STANDARDS TO BE MET

1. Safe Mobilisation and Falls Prevention Assessment

1.1 The multidisciplinary team will:

a) Conduct the Safe Mobilisation and Fall Prevention Assessment;
b) Initiate appropriate interventions to address patients identified risk for falling and document in Multidisciplinary Care Management Plan within eight (8) hours of admission and place the relevant Mobilisation Flipchart at the patient's bedside.
c) Reassess and update the Multidisciplinary Falls Care Plan and flipchart following any change of patient status, on transfers or following a fall.
d) Complete Interdisciplinary team referrals for assessments as required.
e) Evaluate and document outcomes and update Multidisciplinary Care Plan as required.

1.2 Inpatients:

a) All patients are classed as being at HIGH RISK of falling unless assessed otherwise.
b) Any patient assessed and documented as LOW RISK requires no further action.

1.3 Paediatrics and neonates:

a) All paediatric / neonatal patients are classed as HIGH RISK and requiring risk reduction actions - refer to Appendix 1.
b) All parents and caregivers will receive information about maintaining a safe environment to reduce fall risks for babies / children. This will be documented in the patient's health record.

2. Intentional Rounding

2.1 Routine intentional rounding is one of the multidisciplinary strategies / tools used to reduce harm from falls.

3. Post Fall Assessment and Management

3.1 The registered nurse (RN) / registered midwife (RM) responsible for the care of the patient will ensure the Post Fall Assessment and Management algorithm (refer Appendix 2) will be followed for all falls (witnessed / unwitnessed or near miss)

3.2 Doctor notified of fall should examine patient within two (2) hours of notification or sooner if acute care required as advised by RN / RM reporting event. Examination must include assessment of neurological status and any possible injuries. Assessment must be documented in patient's health record. Doctor should be available to discuss the injury, including an explanation of the risks, with the patient / family.

3.3 The incident, the outcome, initial and ongoing assessment, observations and actions taken will be documented in the health record.

3.4 Reassess and update the Multidisciplinary Care Plan and flipchart.

3.5 The RN / RM responsible for the care of the patient will ensure the family is notified in accordance with Incident Management Open Disclosure principles and practice

3.6 Investigation of any major (significant) injury is to be completed as part of the BOPDHB Incident Management process (major injury includes fractures / cerebral incident / death).

4. Reporting and Investigation of Inpatient Falls

4.1 Complete a Reportable Event Form (REF) as soon as possible after the event and before the end of the shift.

4.2 Include all relevant information such as but not limited to these examples:

a) Witnessed (by whom) or unwitnessed
b) Where / when patient was found
c) If patient experienced loss of consciousness
d) Clinical assessment
e) Whether patient hit head
f) Any obvious injuries or harm
g) Any complaints of pain
h) Was a falls assessment and care plan completed
i) Observations and EWS/PEWS
j) Interventions implemented to prevent reoccurrence
k) Actions taken
l) Medical review requested and completed
m) Ask patient what they were doing or where they were going
n) Use of mobility devices
o) Position of bed (high / Low)
p) Bed rails in use or not
q) Footwear in use
r) Family notified

5. Education

5.1 Staff will receive education in safe mobilisation and falls prevention assessment, risk reduction and management of patients at risk.

5.2 Patient / family / whanāu will be explained the risks / care management plan. If patient / family / whanāu request care contrary to falls risk reduction advice this is to be documented in the patient's health record.

6. Monitoring

6.1 All REFs related to a fall incident are reported in the Quality & Patient Safety monthly reports to Clinical Governance Committee and to Cluster Leaders.

6.2 Audit of falls incidence and quality of documentation (of falls reduction and management plan) will be undertaken in response to identified trends within organisational reporting.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.3.5 Falls – Risk Reduction and Management of Inpatient Falls
- Bay of Plenty District Health Board policy 2.1.1 Risk Management
- Bay of Plenty District Health Board policy 2.1.3 Hazard Management

- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 1.2.4 protocol 3 Restraint Minimisation & Safe Practice - Reporting
- Bay Of Plenty District Health Board Policy 6.1.5 Protocol 1 Alerts – Medical (Allergic Responses / Adverse Reactions And High Risk Issues)
- Bay of Plenty District Health Board policy 7.104.1 protocol 2 Care Delivery - Nursing & Midwifery Shift Handover
- Bay of Plenty District Health Board policy 7.104.1 protocol 5 Care Delivery – Nursing & Midwifery Assessment Standards
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.E1.1 Enablers (Restraint Minimisation & Safe Practice)
- Bay of Plenty District Health Board Clinical Practice Manual protocol CPM.D1.1 Delirium, Dementia And Depression In Older Adults - Care Guidelines
- Bay of Plenty District Health Board Emergency Department protocol ED.F1.1 Fractured Neck Of Femur (NOF) Fast Track Standards (Tauranga Only)
- Bay of Plenty District Health Board Adult Multi-Disciplinary Goals & Care Management Plan (7422)
- Bay of Plenty District Health Board Multidisciplinary A to D Planner (7760)
- Bay of Plenty District Health Board Moving Safely & Preventing Falls: Information for Patients, Family and Friends
- Bay of Plenty District Health Board Moving Safely Bed Card

