OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Falls: Risk assessment and management of patient falls

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH and OPH

This document should be read in conjunction with this Disclaimer

Contents

This guideline is to be read in conjunction with:

- Australian Commission on Safety and Quality in Healthcare (ACSQHC): Preventing Falls and Harm from Falls in Older People (2009) (external website, PDF, 3.2MB)
- Department of Health WA Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings (2018) (PDF, 398KB) and
- NMHS Falls Risk Management Policy (2019)

Aim

Falls risk assessment tools and interventions are used collaboratively and can reduce the risk of falls and fall related injuries.

Key points

1. All patients admitted to the gynaecology and obstetric areas, including Day of Surgery Admission (DOSA) patients shall be assessed for risk of falls. Initial falls risk screen and implementation of strategies must be performed as soon as practicable or within a maximum of 10 hours on all patients whom are confirmed for admission.
    - **Gynaecology**: Falls Risk Assessment and Management Plan (FRAMP MR260.04)
    - **Antenatal**: Antenatal Clinical Pathway (MR222.02) - Falls risk screening
    - **Postnatal**: Postnatal Clinical Pathway (MR249.60) - Falls risk screening
2. All maternity and gynaecology inpatients shall have the ‘Minimum Standards / Interventions’ for fall prevention implemented and adhered to at all times. Minimum standards / interventions are listed on relevant falls screening form.
    - If screening indicates that Minimum Standards / Interventions for fall prevention are not adequate, the fall risk management sections on the relevant falls risk form are used to plan for intervention strategies.
3. For each patient assessed as being at a high risk of falling, a fall prevention plan must be prepared and individually tailored to the patient’s specific set of risk factors.
4. Patients are at risk for a variety of reasons, and this risk is not limited to inpatients or the elderly but can include mobility / functional ability, medications, medical conditions, continence / elimination needs and cognitive state.
5. A person’s risk of falling increases as their number of risk factors accumulates.
6. All patients identified as at risk of falls are to have this information included in handover between staff and the falls risk included in iSoBAR handover.

Falls risk screening and management

Outpatient risk screening

The Patient Health Questionnaire is sent to all patients and includes a section for previous falls and mobility concerns. If there are concerns, the outpatient staff member (nurse, midwife, doctor) should consider referral to an appropriate service (e.g. Physiotherapy, Occupational Therapy).

Gynaecology clinical areas

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

Gynaecological patients admitted to WNHS will be assessed using the FRAMP tool and managed with a multidisciplinary approach, in alignment with relevant NMHS and Department of Health WA policies, to minimise the risk of falls.

- The FRAMP shall be completed on all gynaecology patients on admission to KEMH Ward 6, ASCU, or the DSU (DOSA gynaecology patients only).
- If the patient meets **any** of the screening criteria on the FRAMP, a full assessment of each of the components (in the shaded boxes on the second page) shall be performed and documented.
- A full assessment with interventions care plan shall occur if a patient meets the criteria on the form.
- Identify the appropriate interventions required to prevent falls and transfer to the Nursing Care Plan.
- Identify each patient's individual risks for falling and the strategies that have been put in place as per FRAMP are included in iSOBAR handover.
- If no criteria are met, ensure minimum standards are in place.
- Rescreen in the following circumstances: On ward transfer; post fall; and where there is a change in the patient's medical condition (cognitive, functional or environmental)

OPH patients (non-obstetric)- see SCGOPHCG: Falls Management Guideline

Obstetric clinical areas

(**KEMH:** ASCU, DSU, EC, Labour and Birth Suite, Wards 3-5**; OPH:** Ward 1, Birth Suite)

- The Falls Risk Screening page within the relevant Clinical Pathway (Postnatal- MR249.60 or Antenatal- MR222.02) shall be completed on all obstetric women who present for admission to ASCU, Obstetric Wards 3, 4, 5, Maternal Fetal Assessment Unit (MFAU), and Labour and Birth Suite.
- If the patient meets any of the falls risk factors complete the interventions / care plan section on the form to identify the appropriate interventions required to prevent or reduce falls.
- Risks for falling and the strategies that have been put in place as per the risk assessment tool are included in iSOBAR handover.
- A full risk rescreen should be performed:
  - Antenatal patients: If change in condition
  - Postnatal patients: Post birth; and if change in condition.
- For obstetric patients with a neuraxial catheter, refer to Anaesthesia guideline: Neuraxial Analgesia: 'Epidural Analgesia in Labour'.

