.

Steps for risk assessment and planning care should include:

1. Use Table 1 to identify the presenting safety problem(s) that bed rails may help with
 - risk of rolling off the bed
 - difficulty turning over, or moving around in the bed
 - risk of falls or injury when the consumer is attempting to get up from bed
 - risk from challenging behaviour, such as wandering or aggressive behaviour.
2. Assess, as relevant, falls risk, sedation/consciousness, dementia, delirium, behaviour, wandering or agitation, continence, sleep pattern.
3. Discuss with the consumer (or their Substitute Decision Maker [SDM]), family or carers. Provide information about potential harm and alternatives to using bed rails.
4. Use the Bed rail decision matrix to identify risk of bedrails for that individual.
 - If bedrails may be considered, monitor use
 - If bedrails are not recommended or should only be used with caution, try alternatives to bed rail use, guided by what is considered best practice for the presenting problem(s). (See alternative strategies in Table 2 and below).
5. Use Table 2 to plan care with the multidisciplinary team and consumer, carer to minimise risk of harm if bedrails used. Document care plan.
6. Monitor the consumer while the bedrail in situ.
7. Review the need for the bedrail, the consumer's mental and physical status.

Alternative strategies

Some alternative strategies are listed in Table 1. Alternative strategies to address particular risks are also described in relevant guidelines such as:

- > For those at risk of falls, refer to:
 - Falls and Fall Injury Risk Factor Assessment (MR58 or equivalent) Table 1 - Recommended actions for consideration.
 - Table 3 Alternatives to bedrail use for falls risk.
 - Falls and fall injury prevention and management Policy Directive and toolkit.
- > For those at risk of wandering, refer to guidelines relating to dementia care.
- > For those at risk of challenging behaviour refer to:
 - Preventing and Responding to Challenging Behaviour Policy Directive and toolkit.
 - Minimising Restrictive Practices Policy Directive and toolkit.
 - Delirium guidelines.

Consumer or family concerns about bed rail use

If consumers or family ask about using bed rails, health care providers should:

- > encourage consumers or family to talk to their health care planning team to determine whether or not bed rails are indicated
- > reassure consumers and their families that in many cases the consumer can sleep safely without bed rails.

Consumers can request bed rails to help to turn in bed, or to hang call bell etc. Alternative bed mobility aids are available. Assessment by occupational therapist or physiotherapist is recommended for these, where practicable.

Table 1 Safety concerns and alternative strategies

Type of risk, or problem identified	Who, and when is risk greatest?	Alternative strategies
Risk of rolling off the bed	Intentional, eg when leaning or reaching.	<ul style="list-style-type: none"> > Ensuring that personal items are within reach. > Use of overway for personal items.
	Unintentional, for example <ul style="list-style-type: none"> > when turning/rolling over and sedated or drowsy > when there are uncontrolled movements or muscle spasms such as during a seizure (unless the risk of injury from hitting the rails is greater) > being cared for on a narrow barouche, trolley > during transport or while wheeling bed from place to place. 	<ul style="list-style-type: none"> > Use of foam bumpers or concave mattresses (as long as these are removed when the person is able to, and wanting to, get up from the bed). > Review of sedation, medication. > Use beds that can be lowered to floor level or near. > Move onto hospital bed as soon as possible. > Belts or harnesses that the consumer can undo.
Difficulty turning or moving around in bed	People with limited physical mobility.	Other bed mobility aids, such as overhead grab bars, or handles attached.
Risk of falls or injury when the consumer is attempting to get up from or out of bed	Bedrails or any other forms of restraint are not recommended in either SA Health policy or national guidelines as a falls prevention strategy. There are many other strategies recommended to reduce the risk of falls and/or injury.	<ul style="list-style-type: none"> > Falls prevention strategies to reduce the fall risk factors that have been identified during assessment. > Strategies to reduce the risk of harm if a fall should occur, such as hip protectors, limb protectors, helmets. Examples include: <ul style="list-style-type: none"> > Physiotherapy assessment of mobility, aids and/or correct bed height for consumer to safely getting up. > walking aids, footwear and glasses within reach. > anticipate the reasons consumers get out of bed such as hunger, thirst, going to the bathroom, restlessness and pain. Meet these needs by regularly offering food and fluids, pain relief, toileting, and providing calming interventions, distractions or activities. > hourly rounding. > alarms to alert staff when a consumer is moving. However these require a speedy response to prevent a fall. Risk of injury from falls can be reduced by wearing hip protectors, limb protectors, helmets, and/or shock-absorbing crashmats beside the bed (with care not to increase the risk to staff and others from tripping).

<p>Risk from challenging behaviour</p> <ul style="list-style-type: none"> > Unintentional self-harm 	<ul style="list-style-type: none"> > Wandering means ambulation or mobility that appears to be lacking in purpose or intent, associated with dementia. > Consumers with cognitive impairment who are restless, confused about where they are, and attempting to go home. > A consumer is at risk if they are unable to find their way back, unable to recall where they are, or may go to a dangerous area. 	<ul style="list-style-type: none"> > Effective strategies are documented in SA Health policies and in guidelines for care of cognitive impairment, brain injury, dementia, delirium, mental illness. > Anticipate the reasons consumers wander such as boredom, need for social contact, hunger, thirst, going to the bathroom, restlessness and pain. > Meet these needs and provide reassurance, distraction and calming interventions. > Wandering/ambulation per se may maintain activity levels and occupy a consumers time, relieving boredom.
<p>Risk from challenging behaviour</p> <ul style="list-style-type: none"> > Absconding, leaving care or leaving the area 	<p>Risk of leaving care:</p> <ul style="list-style-type: none"> > contrary to a legal order, or > when there is risk to the person's health or safety. 	<ul style="list-style-type: none"> > Communication with consumer and carer. > Consumers with decision-making capacity can choose to leave care. Encourage them to complete forms as required. > Consumers under legal orders (Mental Health, guardianship or other) can be prevented from leaving.
<p>Risk from challenging behaviour</p> <ul style="list-style-type: none"> > To protect staff and/or other people present 	<p>Risk of:</p> <ul style="list-style-type: none"> > Intrusive or physically aggressive behaviour > in an emergency situation raising bed rails can create a temporary barrier between a violent or aggressive consumer and staff to allow planning of other strategies 	<ul style="list-style-type: none"> > Reassess and provide alternative strategies to prevent challenging behaviours. > Strategies to minimise the use of restrictive practices. > Least restrictive practices, for example doorway barriers.

Bed rail decision matrix (for the use of two full length bed rails)

Use this to assist clinical reasoning when there are concerns for patient/consumer safety in bed.