Appendix 1: Neonatal and infant falls risk reduction strategies

	ACTION	RATIONALE
1	**Bed / Change Table** • Never leave baby unattended at any time • Ensure the bed is at a comfortable height • Open Incubator (used for the sick neonate) - Perspex sides must be up when baby is alone • Closed incubators - do not leave baby unattended when the front door is down, or mattress tray has been slid out from incubator	• To eliminate the risk of baby falling - small babies can move / roll • To ensure comfort and correct posture for caregiver • To eliminate the risk of the baby falling • To eliminate the risk of the baby falling
2	**Transportation** • Bassinette - should be in flat position, not in elevated position • Pram – ensure that baby is secured with bedding tucked in as per standard use of a pram • Transport incubator for transportation to X-Ray, Radiology, other wards, and other hospital - for use for smaller babies, or babies requiring oxygen. Ensure battery / oxygen is in working order. • Car seat - ensure baby fits well in the car seat by adjusting shoulder straps. • Educate parents in the correct way of fitting baby in car seat into the car. • For smaller babies, ensure the head is supported by curved roll. • Always leave car seat on the floor rather than on a table/bench/chair	• To ensure bassinette does not slip down from elevated position • The pram provides an efficient comfortable and warm environment for the baby while in transit • A thermo neutral environment is maintained within an incubator which is required by small babies. • Oxygen can be administrate and monitored easily within the incubator. • A charged battery and full oxygen cylinder is needed during the journey. • Baby must fit properly according to manufacturer's instructions to ensure safety. • Parents need information to be empowered / informed to make wise choices for their baby. • Small babies have reduced head control • Car seat could fall or be knocked off.

Appendix 2: Management & Reporting of Inpatient Falls Algorithm

Immediate Response: Initiate clinical care and call for assistance

- **Basic Life Support**: **D**anger, **R**esponsive, **S**end for help, **A**irway, **B**reathing, **C**PR?, **D**efib (DRSABCD)
- **Rapid Assessment**: Pain, bleeding, injury (do not move until assessed: examine cervical spine, and immobilise if there is an indication of injury).
- **Base-line Observations**: Full set: BP, P, R, T, $Sp0_2$, Blood Glucose and Pain score, Neuro obs, calculate **EWS/PEWS** score and escalate as required.
- Notify medical staff of fall.

Observations & Ongoing Monitoring for ALL Patient Falls

- Standard *Adult General Observation Chart* include pain, and
- Adult Neurological Observation Chart
  - ***At least hourly for a minimum of 4 hours: REVIEW***
  - ***4 hourly for the next 24 hours or as required, then REVIEW***
  - ***Ongoing observations as clinically indicated and requested*** (Seek clinical advice)

If patients' observations, EWS/PEWS score or clinical condition deteriorates - *action* EWS/PEWS Escalation Process

Clinical Review Action required for any following presenting signs:

- ***Patients*** on **anticoagulant/or antiplatelet** therapy and patients with known coagulopathy are **HIGH RISK** for bleeding
- ***Fluctuating* Behaviours and/or increasing confusion**: increased agitation, restlessness, or changes in level of alertness –lethargy, flattened: complete assessment for Delirium
- ***Injury* - facial bruising, hit head when fell , fracture**
- ***Vomiting***, headache

Consider CT scan

Ongoing Monitoring is important - there may be manifestations of head injury after 24 hours

- Change in level of consciousness – headache, vomiting
- Increasing confusion and fluctuating behaviours: increased agitation, restlessness, lethargy

Communication and Documentation

- Reassure the patient and explain all treatment and investigations.
- All patient falls are to be reported to medical staff for review.
- Notify the patient's family and inform them about the fall and plan of care.
- Document all assessment, treatment, escalation process and outcome in the patient's health record.
- Reassess and update the patient's Multidisciplinary Care Plan and flipchart.
- Discuss at clinical bedside handover including noting ongoing observations and monitoring requirements and change in care management plan.
- Complete Reportable Event Form.
- Complete investigation and review of fall event with clinical leadership team.