Minimum standards: Implemented for ALL patients

Refer to the list of minimal standards on the relevant risk screening form used, examples include:

- **Orientate** the patient to the bed area, toilet facilities and ward.[1]
- **Place within reach:**
  - Call bell: Demonstrate its use and ensure it is in reach of the patient.[1]
  - Visual aids: Ensure the patient has their usual visual aids such as glasses within reach [1] (and that they are clean)
  - Frequently used items including mobility aids, table, hearing aids telephone, water are within easy reach of the patient.[1]
- **Educate** the patient and carers / family - provide information about the risk of falls and safety issues and record discussion / education in the medical record.[1]
- **Make the environment safe**:
  - Ensure the bed and chairs are at an appropriate height for the patient (In most cases, a height that enables the patient's feet flat on the floor with hips, knees and ankles at approximately 90-degree angles assists for mobilisation. Note that a lower bed may be required as an intervention to reduce falls risk).[1]
  - Ensure bed brakes are employed at all times when the bed is stationary.[1]
  - Consider location of equipment e.g. IV poles, over-bed table to ensure there are no slip or trip hazards.
  - Remove clutter, obstacles and spills from the room[1]
- **Mobilising**
  - Provide appropriate mobility assistance (supervise or help the patient if required).[1]
  - Ensure the patient wears appropriate non-slip footwear if ambulant especially if wearing graduated compression stockings or socks.[1]
- Minimise the use of bed rails.[1] When bed rails are used, the reason for this choice shall be documented in the patient's notes.
- Additional ways for preventing falls in older people-
  - Encourage incidental activity and exercise (minimise prolonged bed rest[1] as it contributes to negative cardiovascular and muscle effects that may lead to falls)
  - Provide adequate lighting according to patient activities / needs[1]
  - Encourage adequate fluids and nutrition[1]

Post fall management

- Please refer to the Department of Health WA: Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018.

Post fall process [2]

- Medical staff document on MR260.07(KEMH) / MR119.10(OPH) Post Fall Medical Assessment form [new 2022].

NURSING GUIDELINE AND 48 HOUR POST FALL PROCESS

Stop and Consider: Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy (e.g. alcohol dependent persons) are at an increased risk of intracranial, intrathoracic, intra-abdominal haemorrhage

DATE AND TIME OF FALL:

IMMEDIATE POST FALL PROCEDURE

DRSABCDE

- Provide patient reassurance and comfort and call for assistance
- Patient not to be moved if any physical injuries identified (unless airway is compromised)
- Activate Medical Emergency Team (or local process) if patient meets criteria
- If significant physical injuries identified, fast track Medical Officer review within 30 minutes
- Immobilise cervical spine if patient is unconscious or reports head or neck pain
- Patient movement to be guided by local policy and clinical assessment
- Commence neurological and baseline physical observations
- Minimum investigations include blood glucose level, ECG cognitive impairment screening using the AMT4/4AT/CAM (as per local policy). Identify immediate pre-fall symptoms e.g., dizzy, feeling unsteady, etc. and consider other investigations as indicated by the pre-fall symptoms, contributing factors to the fall and the patient's condition
- Notify Medical Officer of patient fall and request review. (If no apparent injury, this can occur within 4 hours or as per local policy)
- Notify Ward/Area/ Facility/ Senior Registered Nurse (SRN)/After Hours Clinical Nurse Specialist

