SESLHD GUIDELINE COVER SHEET

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SUMMARY	The purpose of this document is to improve the safety of staff, patients and carers by outlining the approved terminology to describe patient transfers and mobility in South Eastern Sydney Local Health District (SESLHD) and the meaning of these terms. Consistent language is vital so all members of the healthcare team who provide patient care are aware of the level of supervision and/or assistance that a patient requires when mobilising and carrying out daily tasks.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Standardised mobility terminology for use across SESLHD

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Section 1 - Background

Patient safety aims to continually improve the care provided to patients to reduce harm. Falls are the most commonly reported adverse event in hospitals and while the majority of inpatient falls are associated with minor injury, more serious events such as fractures, intracranial injury and death also occur.

Balance and mobility problems are a risk factor for falls in hospital[1]. Balance and mobility are often poorer when a person is in hospital, compared with their usual level of function. This may be due to the effects of medications (including anaesthetics), acute events and illnesses (e.g. stroke, hip fracture, infection), cognitive impairment and/or delirium. Balance and mobility may further deteriorate during a hospital stay if a person is less active than usual due to their medical condition, or due to the hospital environment, which can discourage mobility[2].

The terminology used by clinicians, such as physiotherapists, occupational therapists and nurses, to describe patient mobility and the required level of assistance is therefore a key aspect of promoting safe mobilisation and participation in daily tasks such as toileting, showering and dressing.

Section 2 - Principles

The purpose of the document is to minimise the risk to staff, patients and carers by defining the terminology that should be used across SESLHD to describe the level of assistance a patient requires with transfers, mobility and functional tasks.

Consistent language is vital so all members of the health care team who provide patient care are aware of the recommended level of supervision and/or assistance that a patient requires when transferring, mobilising and participating in daily tasks such as toileting and showering.

Recommendations regarding the level of assistance required should be discussed with patients and/or carers, ensuring that they have an opportunity to be active participants in the development of a care plan. If a patient has a cognitive impairment or is noted to be agitated, anxious or impulsive, additional strategies to manage the requirement for assistance will need to be considered. In these cases, instruction to press the call bell prior to moving from the bed, chair or toilet is unlikely to be a sufficient strategy. Alarm devices and/or increased supervision are possible alternate strategies. Appropriateness should be determined on an individual basis, as part of the patient's care plan and in partnership with the patient, carers and family.

Carers and family members should not be used as a substitute for staff and, in cases where a patient requires assistance to mobilise, patients, carers and families should be informed to ask for assistance from a member of the health care team. Whilst many carers and family members provide support to patient's in their home environment, there may be additional risks associated with the hospital environment, unfamiliar equipment and/or changes in a patient's function due to acute illness or deconditioning. If it is deemed safe for a carer or family member to provide assistance, this should be discussed with all relevant parties and documented in the health care record. Any carer training and/or education provided should also be documented.

This guideline should be used in conjunction with SESLHDPR/380- Falls prevention and management for people admitted to acute and sub-acute care which outlines best practice and details tools to facilitate clinical decision making in the prevention and management of falls and fall injuries in individuals identified at risk of falling.

It is acknowledged that there may be fluctuations in the amount of assistance required for some patients e.g. throughout the day and/or from day to day. The judgement of the clinician who is involved at the point of care overrides the documented required level of assistance. Deviations from recommended levels of assistance or a change in condition should be included in clinical handover and discussed with relevant members of the health care team.

Consideration should also be given to the diverse nature of the health workforce, including such factors as professional skills, level of experience and physical build. It must be reasonable to expect others involved in a patient's care to be able to safely carry out recommendations around the amount of assistance a patient requires.

This guideline does not address required knowledge about work health and safety responsibilities including manual handling principles and safe work practices. Staff are required

to be up to date with mandatory training and to consult local guidelines relating to safe work procedures for carrying out patient-related care activities. Please refer SESLHDPR/315 - Hazardous Manual Task Risk Management for more information on how to reduce the risk of musculoskeletal injuries through the application of WHS manual handling risk management practices and principles.

Additionally, as in any clinical situation, there will be factors which cannot be addressed by a single guideline. This document does not replace the need to use clinical judgement with regard to individual patients and situations.

Section 3 – Definitions

Fall
For the purposes of this Guideline, a fall is defined as "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level"[4].

High falls risk
Refers to patients who score ≥ 9 on the Ontario Modified Stratify (Sydney Scoring) falls risk screening tool or are deemed clinically to be at risk of falls. Clinical judgement overrides an individual risk screen score.

Mobility terminology
Encompasses the terms used to describe the level of assistance required to promote safe transfers, mobilisation and participation in daily tasks. For the purposes of this guideline, these terms include: Independent, Supervision, Standby Assist, Minimal Assist, Moderate Assist and Maximal Assist. Please refer to Section 5 for a description of each of these terms.

