Monash Health

Monash Medical Centre
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Coroner's Prevention Unit - Responses
Coroner's Court of Victoria
65 Kavanagh Street
South Melbourne
Victoria 3006

8 June 2021

Dear Coroner's Prevention Unit

Re: Josephine Clarke (4595-18)

Response to Recommendations by Coroner English (30 March 2021)

I am writing in response to your letter dated 30 March 2021, requesting a written response to recommendations made by Deputy State Coroner English in relation Ms Clarke, who died at Monash Medical Centre on 11 September 2018.

I am requested to provide Monash Health's response to the recommendations is as follows:

1. **Monash Health review its falls related guideline and other supporting documents to clarify ambiguous terms or instruction including but not limited to constant supervision and N/A.**
    - Monash Health updated the Falls Risk Assessment Tool (MRI33) in 2019. This change reflected that all fall mitigation strategies were considered and either employed or a conscious decision made not to apply them. This reduced ambiguity, as each intervention was to be considered and documented whether in place or not. Staff are instructed to either tick or cross against every intervention, making the terminology of N/A no longer a viable notation. (***Appendix 1).***

    - Monash Health updated the Clinical Guideline –"Preventing Falls and Harm from Falls" in January 2021 with updates relating to community and maternity requirements (***Appendix 2)***. The Falls Standard Care implementation tool was updated in November 2019 where the cognitive impairment and consumer engagement elements were strengthened as requirements of standard care.

    - The introduction of an Electronic Medical Record (EMR) at Monash Health in 2019 has assisted in improving clarity in documentation requirements. This is done by a prompted selection electronically of appropriate goals and strategies for each individual patient and these are evaluated at least daily to confirm whether strategies are in place and goals achieved. Monash Health has also benchmarked against other similar hospitals in Metropolitan Melbourne, none of which provided a definition for the word 'supervision'. A review of health literature was also conducted. This review provided only one definition (provided by New South Wales Health) relating to supervision

https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0010/452809/Final-Standardised-Mobility-Terminology-Guide-for-Use-Across-NSW.pdf

As an organisation we realise that a definition is required to reduce ambiguity. The Monash Health Falls Committee is working to develop a definition for this term and will use this information as the basis for review of supervision practice. This will be included within the policy and procedures relating to falls. Due to the complexity of this and an anticipated lead time of six months, completion is anticipated as January 2022. Education around this will also be provided to all staff.

2. **Monash Health review its falls related guidelines and other supporting documentation so that patients' cognitive issues be more clearly identified and documented in order to inform the individual risk mitigation and strategies in place.**

   Monash Health developed a clinical guideline "Delirium and Dementia in Hospital" in November 2020 (***Appendix 3***). On admission, patients > 18 years of age are screened and risk stratified for delirium or cognitive impairment. If the risk score indicates possible or established cognitive impairment, a care plan is initiated outlining interventions and strategies, expected to be implemented and documented.

   In the Medical Falls Risk Assessment procedure, the presence of delirium / cognitive impairment is highlighted as the highest risk for falls (***Appendix 4***). This screening links to a requirement for management according to the "Delirium and Dementia in Hospital" guideline.

   An education module (Delirium: Suspect it, Spot it, Stop it) has been developed and launched in March 2021 to support the implementation of the guideline. This is a learning package aimed to target each discipline and the role they play in identifying and managing delirium. This is part of the organisation's targeted training and is relevant to the medical, nursing and allied health disciplines across a number of sub-specialities. All junior medical and nursing staff are required to complete this training.

   An EMR dashboard is also being prepared to allow oversight of the consistency of practice in completion of risk assessment and care planning, not limited to but including falls and cognitive impairment assessments and care planning. An anticipated completion date for this is the end of September 2021

3. **Monash Health review how the application and implementation of falls prevention mitigation and strategies is recorded for individual patients with a view to providing consistent care.**

   As per response to Recommendation 1.

4. **Monash Health review how consumers and their families are informed of Falls Prevention mitigation strategies and intervention.**

   The updated clinical guideline "Preventing Falls and Harm from Falls" (***Appendix 2)*** indicates the 'Falls Prevention plan must be developed in collaboration between the patient care recipients /family and or carers and interdisciplinary team to address relevant risk factors, physical condition and clinical setting'.

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Every patient admitted to Monash Health receives an orientation to the ward. A "welcome pack" is provided and within this pack is a patient information sheet which explains how to stay safe in hospital. The expectation is that this is discussed with the patient and their carers/family.

The Monash Health Falls Committee has also identified that a strategy to further engage with families in relation to falls prevention is required. There is an organisational action plan to ensure engagement with consumers occurs. The engagement strategy has four touch points in relation to consumer engagement which include on admission, during the inpatient stay, in the last 24 hours and on discharge. This work is a standard agenda item on the Falls Committee action plan and is progressing.

Thank you for the opportunity to provide this response.

Please do not hesitate to contact me should you require any further information or clarification of our response to Coroner English's recommendations.

Yours sincerely

Peter Ryan
Chief Legal Officer
Monash Health

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Appendix 1 – Falls Risk Assessment MRI33 page 1 (unchanged in new version)

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☐ Dandenong Hospital ☐ MMC – Clayton
☐ Kingston Centre ☐ MMC– Moorabbin
☐ Jessie McPherson ☐ Community Health Services
☐ Casey Hospital ☐ Cranbourne Integrated Care Centre

Unit Record Number: .....
Surname: .....
Given Name: .....
D.O.B: ..... Age: ..... Sex: .....

