Fall Prevention in Hospitals

**Adult Risk Assessment or fall risk screen for all adult patients within 24 hours of admission**

- Fall risks identified
  - Clinical judgement over-ride if considered high fall risk

- No Fall Risk
  - Continue with admission

**Fall Risk identified**

**Long Stay Patients/Residents**

- On admission & at a min 6 monthly or change in patients condition

**Fall Risk Assessment and Management Plan (FRAMP) Paper Form**

- Identify fall risks in FRAMP and choose relevant interventions, refer to multidisciplinary team, implement and document
- Communicate fall risk and interventions with staff at clinical handover, safety huddles and post fall

**Engage with Patient/Family/Carer**

- Engage patient/carer in development of the care plan and provide information
- Provide patient/carer with falls prevention information

**Serious Incident Investigation**

- SAC 1 –Follow RCA guidelines
- SAC2 or repeat fall
  - Complete SAC2 Fall Incident Investigation
  - Clinical teams provided with feedback and recommendations to be implemented
  - Discuss at ward meetings

**If Patient Falls**

- Post Fall Management
  - Use CEC Post Fall Guide
  - Complete and document all interventions & IIMS
  - Post Fall Huddle – revise plan of care

**Discharge and Refer**

- Ensure GP, family/carer, RACF and/or other relevant care providers are informed of:
  - patient fall risk
  - interventions
  - recommendations for further assessment

- Consider referral to falls prevention exercises
  - www.activeandhealthy.nsw.gov.au
  - eg Tai Chi, Stepping On, Occupational Therapist/Physiotherapist groups, Otago

**Re-do Fall Plan of care when a patient**

- Falls
- has a change of condition
- transferred to another ward/facility
- prior to discharge

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**Post Fall Management**

Use CEC Post Fall Guide
- Complete and document all interventions & IIMS
- Post Fall Huddle – revise plan of care

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