Instructions for use: Find the point where the consumer's level of mobility (rows) and cognitive/mental state (columns) intersect.

For more detail refer to Fact Sheet – Safe Use of bedrails and Safety with hospital and treatment beds 2014 - WHS Safe Work Procedure (WFS SWP504).

Decision-making capacity	Level of mobility, activity			
	Cognitive/mental state	Unable to mobilise or hoist-dependant	Requires assistance to mobilise	Independently mobile
			<i>Note: Ensure bed is left at the correct height for the consumer – usually hips a little higher than knees with feet flat on floor.</i>	
No	Delirious, confused, disoriented, agitated, restless, unpredictable poor memory.	Consider bed rails, with caution.	Bedrails not recommended. Use alternative strategies.	Bedrails not recommended. Use alternative strategies.
Uncertain	Drowsy/sedated/ impaired consciousness.	Consider bed rails, with caution.	Try alternative strategies, and only use bed rails as last resort. Frequent monitoring required.	Try alternative strategies, and only use bed rails as last resort. Frequent monitoring required.
Yes	Orientated and alert.	Bedrails may be considered if consumer consents or requests them.	Bedrails may be considered if consumer consents or requests them. Ensure they can summon help.	Bedrails not required. Can be requested by consumer.

- > Consider risk of functional decline, falls, injury, entrapment and psychological harm in your decision-making (bed rails can be a form of restraint).
- > For consumers with involuntary movement (eg spasms) bed rails, if used may need to be padded, but caution this may increase entrapment risk.
- > Monitoring means visual checking of the consumer by a qualified staff member.

KEY	Bedrails not recommended. Risk of using is generally higher than risk of not using. Use alternative strategies.	Carefully consider risk vs benefits and try alternative strategies or less restrictive care. Discuss with consumer and carer, and with clinical team. Frequent visual checking and monitoring required. Table 2 suggests risk minimisation strategies.	Discuss with consumer and carer, and with clinical team. Table 2 suggests risk minimisation strategies. If consumer with decision-making capacity consents, bed rails are not a form of restraint. One bed rail or other bed mobility aids may assist bed mobility eg after a stroke, other injury.

Based on Resources for reviewing or developing a bedrail policy with kind permission Frances Healey. NHS National Patient Safety Agency, 2007, UK.

Potential risks and care required to mitigate risk if bed rails are used

Bed rail use can be harmful. If a decision is made to use bed rails, assessment and review will identify the potential risk(s) of harm to the individual consumer and how to optimize bed safety.

When bed rails are specifically used as a restraint, there are monitoring and review requirements that are outlined in the SA Health Minimising Restrictive Practices Policy Directive and Tool 4 Safe application of restrictive practices.

These strategies can also be termed risk control measures. General strategies include:

- > regular visual monitoring of the consumer
- > on-going assessment of the consumer's physical and mental status
- > having the call bell in easy reach so the consumer can call for assistance readily
- > monitoring consumers who are not able to use the call bell or be relied on to call for assistance at least every 15 minutes by visual checking
- > teamwork and team communication - documentation in the care plan and medical record, and, included in handover
- > monitoring and review of the need for, and safety of the bed rails if the consumer's mobility or cognitive status changes or they exhibit signs of distress, or their condition improves.

Required documentation in the medical record includes:

- > alternative strategies attempted, but failed
- > results of discussion with consumer and carer or SDM
- > an agreed care plan to reduce harm while bed rails are used.

Table 2 includes types of risk from bed rail use, which consumers may be most vulnerable, include, and suggested strategies to reduce or control risk. Types of risk include:

- > bodily trauma
- > falls
- > functional decline
- > distress or psychological harm
- > entrapment of limbs or head
- > equipment failure.

Additional strategies to reduce risk of harm

Provide staff training to all staff working in areas where this equipment is present, including, but not limited to:

- > the risk assessment process
- > alternatives to bed rails
- > the safe and appropriate use of bedrails
- > the risks and risk control measures for bed rail use, including installation, monitoring for wear and tear
- > the use of the decision matrix to support clinical reasoning.

Table 2 Types of risk associated with bedrails, and control measures

Type of risk	Consumers most at risk of harm from bed rails	Suggested control measures to reduce risk
<p>Bodily trauma</p> <p>Skin and soft tissue injury can result from collision with the bed rail.</p>	<ul style="list-style-type: none"> > People with fragile skin, malnourishment, and who are anticoagulated or have indwelling devices, agitated or aggressive. > People who experience large uncontrolled or involuntary movement, for example muscular spasm, epileptic seizure. 	<ul style="list-style-type: none"> > Limb or head protection devices. > Medication or other therapy to reduce spasm, involuntary movement. > Padding or covers over bed rails should be used with caution as they may create risk of asphyxiation or entrapment.
<p>Falls</p> <p>Serious falls can occur when attempting to get out of bed and climb over or around bed rails, or a limb or clothing get caught in the bedrails. The extra height of a fall over bed rails increases the severity of the injury.</p>	<ul style="list-style-type: none"> > People with a combination of impaired mobility and cognition or consciousness or mental status. > People with osteoporosis, on anticoagulant therapy or coagulopathy, or fragile skin. 	<ul style="list-style-type: none"> > Fall Prevention strategies. > Injury minimisation strategies. > Refer to Alternatives to bed rail use for falls risk
<p>Functional decline</p> <p>Bedrails use limits activity, mobility and independence, leading to functional decline and risk from pressure injury. Deconditioning can lead to an increased risk of falls, through muscle weakness and unsteadiness.</p>	<ul style="list-style-type: none"> > People who are reluctant to mobilise, frail, passive or withdrawn. 	<ul style="list-style-type: none"> > Encourage regular activity and mobilising. > Physiotherapy and/ or occupational therapist assessment.
<p>Distress</p> <p>The consumer may feel trapped, isolated, unnecessarily restricted, or a passive recipient of care. Carers may also feel distressed, and that the bed rail is a barrier to contact with their loved one.</p>	<ul style="list-style-type: none"> > People with a history of trauma, or dementia. > The use of physical restraints may be contraindicated for consumers at risk of, or with delirium as it may increase agitation and the chance that they will try to climb out of bed. This includes people with a cognitive impairment from dementia or other causes. 	<ul style="list-style-type: none"> > Lower bed rails when there are staff or visitors with the consumer. > Other strategies to reduce distress, such as family photos.

