

**Appendix 3**

*This table has system and patient factors that may assist in identifying contributing factors which led to this fall incident.*

**Contributing factors**

| <b>System and patient factors that lead to the fall</b> |   |                                      |   |
|---|---|--------------------------------------|---|
| <b>Access</b>   | To service/bed eg outlier                               | <b>Observations &amp; Monitoring</b> | Physical/physiological/neuro observations inadequate  |
| <b>Care Planning</b>                                    | Care continuity   |                                      | Significance not recognised/responded                 |
|   | Care coordination                                       |                                      | Visual observations –care level inadequate            |
|   | Discharge planning                                      |                                      |   |
|   | End of life (Advance Care Planning)                     | <b>Policy &amp; guidelines</b>       | None/not known or not available                       |
|   | High risk not considered (History of falls / high risk) |                                      | Not in line with EBP or State directives              |
|   | Inadequate care plan                                    |                                      | Not implemented/routine violation                     |
|   | Patient/carer not involved in care planning             |                                      | Unclear/unworkable                                    |
|   | Over reliance on family/carer for support               | <b>Residential Care</b>              | Inadequate transfer of information between facilities |
|   | Supervised Toileting                                    |                                      |   |
|   | Supervised Mobilisation                                 |                                      |   |
| <b>Communication</b>                                    | Inadequate between care providers                       | <b>Supervision of staff</b>          | Supervision/support inadequate                        |
|   | Inadequate information or education to patient/carer    | <b>Work Force</b>                    | Rostering/adequate staffing/skill mix                 |
|   | Documentation inadequate                                |                                      | Orientation/induction inadequate                      |
| <b>Environment</b>                                      | Physical surrounds                                      |                                      | Training/education inadequate                         |
|   | Noise   |                                      | Scope of practice                                     |
|   | Culture/activity  |                                      | Availability of senior staff/allied health            |
|   | Lighting  |                                      |   |
| <b>Patient/Carer</b>                                    | Patient/carer concerns not considered                   | <b>Equipment</b>                     | Failed  |
| <b>Teamwork</b>   | Delegation/roles unclear or inappropriate               |                                      | Not available   |
|   | No identified lead clinician                            |                                      | Not working/maintained                                |
|   | Team work not evident                                   |                                      | Not used when indicated                               |
|   |   |                                      | Usability/suitability for purpose                     |



| Patient Factors   |   |                           |
|---|---|---------------------------|
| <b>Age</b><br>Age in whole years 75-90 years<br>90 years or older | Compliance with recommended treatment/care plan | No advocate/support       |
| Co- morbidities – physical  | Frequent user of service                        | Out of hours presentation |

**Does the fall come under a clinical risk area?**

**If yes, please indicate as part of the investigation**

| Clinical Risk Group (more than one may be selected)  |
|--|
| Deteriorating patient - failure to recognise   |
| Deteriorating patient - inappropriate/delayed response to escalation   |
| Deteriorating patient - issues with rapid response   |
| Deteriorating patient -delay/failure to escalate   |
| Managing Confusion<br>Cognition<br>Delirium<br>Dementia  |
| Diabetes   |
| Medication related prescribing/management<br>(Antipsychotics, Antidepressants, Sedatives/Hypnotics or Opioids) |
| Medication related - all other (eg anticoagulants)   |
| Out of hours presentation/admission  |
| Restraint  |
| Sedation (eg post op/procedure)  |
| Sepsis   |
| Small Hospital   |
| Other  |