Affix Patient Identification Label

SHF040206

FALLS RISK SCREENING			Interpreter needed?			Y	N
↓Preferred language		Date					
		Interpreter used	Y N	Y N	Y N	Y N	Y N
History of falls	Did the patient present to hospital with a fall? Has the patient fallen within the last 2 months? Has the patient fallen since admission?	No to all = 0 Yes to any = 6					
Mental Status	Is the patient Confused? Disorientated? Agitated?	No to all = 0 Yes to any = 14					
Vision	Does the patient wear glasses continually? Does the patient have glaucoma, cataracts, macular degeneration or report blurred vision?	No to all = 0 Yes to any = 1					
Toileting	Does the patient have frequency, urgency, incontinence or nocturia?	No to all = 0 Yes to any = 2					
Transfer score = transfer from bed to chair	Independent With or without aids	Transfer Score = 0	Add transfer score + mobility score Score 0 or 7 in box below e.g. if the patient requires minor help with transfer & walks with the help of one person then transfer score = 1 mobility score = 1 transfer score + mobility score = 2 Score 0 in box below				
	Minor help Supervision or assistance of 1 person easily	Transfer Score = 1					
	Major help One strong skilled helper or 2 normal people AND can sit	Transfer Score = 2	If the transfer score + mobility score = 0 - 3 Score = 0 in the box below If the transfer score + mobility score = 4 – 6 Score = 7 in the box below				
	Unable No sitting balance	Transfer Score = 3					
Mobility score	Independent With or without aids	Mobility Score = 0	↓	↓	↓	↓	↓
	Walks with help Verbal or physical	Mobility Score = 1					
	Wheelchair Independent	Mobility Score = 2					
	Immobile	Mobility Score = 3					
Score= 0–5 = low risk L Score= 6–16 = medium risk M Score= 17–30 = high risk H		TOTAL SCORE					
		RISK					

Based on the Ontario Modified STRATIFY (Sydney Scoring) Source: Australian Commission on Safety & Quality in Healthcare, Preventing Falls & Harm From Falls in Older People. Best Practice Guidelines for Australian Hospitals, 2009.

FALLS PREVENTION

MRI33

Admission Divider

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Falls Risk Assessment MRI33 Page 2 – old version:

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☐ Kingston Centre ☐ MMC– Moorabbin
☐ Jessie McPherson ☐ Community Health Services
☐ Casey Hospital ☐ Cranbourne Integrated Care Centre

Unit Record Number: .....
Surname: .....
Given Name: .....
D.O.B: ..... Age:..... Sex .....
Affix Patient Identification Label

SHF040206

INTERVENTIONS (V = in place or completed; NA = not available)	DATE					
	TIME					
	RISK					
• Orientate the patient to bed areas, bathroom & ward						
• Provide patient/family/carers with written Falls Prevention Information						
• Involve patient/family/carers in the development of plans to prevent falls occurring while in Hospital						
Low falls risk patients						
• Falls Prevention Standard Care (on Prompt)						
• Complete bedside mobility chart/communication board						
• Discuss the level of risk with patient/family/carers and all staff involved in care						
Medium and high falls risk patients						
• Falls Prevention Standard Care (on Prompt)						
• Complete bedside mobility chart / communication board						
• Discuss the level of risk & required prevention strategies with patient/family/carers and all staff involved in care						
• Supervise/assist with all transfers & ambulation						
• Bed rails NOT TO BE USED						
• Medication review documented						
• Referral to relevant allied health team						
High falls risk patients						
• Place patient in area of enhanced visibility & supervision						
• Low-low bed						
• Floor line bed						
• Bed/chair/floor alarm/sensors						
• Constant supervision by staff/family/carers						
• Constant supervision by CPO						
In addition to the above, consider:						
If the patient is cognitively impaired						
• Contact medical staff to assess for & treat reversible causes						
• Hourly rounding, including a toileting regime						
If the patient is vision impaired						
• Ensure glasses in place before ambulating or transferring						
• Supervise when patient moves away from the bedside						
If the patient has episodes of fainting or a postural BP drop						
• Contact medical staff to assess for & treat reversible causes						
• Record postural BP at least once per shift						
• Encourage patient to sit up slowly from lying, stand up slowly from sitting & wait a short time before walking						
• Encourage patient to avoid hot showers						
• When resting, encourage elevation of bed head						
Other interventions						
Initials of staff member completing						

FALLS PREVENTION MRI33

Admission Divider

Monash Medical Centre Clayton
246 Clayton Road
Clayton
Tel: 9594 6666

Moorabbin Hospital
Centre Road
East Bentleigh
Tel: 9928 8111

Kingston Centre
Warrigal Road
Cheltenham
Tel: 9265 1000

Dandenong Hospital
David Street
Dandenong
Tel: 9554 1000

Casey Hospital
Kangan Drive
Berwick
Tel: 8768 1200

Community-based services across the South East

ABN 82 142 080 338

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Falls Risk Assessment MRI33 Page 2 - New version:

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Unit Record Number: .....
Surname: .....
Given Name: .....
D.O.B: ..... Age: ..... Sex: .....
Affix Patient Identification Label

SHE040206

INTERVENTIONS (√ = assessed and in place; X = assessed and not required)	DATE					
	TIME					
	RISK					
• Orientate the patient to bed areas, bathroom & ward						
• Provide patient/family/carers with written Falls Prevention Information						
• Involve patient/family/carers in the development of plans to prevent falls occurring while in Hospital						
Low falls risk patients						
• Falls Prevention Standard Care (on Prompt)						
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