08 March 2023

9(2)(a)

Tēnā koe 9(2)(a)

Official Information Act 1982 – OIA2023022703

Thank you for your Official Information Act 1982 (the Act) request of 27 February 2023 for information relating to policies. Specifically:

> *I would like a copy of your policy that relates to accidents that occur with inpatients whilst under your care. Could you also include the Falls Prevention Policy.*

Please find the policies you requested attached. They are released to you in full.

Te Whatu Ora Capital, Coast & Hutt Valley take patient safety extremely seriously, and remain committed to providing safe and high quality care.

No injury to a patient while under our care is acceptable, and every incident of patient harm that occurs in our hospitals is one too many.

We are continually monitoring and reviewing our services and looking at what could be done better to improve patient safety and experience. As part of this we foster and promote a strong safety culture, where staff are encouraged and empowered to raise issues and speak up to improve patient safety.

Across the Capital, Coast & Hutt Valley district we discharge an average of 65,000 to 80,000 patients from our hospital facilities, perform more than 28,000 surgeries, manage more than 117,000 ED presentations, and have more than 5000 babies born at our facilities each year.

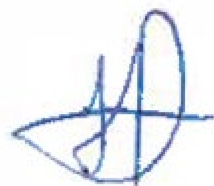
We are confident that the vast majority of our patients receive safe, timely, and high quality service and support.

If you have any questions, you can contact us at hnzOIA@health.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public. Te Whatu Ora may proactively release a copy of this response on our website. All requester data including your name and contact details, will be removed prior to release. The released response will be made available on our website.

Nāku iti noa, nā



Jamie Duncan

Interim Lead – Hospital and Specialist Services

Capital, Coast and Hutt Valley

Type: Policy

Name: Adverse Event and Incident Management

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Purpose

The purpose of this policy is to articulate how all adverse events and health and safety incidents are managed at Capital & Coast District Health Board (CCDHB).

Policy Statement

CCDHB aims for a *just culture* where employees are not blamed for system failings and feel comfortable disclosing adverse events and incidents. The fundamental role of an adverse events reporting system is to enhance safety by learning from adverse events and near misses that occur in health and disability services. Adverse events and incidents will be reviewed and managed in a professional and respectful manner that ensures lessons are learnt, to improve quality and safety for patients and their family/whānau and employees.

These practices comply with legislative requirements:

- The New Zealand Health and Disability Services (CORE) Standards (2008)
- HDC Code of Rights
- The Health & Safety at Work Act (2015)
- Health & Disability Services (Safety) Act (2001)
- Privacy Act (1993), the Health Information Code (1994), and the DHB General Disposal Authority

Scope

Includes:

- All CCDHB employees (permanent, temporary and casual), visiting medical officers and practitioners, students and other partners in care
- All clinical adverse events and incidents (including good catches) that occur or have the potential to occur to any person as a result of the provision of health and disability services (managed in alignment with the National Adverse Events Reporting Policy 2017)
- Health and safety events affecting any employee, contractor or volunteer (managed under the Health and Safety at Work Act (2015).

Excludes:

- Employment relationship issues and events; these are managed under the Employment Relations Act (2000), and should be referred to Human Resources.
- Incidents involving a criminal act, use of illicit drugs or alcohol, deliberate unsafe action or deliberate patient harm should be referred to Human Resources.

Principles

CCDHB supports the principles that underpin the National Adverse Events Reporting Policy (HQSC 2017) for clinical adverse events. These include:

- open communication
- consumer participation
- culturally appropriate review practice
- system changes
- accountability
- reporting must be safe

Definitions

Clinical/non-clinical

Clinical events are those that affect patients/consumers during an episode of care.

Non-clinical events are those that do not directly involve patient care.

Good catch (near miss)

An event which under different circumstances could have caused harm, but did not, and which is indistinguishable from an incident in all but outcome.

Incident

An event with potential or actual negative or unfavourable reactions or results that are unintended, unexpected or unplanned (also referred to as *adverse event or reportable event*).

Just Culture – (No blame)

One in which employees are comfortable disclosing errors, including their own, while maintaining accountability. It recognises individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients or gross misconduct.

Notifiable Event

When any of the following occurs as a result of a work accident: a death, notifiable illness or injury.

Open communication

The timely and transparent approach to communicating with, engaging with and supporting consumers, their families and whānau when clinical incidents occur.