<p>Entrapment of limbs or head</p> <p>Entrapment is an incident in which a consumer, or their head or limb, is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or hospital bed frame. Entrapment can result in serious injury or death.</p>	<p>People who move about the bed or try to exit the bed, and:</p> <ul style="list-style-type: none"> > have reduced cognition and/or consciousness > have condition(s) that cause them to have uncontrolled body movement or limited mobility > have symptoms such as agitation, delirium, confusion, pain, hypoxia, faecal impaction, and acute urinary retention. <p>The risk of entrapment is also associated with:</p> <ul style="list-style-type: none"> > absent or inadequate care such as timely toileting, position change, symptom management and frequent nursing observation > physical factors such as design of bed, mattress and the bed rail, including: <ul style="list-style-type: none"> • mismatch between the size and shape of the mattress and the bed rails, such that there are spaces that can allow entrapment • loose or poorly fitted bed rails, or • bed rails with spaces that allow limbs or heads to pass through. 	<ul style="list-style-type: none"> > The correct rails for the bed should be used, and they should be installed correctly according to manufacturer's instructions. > Ensure the mattress is compatible with the bed and bed rails. > Ensure there are no gaps that could pose an entrapment risk to the occupant. For adult beds, gaps between bars/rails must be less than 120mm. Head /footboard to bed rail gaps must be less than 60mm or greater than 250mm > Bed rails designed for adults should not be used for children. > Ensure that staff who install rails are aware of measuring for entrapment risk.
<p>Equipment failure</p> <p>Incorrectly fitted or damaged bed rails or ones that are of insufficient strength for the weight of the consumer, carry a risk of entrapment, collapse when leaned/pulled on, or injury to staff or consumer/ consumer from faulty raising, lowering mechanisms etc.</p>	<p>Bariatric consumers.</p>	<ul style="list-style-type: none"> > Schedules of maintenance. > Establish systems to ensure bed rails are regularly examined for wear and tear and maintained.

Table 3 Alternatives to bedrail use for falls risk

For further information refer to Falls and Fall Injury Risk Factor Assessment (MR58 or equivalent), and:

- > Table 1 - Recommended actions for consideration.
- > Guidelines for patient environment set-up.

Patient characteristic	Suggested alternatives to bedrails
<p>1. A history of falling, or previous fall from bed.</p>	<ul style="list-style-type: none"> > Establish contributing causes in previous bed-related falls, and care plan to manage and modify identified risk factors. > Engage patient in falls prevention (SA Falls and Fall Injury Prevention - Fact Sheet 5: Keeping safe and independent in hospital) and use of call bell, if able to.
<p>2. The patient is at increased risk of injury or harm, should a fall occur.</p> <p>Risk factors for harm include :</p> <ul style="list-style-type: none"> > osteoporosis and/or existing fracture. > existing wounds and/or poor skin healing. > anticoagulant therapy. > indwelling lines, devices. > low BMI. 	<ul style="list-style-type: none"> > Soft hip protectors. > Helmet. > Limb/skin protectors. > Provide patient information. > Increase supervision, rounding. > Move items of furniture that may cause harm in the event of a fall. > When indicated, use padded bed rails for individuals with an active seizure or movement disorder.
<p>3. Condition(s) affecting patient/consumer behaviour, cognitive state, risk-taking, judgment or insight into own physical ability.</p> <p>For example, delirious or confused, intoxicated.</p>	<ul style="list-style-type: none"> > Repeat orientation, use signs. > Reduce background noise, clutter and distractions. > Screen for delirium and treat reversible causes establish environment to reduce delirium – reduce sleep deprivation, immobility, dehydration, vision and hearing impairment. > Provide opportunities for supervised mobility. > Increased supervision, rounding. > Encourage family to visit often and stay as long as possible. > Bed, chair alarms. > Routine toileting. > Leave bed in low position if there is a risk of rolling out of bed. > Provide pain relief as appropriate. > Treat constipation and urinary retention.
<p>4. Medication(s) that can affect reaction times, motor function, cause dizziness, postural drops in BP or drowsiness.</p> <p>For example, sedated, drowsy, semi-conscious, recovering from anaesthetic.</p>	<ul style="list-style-type: none"> > Medications review. > Increase supervision, rounding. > Bed, chair alarms. > Provide patient information. > Call bell within reach. > Minimize use of medications that alter cognitive state > Dispense diuretics at a time when staff will be able to provide rapid response to toileting requests.

<p>5. A condition(s) or disability that affects patient's/consumer's ability to mobilise safely in bed and/or transfer steadily and safely.</p> <p>For example, muscle weakness, visual impairment, seizures or spasms, partial paralysis, obesity.</p>	<ul style="list-style-type: none"> > Bed mobility aids such as a bed stick or overhead bed aid. > Physiotherapy/Occupational Therapist assessment. > Bed, chair, commode heights and proximity. > Use of one bedrail. > Promote mobility and fitness.
<p>6. Consumer is afraid of falling out of bed and requests bedrails.</p> <p>OR Consumer requests bed rail to assist with bed mobility eg stroke patients.</p>	<ul style="list-style-type: none"> > Bed mobility aids such as bed stick or overhead bed aids (gooseneck / monkey bar). > Use of one bedrail or half rail.

SA Health policies, guidelines and publications

- > Fall and fall injury prevention and management Policy Directive and toolkit.
- > Minimising restrictive practices in health care Policy Directive and toolkit: Tool 1 - What are restrictive practices, and what types are there? 2015.
- > Preventing and Responding to Challenging Behaviour Policy Directive and toolkit 2015.
- > Safety with hospital and treatment beds 2014 - WHS Safe Work Procedure (WFS SWP504).
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For more information

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SA Health

TOOL 4

Topic guide - Reporting a patient fall incident into the Safety Learning System (SLS)



Definition of a fall: An event which results in a person coming to rest inadvertently on the ground or floor or other lower level. (World Health Organization)

(For examples and further information see video *What is a Fall?* in Resources section of the *Falls Prevention online eLearning course*).

This guide contains only key details for notifying falls incidents. Refer to other SLS Guides and Quick guides for further details about incident notification.

This guide should be read in conjunction with the guide *Reporting a patient fall incident – Frequently Asked Questions (FAQs)*.