TYPE OF FALL AND ONGOING OBSERVATIONS AND CARE DELIVERY

WITNESSED FALL – DID NOT HIT HEAD	PATIENTS ON ANTICOAGULANTS/ANTIPLATELETS AND/OR WITNESSED FALL – HIT HEAD, UNWITNESSED FALL
• Medical/SRN's clinical judgment for observations. • Documentation of rationale required. Continue with instructions below.	Neurological observations: • Half-hourly for a minimum of 2 hours until GCS of 15 or patient considered back to their normal level of cognition achieved. • Continue if GCS remains < 15 or patient not considered at normal level of cognition. Report to MO and continue as per instructions. If patient has GCS of 15 or patient considered back to their normal level of cognition then continue: • Hourly for 4 hours. • Two-hourly 4 hours. • Four-hourly for 40 hours (to make total of 48 hours from time of fall). • If clinically assessed as stable, no deterioration, return to observations pre-fall.

RECOMMENDED ACTIONS WITHIN 4 HOURS OF THE FALL

- Next of Kin (NOK) notification
- Physical, behavioural, and cognitive injury care as indicated
- Continue to identify and report clinical deterioration
- Rescreen using FRAMP (or local endorsed falls risk assessment tool) and implement interventions
- Medical review (if not fast tracked)
- Documentation and reporting of the fall
- For an injurious fall that may be considered a SAC 1 injury – complete notification as per local clinical incident management policy

RECOMMENDED ACTIONS WITHIN 6 HOURS:
CONTINUE OBSERVATIONS AS INDICATE BY FALL TYPE

- Continue to monitor for physical, behavioural, cognitive clinical deterioration. Report to MO if this occurs.
- Notification of fall to Occupational Therapist or Physiotherapist.
- Notify the Pharmacist when possible.
- Referral to other health professionals as per clinical assessment (and as per local policy).

RECOMMENDED ACTIONS WITHIN 24 HOURS:
CONTINUE OBSERVATIONS AS INDICATED BY TYPE OF FALL

- Patient and family/carer to receive information and education. Ongoing falls management care developed in partnership with patient and family/carer.
- Review of results of bloods, imaging, microbiology, and observations has occurred and been actioned.
- The multidisciplinary team members have collaboratively discussed the fall and identified any further risks and interventions required.
- Consider a structured multidisciplinary Post Fall Safety Discussion.

RECOMMENDED ACTIONS AT 48 HOURS:

- Review of observations and if no clinical deterioration, return to appropriate observations.
- Completion of all actions within the guidelines.
- Comprehensive care plan review.
- Document and communicate to the appropriate person any outstanding actions and date/time completion required.

COMMUNICATION:

- Ensure patient consents to discussion of care with family/carer (where clinically appropriate).
- Interpreter is always to be utilised where appropriate (and as per local policy).
- Primary nurse to ensure documentation in patient's health care record and local reporting database.
- Medical and allied health reviews documented in the patient's health care record.
- Patient and family/carer to receive information/education about the fall and ongoing instructions if discharged within 48 hours of the fall.
- All disciplines involved are to partner with the patient and family and share decisions to develop ongoing plan of care.
- Communication may require different approaches depending on disability/cultural requirements.
- Documentation of the fall to occur on nursing, medical, allied health handover sheets, and all transfer and discharge documentation.
- Inclusion of the fall in verbal handovers: nursing, medical, allied health.
- All staff involved in the care of the patient to be informed of incident outcome and revised care plan.
- Visual flagging that the patient is at high risk of falls (and as per local policy).
- Contact Ward/Area/Facility/SRN/After Hours Clinical Nurse Specialist (and as per local policy)

ALLIED HEALTH ASSESSMENT: OT, PHYSIOTHERAPY, PHARMACY

- Complete assessments as per specific discipline guidelines within 2 working days of the fall (and as per local policy).
- Work collaboratively with the wider multidisciplinary team.