Review

A formal process that is carried out to analyse an incident or good catch and develop recommendations based on the findings.

SQUARE

Safety Quality and Reportable Events electronic reporting system (RL 6) where incidents are reported

Third Party Administrator (TPA)

An organization that processes and handles ACC claims for an employer (e.g. Wellnz - manages ACC claims for CCDHB)

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Role and responsibilities

Role	Accountability and Responsibility
All CCDHB employees	• Report all incidents using SQUARE. For a clinical event, this should also be documented in the patient's clinical record
Business Manager on-call, or Afterhours Duty Nurse Manager	• Provide expert advice, support and leadership in relation to the management and reporting of adverse events and incidents after hours
Charge Managers and Clinical Leaders	• Ensure staff are aware of their responsibilities in relation to incident management. • Manage, monitor and review incidents within areas of delegated responsibility and implement corrective actions from reviews • Participate in reviews of clinical severe/major incidents and Always Report & Review list 2018-19 (HQSC, 2017) in conjunction with the quality teams.
Chief Executive	• Overall management responsibility for the DHB's safety processes in relation to clinical and non-clinical incidents and adverse events
Clinical Governance Board	• Governance for implementation and compliance with this policy • Oversight of the management of clinical adverse events
Director of Area Mental Health	• Reports patient deaths as required under Section 132 of the Mental Health Act (1992)
Directorate Executive Directors	• Oversight across their directorate including service incident and adverse event data, compliance, analysis, trends and risk identification and management • Responsibility to ensure compliance with policy within their directorate for reporting, reviewing reportable events and implementation of corrective actions
Directorate Quality Teams	• Provide support and expertise with review and management of incidents and adverse events with the purpose of highlighting where systems, processes, human factors, policy, or procedure could be improved; emerging trends; and/or where further change is required. • Provide *adverse event and incident management* education to managers/senior staff • Support open communication process • Oversight of trends emerging from adverse events and incidents
Executive Leadership Team	• Strategic oversight of all events and incidents
Executive Director QIPS	• Ensure training for review of incidents and adverse events • Support the identification of areas for quality improvement, particularly in relation to patient care • Supports the clinical adverse events reporting and reviewing system
General Manager Corporate Services	• Strategic oversight of non-clinical incidents, work injury rates and notifiable events
General Manager	• Strategic oversight of clinical incidents and adverse event reviews and

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QIPS	management processes • Maintain a system of reporting and reviewing clinical adverse events which engages with consumers and aligns with National Adverse Events policy (HQSC 2017)
Health & Safety Service	• Review of health and safety events where an employee or other person was seriously harmed • Notification of work related injuries resulting in treatment to TPA • Assist and support managers with incident investigation • Report notifiable events to WorkSafe
Medical Staff	• Coroners notification, notifiable diseases, ACC treatment injuries
Non-clinical Managers	• Ensure all reporting staff are aware of their responsibilities in relation to incident management. • Manage, monitor and review incidents within areas of delegated responsibility and implement corrective actions from reviews
Operations Managers	• Ensure oversight of service compliance, data analysis and risk management • Inform directorate executive management of serious adverse events.
Patient Safety Coordinator	• Develops organisational learnings from patient safety issues • Strengthens the patient safety culture through the development and coordination of relevant patient safety projects • Monitors compliance with the National Adverse Events Reporting policy • Provides monthly reports to HHS, annual serious adverse events report and facilitates reporting SAC 1&2 and *Always Report and Review* events to the HQSC.
The Board	• Governance oversight of DHB safety in relation to adverse events and incident management

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External Reporting Requirements

Incident Description	Reporting Agency
Always Report Events and SAC 1&2 Clinical Incidents	Health Quality & Safety Commission (HQSC)
Deaths that must be reported under Section 13 (2) 2 & 3 Coroners Act (2006)	Coroner
Notifiable Diseases under the Health Act (1956)	Medical Officer of Health, Ministry of Health
Treatment injuries	ACC
Employee work related ACC injury	TPA
Death, notifiable illness, injury or incident occurring as a result of work (Notifiable Event)	Worksafe
Unintended adverse reaction to medicine, psychoactive substances, recreational substance and legal high substances	Centre of Adverse Reactions Monitoring (CARM)
Incidents related to quality of medicines or medical devices	Medsafe, Ministry of Health
Any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided. Any investigation commenced by a member of the police into any aspects of the service. Any death of a person to whom you have provided services, or occurring in any premises in which services are provided, that is required to be reported to a Coroner under the Coroner's Act (2006)	Director General, Ministry of Health
Events relating to misadministration of radioactive material	Office of Radiation Safety, Ministry of Health