Tips for quick and easy reporting of a fall into SLS

Subject of incident/event	Select ' incident affecting patient ' under 'Type', select 'patient/consumer/client' and complete details. Harm - a question at the end of this section asks if the patient was harmed or not. If yes, another section will appear asking you to describe the harm/injury.
Incident Classification	<ul style="list-style-type: none"> • Level 1 – Select 'Patient falls and other injuries'. • Level 2 – Select the most applicable option. Select 'Falls' if you are confident that the incident was a fall (see definition above). Falls are the most common option, but this is where other accidental injury is reported, for example where the patient was knocked to the ground by a collision with or push from a trolley. <i>Refer to FAQs 'Was it a fall or other injury?'</i> • Level 3 - If 'falls' is selected, Level 3 then asks if it was a fall or a near miss (either prevented by staff, or near miss with no staff intervention.) <i>Refer to FAQs 'Was it a fall or a near miss?'</i> <p>NB If the patient was harmed/injured it is not a near miss.</p>
SAC rating	The Safety Assessment Code (SAC) matrix and the SAC rating guide for fall incidents have extra information to assist you. <ul style="list-style-type: none"> • For falls, the consequence is the major determinant of SAC rating. • The consequence of a fall can range from 'insignificant' to 'major', only being 'extreme' if death directly results or length of stay is increased as a direct result of the fall by >125 days. • The likelihood – how likely is this patient to fall again in similar circumstances – how often will they do the same activity, and number of risk factors for falls. <i>Refer to FAQs 'SAC rating for fall incidents'</i>
Fall details	<ul style="list-style-type: none"> • Please complete all of these 5 questions. Each has several choices. These ask about the height of fall; place where the incident happened; mechanism of the fall; whether the fall was witnessed by anyone or not; and the patient's activity at or immediately before the fall. • Select the most appropriate option for each. This information will help you and the Falls Prevention committee to work out the problem areas for your service.
Current fall and injury risk at time of incident	<ul style="list-style-type: none"> • Refer to the consumer's current falls risk assessment form (sometimes known as MR58) for list of identified risk factors. • Five questions about the consumer's risks and the fall prevention or harm minimisation strategies that were in place before the fall. • Select all risk factors identified and interventions provided. • This section provides information about the assessment and care plan and characteristics of people who fall. This will be useful evidence for accreditation and can help establish the effectiveness of particular interventions.

For more information

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SA Health

TOOL 5

Reporting a patient fall incident into the Safety Learning System (SLS)

Frequently asked Questions (FAQs)



This guide should be read in conjunction with the *Tool 4 Topic Guide - Reporting a patient fall incident into Safety Learning System (SLS)*.

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Throughout this document the term consumer is used to refer to people in receipt of SA Health services. Alternative terms are client, patient and resident (of residential care facilities). The terms staff or workers are used to indicate people providing health care services on behalf of SA Health.

Some scenarios have been adapted from 'Inconsistency in Classification and Reporting of In-Hospital Falls' 2009 TP Haines et al Journal American Geriatric Society 57:517–523.

1. Why report a fall?

The *National Safety and Quality Health Service Standards* and the *SA Health Fall and fall injury prevention and management Policy Directive* recommend reporting incidents, so that action can be taken to improve care for that consumer and for others who may be at similar risk.

Reporting fall incidents provides evidence for accrediting surveyors that the organisation is compliant with requirements of national standards.

Health services should aim for minimisation of both falls (particularly repeat falls) and harm from falls.

Good data will help services to monitor patterns and plan improvements. Notifiers and managers have joint responsibility for accurate reporting and review and quality improvement.

Managers have responsibilities for managing follow-up after fall incidents, including review of the incident and post fall team review (Appendix 1), if applicable. The managers page in SLS is designed to assist with this (refer to section 7 for further information).

2. Was it a fall or other injury? (Level 2 Incident classification)

Definition of a fall: An event which results in a person coming to rest inadvertently on the ground or floor or other lower level. (World Health Organization)

(For examples and further information see video What is a Fall? in Resources section of the Falls Prevention online course).

Level 2 classifications under 'Patient falls and other injuries' provide a range of options. Falls are the most common.

Incident Classification (Subject to disclosure)	
* Level 1	Patient Falls and other injuries
* Level 2	
* Level 3	Collision or external force with object or person
* Safety Assessment Code (SAC) (Click here to view the Safety Assessment Code Matrix)	Accident caused by some other means Exposure to electricity, hazardous substance, infection etc Falls Injury caused by physical or mental strain
* Result	Lifting accidents Needlestick injury or other incident connected with Sharps
Further Information	

Table 1 Examples of incidents that match Level 2 options.

Level 2 Classification options	Example scenarios
Collision or external force	<ul style="list-style-type: none"> > Consumer pushed over as a result of a collision with a trolley, or a heavy door. > Consumer hit or pushed by another consumer causing skin graze.
Accident by some other means	<ul style="list-style-type: none"> > Consumer found in bed with bleeding area on elbow – cause unknown. > Consumer twisted knee/skin tear skin on ankle getting into wheelchair. > Consumer knocked hand on bedrail causing bruise. > Monkey bar triangle fell and hit consumer’s forehead.
Exposure to electricity, hazardous substance, infection etc	<ul style="list-style-type: none"> > Consumer accidentally squirted hand gel into eye. > Consumer spilt hot cup of tea on abdomen. > Consumer developed blisters under areas where ice packs had been applied. > Consumer accidentally put ointment on toothbrush.
Falls	<ul style="list-style-type: none"> > Consumer fell. See definition above.
Injury caused by physical or mental strain	<ul style="list-style-type: none"> > Consumer hurt shoulder moving a chair next to bed. > Consumer jammed fingers in her bedside cupboard drawer causing bruising.
Lifting accidents	<ul style="list-style-type: none"> > Consumer sustained skin tear while being hoist transferred. > Consumer fell out of hoist lifter sling onto floor. > Consumer’s hand crushed between chair arm and lifter.
Needle stick injury or other sharps injury	<ul style="list-style-type: none"> > Consumer’s skin nicked with scissors when removing a dressing. > Uncapped syringe left on consumer bed after procedure, and consumer rolled onto needle piercing skin. > Consumer cut finger while chopping fruit in rehab kitchen. > Consumer reaching for reading glasses and pierced hand on uncapped Insulin needle left on the bed-side table.

3. Was it a fall, or not? Was it a near miss? – (Level 3 Incident classification)

A ‘near miss’ is an incident where a fall was likely but averted through the action of staff or by the consumer themselves, or other. The incident cannot be a near miss if the consumer was harmed or injured, or if the fall occurred.

Incident Classification
(Subject to disclosure)

★ Level 1 Patient Falls and other injuries

★ Level 2 Falls

★ Level 3 [Dropdown arrow]

★ Safety Assessment Code (SAC)
[\(Click here to view the Safety Assessment Code Matrix\)](#)

Fall
 Near miss - fall prevented by staff
 Near miss - no intervention by staff

The 18 scenarios in Table 2 may assist understanding of whether an incident is a fall or not, or what type of near miss. For each scenario Table 2 has tips for easy, accurate reporting into SLS.

continued

Some scenarios have been adapted from 'Inconsistency in Classification and Reporting of In-Hospital Falls' 2009 TP Haines et al Journal American Geriatric Society 57:517–523.

