Patient Falls
Safety Learning System Topic Guide

Introduction

The aim of this Topic Guide is to provide guidance for clinical staff, about the accurate reporting of patient fall incidents into the Safety Learning System (SLS). Please refer to SA Health How to notify a patient incident SLS Guide for more information.

The National Safety and Quality Health Service Standards and the SA Health Fall Injury Prevention and Management Clinical Guideline recommends reporting incidents, so that action can be taken to improve care for that patient or consumer and for others who may be at similar risk.

A patient fall or injury sustained from a fall is considered a clinical incident. It is an event or circumstance that occurs during SA healthcare that could have or did result in harm to a patient, client or consumer of SA Health Services. All staff must notify falls incidents into the SLS. This can involve events that also require mandatory reporting to external agencies such as NDIS, Aged Care Serious Incident Response Scheme (SIRS), where appropriate.

The SA Health Clinical Incident Management Policy outlines the reporting, investigation and response to all clinical incidents.

Notifiers and managers have joint responsibility for accurate reporting, review and quality improvement.

Managers are responsible for clinical management of the falls incident in the SLS and post fall team review in line with the SA Health Fall Injury Prevention and Management Clinical Guideline.

Incident Description

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).

- **What happened?** Briefly and factually describe what happened outlining the key events pertaining to the patients fall event ensuring clinicians and patient names are de-identified.
- **What was the outcome of the incident/event?** Describe the clinical outcome of the incident and any additional care requirements resulting from the event.

Incident Classification

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

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

Examples of incidents that match Level 3 classification options

Scenario	Is it a fall?	Level 3 classification
Patient is mobilising with walking frame and stand-by assistance. Patient overbalances sideways. Assistant helps patient to regain balance and continue walking.	Near miss	*Near miss – fall prevented by staff* Select *Witnessed fall* in section Fall Details
Patient is observed to stumble while walking along hall with walking stick. Grabs rail and steadies himself.	Near miss	*Near miss – no intervention by staff*
Patient is mobilising with walking stick and one-person assistance and trips at junction of carpet and vinyl. Assistant slowly lowers patient to floor.	Near miss	*Near miss – fall prevented by staff* Select *Witnessed fall* in section Fall Details
Patient observed to trip on dressing gown cord as they walked and landed on floor.	Fall	*Fall* Select *Tripped over an* object from options in What was the mechanism of the fall?
Patient found lying on floor. Incident unwitnessed.	Fall	*Fall* Unless there is a reliable witness assume there was a fall Select *Unwitnessed fall* in section Fall Details
Patient found on floor, unresponsive. Doctor diagnosed stroke.	Fall	*Fall* Under *What was the mechanism of the fall,* select *Faint, LOC cardiac collapse*
Patient with cognitive impairment (NOT a reliable historian) found sitting on floor. Reports that they are attempting to get dressed.	Fall	*Fall* Select *Unwitnessed fall* in section Fall Details Also select *Dementia/cognitive impairment* in Risk factors for falls – behaviour/mental state/cognition
Patient who is cognitively intact and IS a reliable historian, is found sitting on floor. Reports that they are attempting	Not a fall	No SLS report required

to get dressed, clothes and shoes nearby.		The definition of a fall is that it is inadvertent/or unintentional. Sitting on the floor to dress is deliberate/intentional
You notice that a patient 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	*Fall* Select *Unwitnessed fall* in section Fall Details

Incident Severity Rating (ISR)

The Incident Severity Rating (ISR) tool is a numerical score applied to patient incidents that considers the direct outcome and follow up treatment required following a clinical incident. The Notifier and Manager ISR guides the level of escalation and investigation required for all patient incidents reported into the Safety Learning System (SLS).

Examples of scenarios and the likely ISR (based in ISR Matrix patient outcome and treatment required

Relevant Case History	What Happened	Patient Outcome	Treatment required	ISR
92 years old. Osteoporosis and low body mass index. Generalised muscle weakness. History of falls. Generalised muscle weakness and poor balance.	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 (Death)	Death – no further treatment required	ISR 1
70 year old male. Osteopenia; malnutrition and low body mass index; Generalised muscle weakness. Emphysema.	Patient found unconscious at bottom of steps by visitor. Visitor called nursing staff for assistance. Emergency response team called. Fractured neck of femur requiring surgical fixation Rehabilitation - length of stay 65 days.	Harm or injury Or Permanent loss of function expected	Immediate emergency or palliative treatment for life-threatening condition	ISR 2
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	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.	Harm or injury or Permanent loss of function expected	Unplanned procedure resulting in higher level of care/therapy	ISR 2

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.	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.	Harm or Injury	Clinical Review, additional treatment or therapies	ISR 3
40-year-old post anaesthetic. No intrinsic risk factors.	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 harm or injury	Increased monitoring or assessment only	ISR 4
55-year-old patient in for investigation of persistent headaches.	Patient reports reaching to get something out of the locker drawer and rolling out of bed onto the floor.	No harm or injury	No change	ISR 4

Current falls and injury risk at time of incident

- Refer to the patient's current falls risk screen, assessment or review form (MR58b, MR58 or MR58a) for list of identified risk factors.
- Consider the five questions about the patient'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, care plan and characteristics of people who fall. Completing this section provides useful evidence for falls prevention quality improvement activities and can help establish the effectiveness of particular interventions.
- The SA Health Falls Injury Prevention and Management Clinical Guideline describes which patients should have these completed and when. (See Tool 2 - When how to do fall risk screening, assessment, care planning and discharge planning).

Post fall team review

Post Fall Team Review is used to guide investigation and review by the clinical team after a patient fall. It describes the process for a clinical team review within two days of a serious or repeat fall. This quick process will enable the review of many fall incidents, and improvement of patient and service safety in a timely fashion, with reduced repeat falls.
In the managers section of Safety Learning System (SLS) there is a section to record the outcomes of a post fall review. SA Health managers can use this to easily generate reports of these actions.

Related Documents

See the SA Health sahealth.sa.gov.au/falls

For more information

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