CCDHB-related Documents

Risk management policy policy

Health and safety policy policy

First Aid at Work procedure

Control of Contractors procedure

2DHB Workplace rehabilitation Procedure – under review

Clinical Adverse Event procedure – under review

CCDHB Consequence Table – under review

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Document facilitator: Patient Safety Coordinator
Senior document owner: CCDHB CEO
Document number: 1.8723 **Issue Date** 8 March 2019 **Review Date** 8 March 2024

References

Health and Disability Services (CORE) Standards (2008)
Health Quality & Safety Commission (June 2017). National Adverse Events Reporting Policy 2017: New Zealand health and disability services.

HQSC (December 2012). Serious Incidents involving users of Mental Health services.
Occupational Health and Safety Management Systems – specification with guidance for use (2001). Standards New Zealand and Standards Australia

Legislation

The documentation, notification and disclosure of incidents are subject to the following legislation:

Coroners Act 2006

Health Act (1956)

Health and Disability Commissioner Act 1994

Health and Disability Services (Safety) Act 2001

Health and Safety at Work Act (2015)

Health Practitioners Competence Assurance Act 2003

Injury Prevention Rehabilitation and Compensation Act 2001

Mental Health Compulsory Assessment and Treatment Act 1992

Accident Compensation Act 2001

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Level: **Organisation wide**

Type: **Policy**

Name: **Prevention and Management of Patient Falls**

Purpose

This policy outlines a practical, evidence-based approach to identifying patients with mobility and falls risk factors, including recent falls and planning and implementing appropriate care for them. The aim is to target strategies that maintain patients' mobility and safety in order to reduce harm. Staff responsibilities and actions that must be taken to reduce and address falls in DHB are included.

Scope

All registered health professionals (HP) involved in the assessment and treatment of patients in adult and child health services.

Technicians, assistants and support staff who have patient contact ,Students

Minimum safety standards: Implemented for ALL patients

- Encourage early mobilisation - Get up, get dressed, get moving ID 1.104573
- Orientate the patient to the bed area, toilet facilities and ward.
- Educate the patient and family and provide information about the risk of falls and safety issues.
- Demonstrate the call bell's use to the patient and ensure it is within reach of the patient.
- Ensure frequently used items, including mobility aids, are within easy reach of the patient.
- Provide appropriate mobility assistance.
- Ensure the bed and chairs are at an appropriate height for the patient.
- Ensure that bed brakes are employed at all times when the bed is stationary.
- Position the over–bed table on the non-exit side of the bed when possible, considering the siting of IV cannulas and wound drains.
- Place the IV pole and all other devices/attachments (as appropriate) on the bed's exit side when possible. – remove lines as soon as possible
- Remove clutter and obstacles from the room.
- Ensure the patient is using appropriate aids such as glasses or a hearing aid.
- Ensure the patient wears appropriate footwear if ambulant
- Use bed rails as appropriate. When bed rails are used, the reason for this choice

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should be documented in the patient's notes. Safe use of bedrails ID 1.104638

All staff must understand the safe mobility signalling system – a system to signal level of assistance needed with mobility. While the assistance level can relate to falls risk factors, it is not about rating falls risk.

Management & Reporting of Inpatient Falls Algorithm **Appendix 1 –** follow the actions required and put this information the clinical record

Roles and responsibilities

Health professionals must:

- Ensure all patients have a documented mobility/falls risk assessment
- Implement minimum safety standards (see page 1) for all patients and, when applicable, an individualised falls prevention plan.
- **Follow the** management & Reporting of Inpatient Falls Algorithm **(Appendix 1) in the event of a patient fall**
- Integrated falls safety in co-ordination/care planning
- Provide education on falls prevention to patients
- Clinical and bedside handovers, including falls safety

Medical staff must:

- Investigate and evaluate any syncope concerns
- Follow Management & Reporting of Inpatient Falls Algorithm **Appendix 1**
- Review patient when notified of a fall,
- Consider a CT scan whenever a head injury is suspected, reduced level of conscious anticoagulants, neurological signs etc. Neurological recordings are also required for any head/face injury.
- Notify the registrar covering the clinical team when a fall occurs outside of normal working hours and results in an injury that requires increased monitoring.
- The registrar must then review the patient with the assessing doctor as appropriate, either via telephone call/or in-person
- Clinical and bedside handovers, including falls safety
- Include in-patient falls history and the patient's falls risk factors in the discharge summary.