Table 2 Examples of incidents that match Level 3 options.

	Scenario description	Fall, near miss, or not a fall	SLS tips and tricks
1	Consumer is mobilizing with walking frame and stand-by assistance. Consumer overbalances sideways. Assistant helps consumer to regain balance and continue walking.	Near miss	Level 2 Falls Level 3 – select <i>Near miss – fall prevented by staff</i> Select <i>Witnessed fall</i> in section Fall Details
2	Consumer is observed to stumble while walking along hall with walking stick. Grabs rail and steadies himself.	Near miss	Level 2 Falls In level 3 – select <i>Near miss – no intervention by staff</i>
3	Consumer is mobilizing with walking stick and one-person assistance and trips at junction of carpet and vinyl. Assistant slowly lowers consumer to floor.	Near miss	Level 2 Falls Level 3 select <i>Near miss – fall prevented by staff</i> Select <i>Witnessed fall</i> in section Fall Details
4	Consumer observed to trip on dressing gown cord as they walked, and landed on floor.	Fall	Level 2 Falls Level 3 Fall Select <i>Tripped over an object</i> from options in What was the mechanism of the fall?
5	Consumer found lying on floor. Incident unwitnessed.	Fall	Unless there is a reliable witness assume there was a fall Level 2 Falls Level 3 Fall Select <i>Unwitnessed fall</i> in section Fall Details
6	Consumer found on floor, unresponsive. Doctor diagnosed stroke.	Fall	Level 2 Falls Level 3 Fall Under <i>What was the mechanism of the fall?</i> , select <i>Faint, LOC cardiac collapse</i>
7	Consumer with cognitive impairment (NOT a reliable historian) found sitting on floor. Reports that they are attempting to get dressed.	Fall	Level 2 Falls Level 3 Fall Select <i>Unwitnessed fall</i> in section Fall Details Also select Dementia/cognitive impairment in Risk factors for falls – behaviour/mental state/cognition
8	Consumer who is cognitively intact and IS a reliable historian, is found sitting on floor. Reports that they are attempting to get dressed, clothes and shoes nearby.	Not a fall	No SLS report required The definition of a fall is that it is inadvertent/or unintentional. Sitting on the floor to dress is deliberate/intentional
9	Consumer who has been restrained in chair by tray table for hours, deliberately slides down to floor.	Not a fall	Level 1 Restraint or seclusion

10	You notice that a consumer has bruising on their elbow and forearm. He reports that he slipped in the bathroom last night and hit his elbow and arm on the toilet.	Fall	Level 2 Falls Level 3 Fall Select <i>Unwitnessed fall</i> in section Fall Details
11	Consumer is drowsy and unintentionally slides from chair to ground level. There is no injury.	Fall	Level 2 Falls Level 3 Fall Select <i>low fall</i> in Height of fall question
12	In sitting, consumer experiences a seizure and slides from chair to ground level. Known epileptic.	Fall	Level 2 Fall Select <i>Epilepsy</i> from options in What was the mechanism of the fall? Select <i>low fall</i> in Height of fall question
13	Consumer steadily lowers himself to kneeling position on floor to pull shoes out from under bed.	Not a fall	There is no incident to be reported The definition of a fall is that it is inadvertent/or unintentional. This movement is deliberate.
14	Consumer lowers himself unsteadily and, without control, lands heavily on one wrist and knees, then pulls shoes out from under bed.	Fall	A difficult movement was attempted and the patient/consumer fell for the last part of it. Later injury may be apparent eg bruises. The environment set-up was not optimum for the patient/consumer. Level 2 Falls Level 3 Fall
15	Consumer stands up from sitting in chair, mobilizes forward 1 step using walking frame, and then overbalances sideways to ground level.	Fall	Level 2 Falls Level 3 Fall Select <i>fall from standing height</i> in Height of fall question
16	Consumer stands up from sitting in chair, mobilizes forward 1 step using walking frame, and then overbalances sideways onto bed, OR backwards onto chair or arm of chair.	Fall	Level 2 Falls Level 3 Fall Select <i>low fall</i> in Height of fall question
17	Consumer returning from the bathroom to sit in bedside chair. Falls back into the chair in an uncontrolled manner hitting their head on the wall behind.	Fall	Level 2 Falls Level 3 Fall Select <i>low fall</i> in Height of fall" question
18	2 consumers Consumer A (mobilizing with single-point cane) momentarily overbalances onto Consumer B (mobilizing with walking frame). Consumer B overbalances sideways and falls to floor. Consumer A regains balance and stay upright.	Consumer A Near miss Consumer B Fall	Consumer A Level 2 Falls Level 3 – select <i>Near miss – no intervention by staff</i> Consumer B – Level 2 select <i>Collision or external force with object or person</i> Add Consumer A in Additional information <i>Was anybody else involved?</i>

4. Does this fall need to be reported?

All falls that are incidents related to care or during care should be reported to SLS as soon as practicable (within 24 hours).

Definition of an Incident: Any event or circumstance which could have (near miss) or did lead to unintended and / or unnecessary psychological or physical harm to a person and/or to a complaint, loss or damage (SA Health Incident Management Policy).

Tables 3 and 4 provide further examples from community and hospital settings, and whether these patient falls incidents should be reported.

Table 3 Community setting - examples of fall incidents, and whether they should be reported

Incident	Report to SLS?	Explanation
1. Consumer fell at home whilst SA Health staff were assisting them in the shower.	Yes	Consumer fell during an episode of care.
2. During a home visit the consumer informs you that the shower chair SA Health had provided slipped whilst in use and he ended up on one knee in the shower alcove, sustaining bruising to that knee and he is now anxious about showering alone.	Yes	The consumer's fall was directly related to service provided by the health care organisation.
3. During a home visit the consumer informs you that he fell on the footpath while walking around the block as instructed by the physiotherapist as part of their rehabilitation program (who works for your organisation). He grazed knees and right hand.	Yes	The consumer's fall was related to service provided by the health care organisation.
4. A consumer with Parkinson's disease freezes when walking down the ramp at home provided by SA Health. They are unable to stop their wheeled walking frame and fall forward to ground level, sustaining facial and lower limb abrasions and contusions.	Yes	The consumer's fall was directly related to service provided by the health care organisation.
5. During a home visit the consumer informs you that she fell in the car park outside local shops. She grazed lower limbs and fractured their left wrist.	No	The incident has nothing to do with the care provided by the health care organisation. It does however indicate that the person may be at risk of further falls, so falls risk screening, and bone health checks are indicated. The fractured wrist may necessitate a change to the care plan.
6. A resident of an aged care facility reports falling off the toilet whilst visiting their niece's home.	No	The incident has nothing to do with the care provided by the aged care organisation. It does however indicate that the person may need more assistance/equipment for use outside the aged care facility.
7. A community mental health client fell during an outing with the local council group. Recent screening had indicated low risk for falls.	No	The fall was not related to any services provided by SA Health, and was not predicted.