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

Further considerations post fall

Optimise secondary prevention of further falls using the following strategies where applicable and age-appropriate:

- Consider Vitamin D testing.

- Consider a bone mineral density scan if the patient is at risk of osteoporosis and is deemed appropriate by the Medical Officer.
- Continued patient, family and carer education on falls risk management.
- If patient has developed a fear of falling, offer referral to a Social Worker or Clinical Psychologist.
- Plan the discharge with consideration of the patient's ongoing fall risk and the need for home assessment and equipment.

Neonates: Educate new parents for baby falls prevention

Provide education on how to keep their baby safe from falling

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

Care in the event of a neonatal fall

- Follow CAHS Neonatology Guideline: Postnatal Wards: Falls: Care of a Newborn Following a Drop / Fall

References

1. Australian Commission on Safety and Quality in Health Care [ACSQHC]. Preventing falls and harm from falls in older people: Best practice guidelines for Australian Hospitals: ACSQHC; 2009 [cited 2022 Jan 10]. Available from: https://www.safetyandquality.gov.au/sites/default/files/migrated/Guidelines-HOSP1.pdf
2. Department of Health WA. Post fall multidisciplinary management guidelines for Western Australian health care settings 2018. Perth: Post Fall Working Group; Department of Health WA; 2018. Available from: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Networks/Falls%20prevention/WA%20Post%20Fall%20Guidelines_Final_2018_PDF.pdf

Related standards, policies and guidelines

- ACSQHC: Comprehensive Care Standard (Minimising patient harm- actions 5.24-5.26): Falls Prevention (external websites)
- Department of Health WA: Post Fall Multidisciplinary Management Guidelines and Tools, including Post Fall Multidisciplinary Management Guidelines for Western Australian Health Care Settings 2018
- NMHS: Falls Risk Management Policy
- SCGH/OPH: Falls Management Guideline (HG018)
- CAHS Neonatology: Postnatal Wards: Falls: Care of a Newborn Following a Drop/Fall

Resources (including relevant forms)

- Stay on Your Feet WA (external website)
- Department of Health WA: Falls Prevention Health Network (external website)
- WNHS Patient Information: 'Pregnancy Birth and Your Baby' book: After the birth of your baby: 'Preventing falls for you and your baby'

Forms

- MR222.02 Antenatal Clinical Pathway - Falls risk screening
- MR249.60 Postnatal Clinical Pathway - Falls risk screening
- MR260.04 Falls Risk Assessment and Management Plan (FRAMP) (Gynaecology)
- MR260.07(KEMH) / MR119.10(OPH) Post Fall Medical Assessment form [new 2022]
- MR337(KEMH) / MR74.1(OPH) Adult Neurological Observation Chart

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Version history

Version number	Date	Summary
1	July 2007	First version
2	June 2009	Archived. For details contact the OGD Clinical Guideline Coordinator
3	Sept 2010	
4	Aug 2014	
5	Feb 2018	• For patients identified at risk of falls, to include risk in iSoBAR handover • Post fall management section: A full physical examination of the patient should be undertaken by the medical team to assess if intracranial, intrathoracic or intra-abdominal bleeding has occurred • Baby fall prevention section: Provide parent education that includes: Address the safety issues of placing the baby on the bed unattended as all babies have the potential to roll off the bed
6	Mar 2020	• Added links to SCGH, NMHS and Department of Health WA Post fall guidelines • Removed 'post fall instruction text' and replaced with the post fall process chart - to align with Department of Health Post Fall guideline
7	Dec 2022	• Updated minimum standards for fall prevention • Updated screening forms- admitted maternity patients now use risk screening in their relevant (antenatal or postnatal) clinical pathway • Includes outpatient screening, Patient Health Questionnaire, and referral to services • Newborn falls- added link to CAHS guideline to follow
7.1	22/12/2022	New form to document medical practitioner assessment

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