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Nursing Staff must:

- Pre safety Huddle Clinical and bedside handovers, including falls safety
- Identify frequent falls and ensure alerts and communication is in place
- Follow Management & Reporting of Inpatient Falls Algorithm **Appendix 1**
- Carry out close observation before and following medical review for any patient who has suffered a fall.
- Carry out neurological observations half-hourly for four hours following the fall if a patient's head (including face and nose) is struck.
- Report any change in neurological observations or any clinical concerns for an urgent medical review.
- Review the care plan of the patient following a fall.
- Include in-patient falls history, prevention strategies and information relating to the patient's risk factors for falls and intervention to promote and maintain safe mobility when completing discharge and transfer paperwork.

Mobility/falls prevention screening

All patients are considered a falls risk until formally assessed. Mobility/falls prevention screening must commence on admission and must be documented within 8-hours in PADP or care pathway

- Patients aged 75+ (Māori/Pacifica aged 55+) are deemed at higher risk of falling, so it is essential that they are assessed at the point of admission
- The patient and their family/whānau/carer must be, when practical, included in the mobility/falls risk assessment process
- An initial mobility/falls risk assessment by a registered nurse or another health professional must be documented clinical record
- Screening questions are included in the Emergency Department and Surgical Preassessment documentation

For children, use risk assessment (Appendix 2). All parents and caregivers should receive information about maintaining a safe environment to reduce fall risks for babies/children. This should be documented in the patient's health record.

For adults, the Initial Assessment (Appendix 3) will identify risk related to intrinsic (patient-specific) and extrinsic (environmental) factors from admission and these must be documented **with an appropriate care plan within eight hours of admission**

If **no risk** is identified, ensure the minimum safety standards to prevent in-patient falls are applied.

Patients should be re-assessed for their falls risk:

- Daily as per care plan if at risk
- After a fall or near miss
- If their medical status changes
- If they are transferred to a new environment

The receiving team should review the transfer Between Wards Inpatient Falls assessment. The receiving team should complete any gaps in the assessment, and that team must ensure they are confident that a robust falls management plan is in place for those at risk of falls.

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Management includes:

Patients being investigated for possible cardiogenic syncope Guideline for Continuous Cardiac Monitoring in the ED or EDOU ID ID 1.103954
Consider Investigation and evaluation of episodes of syncope (Vasovagal syncope, Situational syncope, postural hypotension) supported by Syncope (Fainting) Patient Information ID 1.105253
Intentional Rounding Routine intentional rounding is one of the multidisciplinary strategies/tools used to reduce harm from falls.
Pre safety Huddle reviewing patients at risk from their assessment MDT Safety Huddle Sticker ID 1.104007
All facilities must provide a **safe environment** Appendix 7 Environment and Bed safety checklist assist with the assessment
The **minimum safety standards** (safe environment and falls prevention information) to reduce the risk of slips, trips and falls must be implemented for all patients.
Apply Moving and Handling device/equipment and principles – Moving and Handling Procedure ID 1.1709
Document in clinical record referral to another health professional to address falls risks factors.
Document the use of bed rails when applied as a falls prevention strategy. Refer to DHB policy Safe use of bedrails ID 1.104638 , Bedrails Patient Family Carer Information ID 1.104641, Restraint minimisation and safe practice ID 1.772 If increased observation and supervision is required, document change of environment, level of assistance required and if a patient observation is required. Refer to 2 DHB policy Partners in care Observation and Engagement ID 1.104648 and use 1st and 2nd line interventions to assist management
Apply and ensure accurate use of falls risk signalling system Provide patient and family with falls prevention information from Health Quality and Safety Commission/ACC, e.g. brochure, resources (available from the print room) Patient Education Fall Prevention: information for patients and carers in-patients ID 1.103726
Documentation post-fall – Falls Incident Sticker ID 1.102008 and MDT Safety Huddle Sticker ID 1.104007
Discharge or transfer from hospital Consider risk of falls at home as part of discharge planning process. Consider falls prevention exercise classes or rehabilitation back to baseline. Ensure GPs are aware of any in-patient falls, investigations, treatment given, and changes to medications.
Auditing, Monitoring and Reporting Patient – Falls resource reps from clinical areas complete Patient Tracer Audit Preventing Injury from Falls ID 1.104593 and action plan as per Inpatient Audit / Tracer schedule and Organisational internal/ external checks ID 1.102504
Guidelines on Older and more vulnerable patients **(Appendix 8)**