Table 4 Hospital, health setting – examples of fall incidents, and whether they should be reported

Incident	Report to SLS?	Explanation
1. Consumer fell outside the hospital while having a cigarette.	Yes	The consumer fell during an episode of care.
2. Day surgery or dialysis patient fell off the toilet hitting their head on the wall.	Yes	The consumer fell during an episode of care.
3. Consumer discharged from emergency department and fell while transferring from hospital wheelchair into private vehicle.	Yes	Even though the “episode of care” was complete, the consumer fell on hospital grounds. Also a fall so soon after discharge indicates that not all issues had been dealt with adequately during that episode of care.
4. A consumer was on weekend leave from rehabilitation and fell at home.	Yes	Preparation for weekend leave from rehabilitation includes consideration of the safety of the home environment.

5. How do I use the Safety Assessment Code (SAC) matrix for a fall incident?

The SAC rating is derived from consideration of the consequence (insignificant to extreme) and the likelihood (frequent to remote) of the incident recurring. Refer to the *SA Health SAC matrix* accessible through SLS.

Incident Classification (Subject to disclosure)	
* Level 1	Patient Falls and other injuries
* Level 2	Falls
* Level 3	Fall
* Safety Assessment Code (SAC) (Click here to view the Safety Assessment Code Matrix)	Consequence: <input type="text"/> Likelihood: <input type="text"/> SAC: <input type="text"/>
* Result	Harm caused to
Fall Details (Subject to disclosure)	

Insignificant

Minor

Moderate

Major

Extreme

For falls, the main determinant of the SAC rating is the consequence (harm) of the fall (Table 5).

At the time of reporting, notifiers may not know the final consequence of the fall. The notifier makes a judgement of the harm done by the fall based on their current knowledge, not the predicted outcome. For example, the consumer may have a bruise, and a fracture is suspected. If the incident is being reported before an x-ray, then it is reported as a bruise.

After further investigation by the manager, a final (actual) SAC rating is allocated, based on the known outcome or consequence.

Table 5 Examples of consequences of falls.

Consequence	Examples	Applying the SAC matrix to fall incidents
Extreme	<ul style="list-style-type: none"> > A fall leading to death. > Subdural haematoma requiring surgery and extensive rehabilitation. 	<p>Death unrelated to the natural course of the illness/ injury and differing from the expected outcome of the consumer management or, any of the following:</p> <ul style="list-style-type: none"> > An actual or near miss incident/complaint with serious identified system issues. > Increased length of stay >125 days. > Incidents which may involve media interest. > Sentinel Events.
Major	<ul style="list-style-type: none"> > Fractured neck of femur requiring surgery. 	<p>Major permanent loss of function (sensory, motor, physiologic or intellectual) unrelated to the natural course of the illness and differing from the expected outcome of consumer management or, any of the following:</p> <ul style="list-style-type: none"> > Disfigurement. > Patient assault requiring external involvement eg police, external emergency services. > Surgical intervention required > Increased length of stay 25 -125 days.
Moderate	<ul style="list-style-type: none"> > Broken nose. > Fracture requiring plaster. > consumer requires sutures. 	<p>Permanent lessening of bodily functioning (sensory, motor, physiologic, or intellectual) unrelated to the natural course of the illness and differing from the expected outcome of consumer management or any of the following:</p> <ul style="list-style-type: none"> > Increased length of stay or additional operation or procedure. > Increased length of stay 5 -25 days.
Minor	<ul style="list-style-type: none"> > Bruise. > skin tear. > pain/discomfort. > Fall resulting in abrasion > Fall requiring Medical Officer/ Physiotherapist review. > Fall resulting in x-ray. 	<p>Consumer requiring increased level of care including:</p> <ul style="list-style-type: none"> > Review and evaluation. > Additional investigations. > Referral to another clinician.
Insignificant	<ul style="list-style-type: none"> > Fall that resulted in no injury or assisted to floor. 	<p>No injury or increased level of care or length of stay, (will include near misses).</p>

To establish prevalence for this patient/consumer consider the number of risk factors for falls (eg polypharmacy; cognitive impairment; mobility issues) and the frequency of the activity.

For example, a person with a history of falls and multiple risk factors who falls while getting out of bed is likely to fall again when performing this common activity. Whereas a person who has no falls risk factors, but fell out of bed because they reached too far to get their glasses from the bedside table, is unlikely to do this again.

Incident Classification (Subject to disclosure)	
* Level 1	Patient Falls and other injuries
* Level 2	Falls
* Level 3	Fall
* Safety Assessment Code (SAC) (Click here to view the Safety Assessment Code Matrix)	Consequence: Moderate Likelihood: SAC: Remote (rare) Uncommon (unlikely) Occasional (possible) Probably (likely) Frequent (almost certain)
* Result	Harm caused to
Fall Details (Subject to disclosure)	
Height of Fall	

Table 6 Prevalence of the fall incident (How likely is this patient to experience another fall in similar circumstances?).

Prevalence	Examples	Description as it appears in SAC matrix
Frequent	Fell going to the toilet. 80 year old consumer with history of falls; cognitive impairment, polypharmacy including psychoactive medication, urge incontinence; diabetic retinopathy and peripheral neuropathy	Almost certain – is expected to occur again either immediately or within a short period of time (likely to occur most days or weeks).
Probable	Fell when getting out of bed. 75 year old consumer with Parkinson’s disease and associated mobility impairment; polypharmacy and mild dementia	Likely – will probably occur in most circumstances (monthly).
Occasional	Fell while walking. > 45 year old patient/consumer with multiple sclerosis resulting in decreased peripheral sensation and muscle weakness and double vision > 28 year old patient/consumer lower limb amputee	Possible – possibly will recur, might occur at some time (several times a year).
Uncommon	55 year old consumer in for day procedure Rolled out of bed when overreaching to get book from far edge of bedside table.	Unlikely – possibly will recur – could occur at some time in (every 1-2 years).
Remote	> 23 year old consumer in for day procedure tripped over “caution wet floor” sign whilst walking along the corridor texting on phone. > Consumer attempted to climb worker’s ladder during psychotic episode.	Rare – unlikely to recur – may occur only in exceptional circumstances (may happen every 2 to 5+ years).