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Staff Education

Identification of relevant staff involved in patient contact that must be provided with falls prevention education/management. Face to face training in clinical areas resources on connectme to support clinical area. Policy revisions will be communicated within services and DHB wide. Clinical resource representatives to ensure education and resources within areas assigned.

Monitoring and Clinical Governance

Each service is responsible for monitoring the impact of falls prevention strategies to prevent falls and enhance safety. This includes the initial review of all falls incidents (REs) and action from these. Monitoring falls or near-miss incidents in each service is an essential aspect of critical practice review.

Safe Mobility and Falls Committee Meeting

Is responsible for the promotion of the falls agenda in line with national and local guidelines. This includes ensuring that the outcomes of incidents and lessons learnt are shared effectively. Providing a multi-professional investigation of falls incidents that have been declared as a serious incident. Working with the Clinical Board to review incidents such as using a falls root cause analysis (RCA) investigation to identify the root causes to reduce the likelihood of recurrence.

Monitoring the effectiveness of clinical audit/tracer activity

The Fall prevention safety committee will review audit reports and action plans. Any action plans that are not being implemented or resourced or have governance issues will be escalated to the patient safety committee for consideration and resolution or further escalation. Inpatient & Outpatient Audit / Tracer schedule and Organisational internal/ external checks ID 1.102504

Definitions

Fall

Any unintentional change in position (with or without injury) where the person ends up on the floor, ground or other lower level; includes falls that occur while being assisted by others (Morris, Berg, Bjorkgren et al, 2010).

Describing falls includes:

Slips

An accidental loss of traction causing a change in position to a lower level. Slips happen where there is too little friction or traction between surfaces – e.g. inappropriate footwear and the walking surface, chair and patient's body. Common causes of slips are: loose unanchored surfaces (cushions, mats), spills, wet or slippery surfaces.

Trip

Is to stumble accidentally often over an obstacle causing the person to lose their balance. Common causes are obstructed view, poor lighting, clutter, uneven (steps, thresholds) walking surfaces.

Fall near miss

Occurs when slips or trips are corrected preventing a fall or injury but a safety threat remains. The threat is related to intrinsic (specific to the individual patient e.g. medical,

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physiological or psychological) factors or extrinsic (environmental) factors that are safety threats to the individual and others.

Related policies

Patient Education Fall Prevention: information for patients and carers in-patients ID1.103726

Get up, get dressed, get moving ID 1.104573

syncope Guideline for Continuous Cardiac Monitoring in the ED or EDOU ID 1.103954

Syncope (Fainting) Patient Information ID 1.105253

Inpatient & Outpatient Audit/Tracer schedule and Organisational i...ID 1.102504

Moving and Handling Procedure ID 1.1709

Safe use of bedrails ID 1.104638

Bedrails Patient Family Carer Information ID 1.104641

Restraint minimisation and safe practice 1.772

References

Healey F, Darowski A. (2012). Older patients and falls in hospital. Clinical Risk 18(5): 170–6.

Healey F. 2014. In-patient falls prevention in the UK: The 10 biggest challenges we all face, and some new ideas for tackling them. Presentation at seminar 3 April 2014. Knowledge to action in falls prevention across the care continuum, Centre of Research Excellence in Patient Safety, Monash University.

Healey F, Lowe D, Darowski A et al. 2013. Falls prevention in hospitals and mental health units: an extended evaluation of the FallSafe quality improvement project. Age and Ageing, aft190.

Health Quality & Safety Commission New Zealand. (2019). Reducing harm from falls:

Recommended evidence-based resources 2019. HQSC: Wellington.

HQSC: Quality Safety Markers 2012.

Bjerk, M., Brovold, T., Skelton, D. A., Liu-Ambrose, T., & Bergland, A. (2019). Effects of a falls prevention exercise programme on health-related quality of life in older home care recipients: a randomised controlled trial. Age and ageing, 48(2), 213-219.