Table 7 Examples of scenarios and the likely SAC rating (based mostly on the consequence of the fall).

What happened	Harm	Consequence rating	Relevant case history	SAC
Unwitnessed fall. Patient found on floor near bed. Complained of left sided pain. X-rays ordered.	Fractured left shoulder and hip requiring surgery. Did not survive surgery.	Extreme (death)	92 years old. Osteoporosis and low body mass index. Generalised muscle weakness. History of falls. Generalised muscle weakness and poor balance.	1
Patient found unconscious at bottom of steps by visitor. Visitor called nursing staff for assistance. Emergency response team called.	Depression fracture of skull; fractured pelvis; right neck of femur, right tibia and fibula; bilateral forearm fractures. Surgery for intracranial bleed. Total hip replacement. Lower right leg in cast. Bilateral casts to upper limbs. Rehabilitation - length of stay 130 days.	Extreme (Required surgery and increased length of stay greater than 125 days)	70 year old male. Osteopenia; malnutrition and low body mass index; Generalised muscle weakness. Emphysema.	1
Patient found in bathroom slumped near the sink with back against the wall. A small abrasion was found on the top of head. CT scan ordered.	Brain haemorrhage requiring surgery. Increased length of stay by 76 days.	Major patient required surgery, increased length of stay between 25 – 125 days	80 years old. History of falls (2 in previous 6 months) mild dementia; poly-pharmacy; psychoactive medications; walking aid; poor balance; generalised muscle weakness; cataracts; anticoagulant therapy	2
Patient found on floor near bed. Conscious and complaining of right hip pain.	Fractured neck of femur requiring surgery. Increased length of stay 14 days.	Major patient required surgery	79 year old. Polypharmacy; psychoactive meds; osteopenia; dizziness; foot pain.	2
Patient found on floor leaning head against corner of wall, between bathroom door and cupboard. Blood on face.	Laceration above left ear requiring sutures. Skin tear, right lower leg. Haematoma above left arm. MO ordered CT scan of head. Increased length of stay 4 days.	Moderate Required sutures and CT scan; increased length of stay of less than 5days	76 years old. History of falls. Moderate dementia. Impulsive behaviour. Severe difficulty hearing. Psychoactive medication. Gait disturbance. Occasional incontinence.	2
Patient found lying on floor next to bed. Laceration to head and deformed nose. MER team assessed patient.	Fractured nose, and bilateral black eyes. Ice packs and neuro obs for 48 hours. Laceration dressed and fractured nose bandaged. Increased length of stay of 3 days.	Minor Required increased observation; another procedure. Less than 5 day increase to length of stay	75 years old. History of 5 falls in past 6 months; poly-pharmacy; impaired peripheral sensation. Neurological condition (Parkinson's disease) with associated gait disturbance; urge incontinence.	3

Patient found lying on floor. The patient was conscious, and informed the RN that she had hit her head and complained of pain in her right hip.	Bruise and pain in left hip. X-ray did not reveal a fracture. Neurological observations done for 48 hours. Increased length of stay by 2 days.	Minor patient required further investigation. Less than 5 day increase to length of stay	78 year old. No history of falls. Mobilises with walking stick. Generalised muscle weakness. Polypharmacy.	3
Patient tripped whilst outside with family member. Fell against curb. Pain in pelvis.	X-ray confirmed fractured pelvis, conservatively managed. Additional pain relief and constipation. Increased length of stay 4 day.	Minor patient required further investigation. Less than 5 day increase to length of stay	66 year old with no history of falls or falls risk factors.	3
Unwitnessed fall. Patient states he was returning from smoking outside. He did not lift the footplate of the wheelchair up prior to standing to transfer into bed. He tripped on the footplate.	Skin tear cleaned and dressed.	Minor patient required wound dressing	67 year old. Non-weight bearing on left leg after foot surgery.	3
Patient's legs gave way as she was being assisted to the toilet by 1 nurse. Nurse unable to stop fall, so lowered to ground.	No injury.	Insignificant (no injury or extra care required)	40 year old post anaesthetic. No intrinsic risk factors.	4
Patient reports reaching to get something out of the locker drawer and rolling out of bed onto the floor.	No injury	Insignificant (no injury or extra care required)	55 year old patient in for investigation of persistent headaches.	4

6. What were the fall and injury risks and interventions in place at the time?

One of the last sections of the SAC online form asks for the consumer's current risk factors and the interventions that were in place. This information across a health service indicates which consumers are most at risk and the interventions that were in place at the time of the fall. This assists quality improvement. To find this information refer to the most recent:

- > falls risk screen (sometimes known as MR58b), or
- > falls risk assessment (sometimes known as MR58) or
- > falls risk review form (sometimes known as MR58a).

These documents will provide the identified risk factors and actions to manage and modify those risk factors.

The SA Health *Falls and fall injury Prevention and Management Policy Tool 2* describes which consumers should have these completed and when. (Tool 2 - When how to do fall risk screening, assessment, care planning and discharge planning).

7. What is the Manager's role in review, investigation and managing fall incidents?

The clinical manager of the area has responsibilities under:

- > National Safety and Quality Health Service Standard – Standard 10 Preventing Falls and Harm from Falls (Australian Commission on Safety and Quality in Health Care).
- > Criteria 10.2 Using a robust organisation-wide system of reporting, investigation and change management to respond to falls incidents.
- > SA Health Fall and fall injury prevention and management Policy Directive.

1. Review the notifier's report.

2. Decide if a post fall team review will be done.

These are recommended for all SAC1 and SAC2 rated falls unless an RCA is warranted. Additionally consumers who have had more than one fall during the admission warrant team review as the care plan is not effective in reducing risk. Other SAC 3 and 4 falls may benefit from team review.

- > **Benefit to consumer** – Review of care plan, and contribution to new care plan. Additional strategies to reduce risk of future falls.
- > **Benefit to team** - opportunity for the interdisciplinary team learning and to improve care.
- > **Benefit to manager** – The team reviews the incident and takes action to reduce further falls. The manager participates, records outcomes into the Managers section of SLS, and escalates any concerns about issues that affect other areas of the service. Tasks can be delegated to other team members. Records of post fall team reviews can be used as evidence for accreditation.

3. Conduct the post fall team review.

Refer to the SA Health post fall team review process Tool 6 - Post fall team review.

This process is somewhere between a 'huddle' and a 'debrief' (in TeamSTEPPS® terminology). That is, it is brief (5-10 minutes), fairly informal, and occurs when the team is most easily able to gather, and as soon as possible after the fall (ideally that day or the next).