De Jong, L. D., Lavender, A. P., Wortham, C., Skelton, D. A., Haines, T. P., & Hill, A. M. (2019). Exploring purpose-designed audio-visual falls prevention messages on older people's capability and motivation to prevent falls. Health & social care in the community, 27(4), e471-e482.

Associated Patient Information

Syncope (fainting) Patient information ID 1.105253

Appendices

Appendix 1: Management & Reporting of Inpatient Falls Algorithm 1.105351

Associated form
Raizer chair checklist prior to use with a patient ID 1.105382

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Appendix 1a: Prevention and Management of Falls in ICU Appendix 1a 1.105367

Appendix 1b: Falls Algorithm Appendix 1b (2 Related Items) 1.105830

Appendix 2: Humpty Dumpty fall assessment scale 1.102829

Appendix 3: Mobility / Falls risk assessment tool and action plan (PADP)
ID 1.103893

Appendix 4: Falls Incident Sticker 1.102008

Appendix 5: MDT Safety Huddle Sticker ID 1.104007

Appendix 6. Guidelines on High Risk Medications associated with Falls

Appendix 7 Environment and Bed safety checklist ID 1.105252

Appendix 8 Guidelines on Older and more vulnerable patients

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Appendix 1 Management & Reporting of Inpatient Falls Algorithm

Management and Reporting of Inpatient Falls Alg... (1 Related Item) ID 1.105351

Associated form

Raizer chair checklist prior to use with a patient ID 1.105382

Appendix 1a: Prevention and Management of Falls in ICU

Prevention and Management of Falls in ICU Appendix 1a ID 1.105367

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Appendix 2 Humpty Dumpty falls assessment tool

This form is page 3 of the Paediatric PDAP capitalDocs ID 1.102829

Surname:………………………NHI:……………………
First Names:……………………………………………
Date of Birth:……/……/…… Sex:………………
PLACE PATIENT ID LABEL HERE

Humpty Dumpty Falls Prevention Program™

Preventing falls, enhancing safety.

Falls Assessment Tool
The Humpty Dumpty Scale - Inpatient

Parameter	Criteria	Score (circle)
Age	Less than 3 years old	4
	3 to less than 7 years old	3
	7 to less than 13 years old	2
	13 years and above	1
Gender	Male	2
	Female	1
Diagnosis	Neurological Diagnosis	4
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia, Syncope/Dizziness, etc.)	3
	Psych/Behavioral Disorders	2
	Other Diagnosis	1
Cognitive Impairments	Not Aware of Limitations	3
	Forgets Limitations	2
	Oriented to own ability	1
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4
	Patient uses assistive devices or Infant-Toddler in Crib or Furniture/Lighting	3
	Patient Placed in Bed	2
	Outpatient Area	1
Response to Surgery/Sedation/ Anesthesia	Within 24 hours	3
	Within 48 hours	2
	More than 48 hours/None	1
Medication Usage	Multiple usage of: Sedatives (excluding ICU patients sedated and paralyzed) Hypnotics Barbiturates Phenothiazines Antidepressants Laxatives/Diuretics Narcotic	3
	One of the meds listed above	2
	Other Medications/None	1
	TOTAL	

Rev: 09/2008
At risk from falls if score 12 or above
Minimum score 7, maximum score 23

PATIENT FALLS SAFETY PROTOCOL

Low Risk Standard Protocol *(score 7-11)*

- Orientation to room
- Bed in low position, brakes on
- Side rails x 2 or 4 up, assess large gaps, such that a patient could get extremity or other body part entrapped, use additional safety procedures
- Use of non-skid footwear for ambulatory patients, use of appropriate size clothing to prevent risk of tripping
- Assess eliminations need, assist as needed
- Call light is within reach, educate patient/family on its functionality
- Environment clear of unused equipment, furniture is in place, clear of hazards
- Assess for adequate listing. Leave nightlight on
- Patient and family education available to parents and patient
- Document fall prevention teaching and include in plan of care

High Risk Standard Protocol
(score 12 and above)

- Identify patient with a "humpy dumpty sticker" on the patient, in the bed and in patient chart
- Educate patient/parents of falls protocol precautions
- Check patient minimum every one hour
- Accompany patient with ambulation
- Developmentally place patient in appropriate bed
- Consider moving patient closer to nurses' station
- Assess need for 1:1 supervision
- Evaluate medication administration times
- Remove all unused equipment out of the room
- Protective barriers to close off spaces, gaps in the bed
- Keep door open at all times unless specified isolation precaution are in use
- Keep bed in the lowest, unless patient is directly attended
- Document in nursing narrative teaching and plan of care