The inter-professional team reviews the incident, the patient's fall risk and what strategies were in place, with the consumer and care if possible.

Then a revised care plan is documented to address the patient's risk and prevent further falls. This is communicated through medical records and handover processes

If a post fall team review is to take place the manager changes the incident from 'holding area, waiting review' to 'being reviewed'.

4. Record the outcome of the team review into the manager's section of SLS.

For further information:

A video showing a post fall team review is included in the SA Health *Falls Prevention* on-line learning course.

Table 8 The Post fall team review questions in SLS

	Managers section of SLS - Falls specific questions	Additional information
Post fall review	Was the care provided immediately after the fall in accord with the post fall management protocol? (*) yes/no . Comment and actions	Refer to the SA Health <i>Post fall protocol</i> (in draft).
	Was a team review arranged? yes/no	Refer to the SA Health <i>Tool 6 - Post fall team review</i> .
	Was Root Cause Analysis conducted if required?	Refer to the SA Health <i>Incident Management Policy</i> .
Summary from team review	<ul style="list-style-type: none"> > Agreed actions/recommendations have been documented and communicated as appropriate. > Agreed actions discussed with patient/family. 	<ul style="list-style-type: none"> > Track the progress of review and follow-up. > Provide evidence of follow-up and consumer engagement for auditing and accreditation requirements.
Likely contributory factors, and actions completed to address these	<ul style="list-style-type: none"> > Patient factors – incomplete identification or management of risk factor(s). > Environment/ward factors. > Factors related to clinical practice. > Factors relating to the severity of injury sustained. 	<p>This information will assist with:</p> <ul style="list-style-type: none"> > planning quality improvement activities > reporting and auditing requirements.

**The SA Health Post fall management protocol (in draft) provides information about immediate first aid, observations and management in the hours and days after a fall with injury.*

For more information

**SA Health
Safety and Quality Unit
Telephone: 08 8226 6539
www.sahealth.sa.gov.au/fallsprevention**

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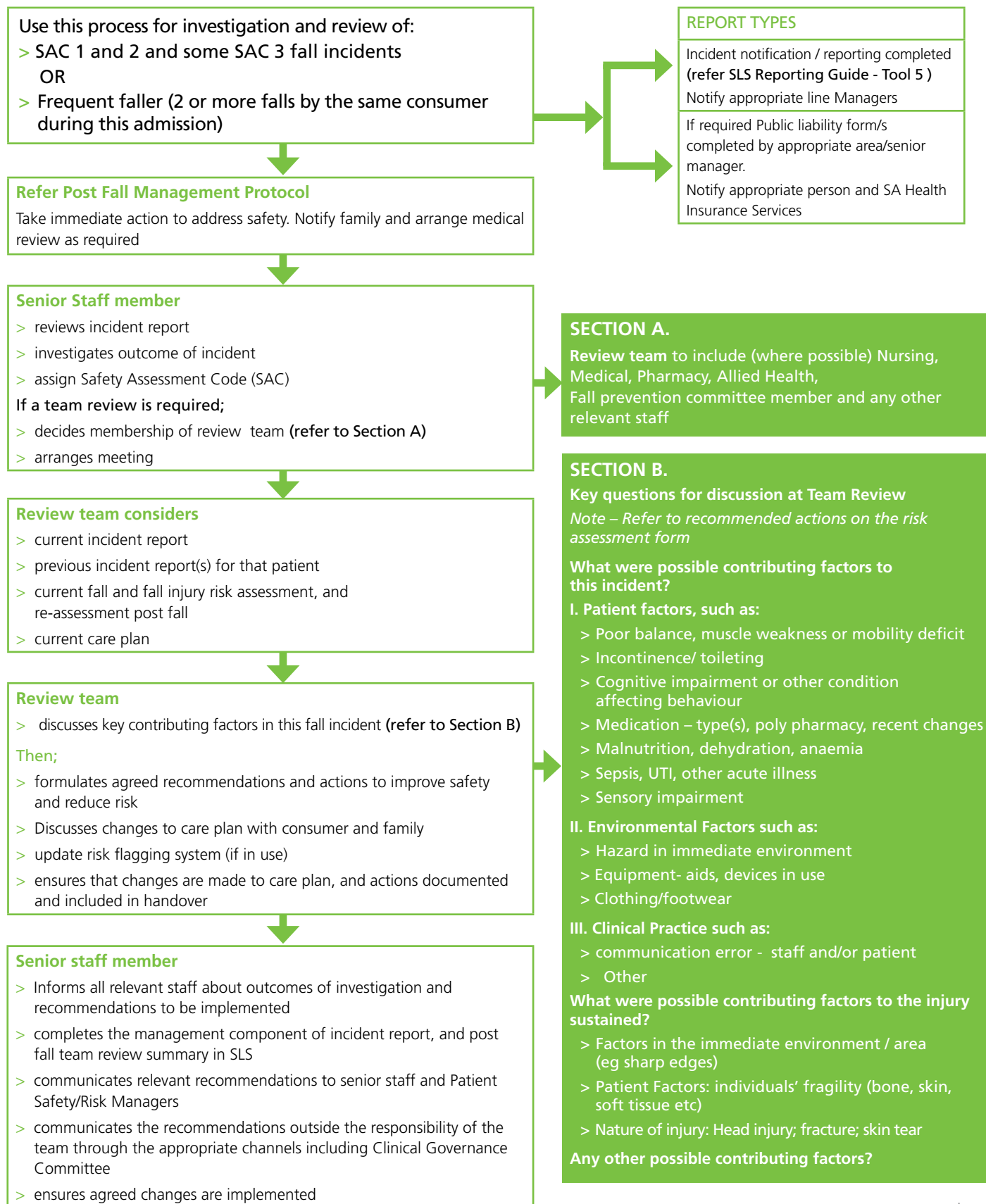
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TOOL 6

Post fall team review

A review by the clinical team after a consumer fall will promote improvement to care, team learning, and highlight issues that may be a risk for other consumers



A post fall team review forms part of the Incident review and analysis phase of the patient incident.

As such, any documents developed:

- are to be used for quality improvement purposes
- are to be uploaded into the managers section of the SLS incident
- are not to be released publicly
- do not form part of the medical record

The recommendations arising from the post fall team review can be used to:

- inform changes to the consumer's care plan, which are documented in the medical record
- support shared team learning and quality improvement
- inform consideration of area or service-wide practice changes

Reference: *Health Care Act 2008 (SA)* Part 7 and 8 s72(1)(b)

For more information

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