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Appendix 3:

Mobility / Falls risk assessment tool and action plan (PADP) ID 1.103893

Appendix 4:

Falls Incident Sticker ID 1.102008

Appendix 5:

MDT Safety Huddle Sticker ID 1.104007

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Appendix 6 High Risk Medications associated with Falls / Quick Reference Chart

Class of Medication	Impact of Medication	Examples*
Sedatives, Hypnotics, Anxiolytics	These medications tend to cause an altered or diminished level of consciousness impairing cognition and causing confusion	Benzodiazepines (Diazepam, Oxazepam, Lorazepam, Chloral Hydrate, Zopiclone)
Antidepressants	Increase risk of a fall by causing the individual to feel restlessness, drowsiness, sedation, blurred vision	Tricyclic antidepressants (amitriptyline, nortriptyline), SSRI (citalopram, fluoxetine, sertraline), SNRI (venlafaxine, mirtazipine)
Psychotropics/ Neuroleptics	Neuroleptics tend to cause individuals to experience agitation, cognitive impairment, dizziness, gait or balance abnormalities, sedation and visual disturbances (e.g., hallucinations)	Neuroleptics (haloperidol, risperidone, olanzapine, quetiapine, chlorpromazine, perphenazine)
Cardiac Medications	Medications that affect or alter blood pressure can increase the individual's risk to experience a fall Can be expressed as syncope	Vasodilators: hydralazine, minoxodil, nitroglycerin Diuretics: hydrochlorthiazide, lasix, spironolactone Calcium Channel Blockers: amlodipine, diltiazem, nifedipine, verapamil Beta Blockers: metoprolol, carvedilol, atenolol Alpha Blockers: terazosin Ace-Inhibitors: captopril, enalapril, fosinopril, ramipril Antiarrhythmics: amiodarone, digoxin
Anti-histamines/ Antinauseants	Affect balance, impair coordination, can cause sedation, and have anticholinergic properties	Antihistamines: meclizine, hydroxyzine, diphenhydramine (benadryl), chlorpheniramine Anti-nauseants: dimenhydrinate (gravol), prochlorperazine, metoclopramide
Anticonvulsants	Tendency to decrease level of consciousness or cause disequilibrium (problems with balance)	gabapentin, valproic acid, phenytoin, carbamazepine
Opioids, Narcotic Analgesics	Primarily cause change in level of consciousness leading to confusion, sedation and potential visual hallucinations	Codeine, morphine, hydromorphone, fentanyl, oxycodone

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Appendix 7 Environment and Bed safety checklist ID 1.105252

Appendix 8 Guidelines on Older and more vulnerable patients

A cognitive assessment (mini-mental state examination (MMSE). Those at risk are tested for delirium (confusion assessment method). This should include:

- When possible, being cared for by staff who are familiar to them
- Avoiding moving patients within and between ward or rooms unless absolutely necessary
- Addressing cognitive impairment and/or disorientation by providing appropriate lighting, clear signage, a easily visible clock and calendar
- Talking to the patient to re-orientate them, explaining where they are, who they are, and the roles of the members of the team
- Introducing cognitively stimulating activities (e.g. reminiscence)
- Facilitating regular visits form family and friends
- Addressing dehydration, constipation, poor nutrition, pain and sensory impairment
- Assessing for hypoxia
- Looking for and treating infection, and avoiding unnecessary catheterisation
- Encouraging mobility
- Promoting good sleep patterns and sleep hygiene.
- Visual assessment is conducted. The ability to recognise objects from end of the bed can be used as a screen for severe eyesight problems, and fuller assessment should be carried out if required.
- Lying and standing blood pressure are taken with a manual sphygmomanometer.
- Medication is reviewed with respect to cardiovascular and central nervous system acting medications .Nurses should request a review of medication to try and reduce the burden of drugs, particularly those associated with falls, and in patients who are unsteady, hypotensive, or have orthostatic hypotension. Appendix 6 High Risk Medications associated with Falls
- Based on observation, toileting arrangements are assessed and planned (tailored to needs rather than the standard two-hourly arrangement).

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