Equipment
Refers to patient care equipment that assists with safe manual handling, patient transfers and mobility. It includes but is not limited to transfer belts, walking aids, wheelchairs and hoists. Refer to Appendix A for a list of commonly used transfer and mobility aids, the approved SESLHD abbreviation (where applicable) and an image.

Bariatric equipment
Patient care equipment designed for users whose weight exceeds 120kg and hence require specialised equipment for safe assistance with manual handling, transfers and mobility.

Weight bearing status (WB status)
Refers to the amount of weight that a patient is allowed to put through the affected limb after surgery or an injury such as a fracture. Weight-bearing status is determined by an orthopaedic surgeon and should be documented in an operation report or in the clinical record. If the documented weight bearing status is different from those detailed below, please seek clarification from the orthopaedic team.

The following descriptions relate to weight bearing status of the lower limb[5].

Weight Bearing Status	Description
Non Weight Bearing (NWB)	The patient can hop on their unaffected leg using a mobility aid. The affected leg must remain off the ground.
Touch Weight Bearing (TWB)	The foot or toes of the affected leg may touch the floor (such as to maintain balance) but not support any weight. The weight of the leg on the floor should be no more than 5% of the body weight.
Partial Weight Bearing (PWB)	The patient may apply 50% of their body weight through the affected leg maintaining a heel toe gait.
Full Weight Bearing (FWB) or Weight Bearing as Tolerated (WBAT)	The patient is allowed to put their full body weight through the affected leg. The actual amount tolerated may vary according to the circumstances.

Section 4 - Responsibilities

Allied health clinicians are responsible for:

- Ensuring consistency with these guidelines when making recommendations about the amount of assistance that a patient requires with transfers, mobility and functional tasks as relevant to discipline-specific role
- Ensuring that any students under direct supervision of a physiotherapist or occupational therapist understand the approved terms and the implications for patient care, documentation and clinical handover
- Considering falls risk when making recommendations for individual patients
- Contributing to the Falls Risk Assessment and Management Plan (FRAMP) for patients at risk of falls
- Understanding how recommendations about the amount of assistance that a patient requires with transfers and mobility relate to functional tasks e.g. if requires supervision with transfers and mobility, requires supervision in the toilet/shower
- Adhering to these guidelines when delivering clinical care to patients, providing at a minimum, the recommended level of assistance
- Documenting and providing clinical handover as to the level of assistance a patient needs using the approved terms and abbreviations
- Discussing a change in condition or deterioration in function with relevant members of the health care team
- Ensuring documentation and clinical handover includes any additional information and/or requirements related to patient transfers, mobility and functional tasks, if the terms described within this document do not provide sufficient detail for a particular patient or patient group.

Allied health assistants are responsible for:

- Adhering to these guidelines when delivering clinical care to patients, providing at a minimum, the recommended level of assistance
- Being aware of an individual patient's risk of falls and the implications for patient safety
- Understanding how recommendations about the amount of assistance that a patient requires with transfers and mobility relates to functional tasks e.g. if requires supervision with transfers and mobility, requires supervision in the toilet/shower
- Documenting and providing clinical handover as to the level of assistance a patient needs using the approved terms and abbreviations
- Ensuring documentation and clinical handover includes any additional information and/or requirements related to patient transfers and mobility e.g. if the terms described within this document do not provide sufficient detail for a particular patient or patient group
- Discussing any changes in patient condition or level of assistance required with relevant supervisor/treating therapist.

Allied health managers are responsible for:

- Promoting awareness of this guideline, ensuring clinical staff have read and acknowledged it
- Ensuring that relevant Allied Health staff receive any necessary training around the use of the approved terminology and are aware of their discipline-specific role
- Including the guideline and its contents as part of orientation for new staff and students
- Providing staff with access to this guideline via the Intranet and any other accepted means e.g. shared drives.

Nurses and midwives are responsible for:

- Ensuring consistency with these guidelines if making recommendations about the amount of assistance that a patient requires
- Ensuring that any students under direct supervision of a registered nurse or midwife understand the approved terms and the implications for patient care, documentation and clinical handover
- Considering falls risk when making recommendations for and/or providing care to individual patients
- Completing the Falls Risk Assessment and Management Plan (FRAMP) for patients at risk of falls and making referrals to relevant Allied Health professionals
- Adhering to these guidelines when delivering clinical care to patients, providing at a minimum, the recommended level of assistance
- Understanding how recommendations about the amount of assistance that a patient requires with transfers and mobility relate to functional tasks e.g. if requires supervision with transfers and mobility, requires supervision in the toilet/shower
- Providing clinical handover as to the level of assistance a patient needs using the approved terms and abbreviations
- Discussing any changes in patient condition or level of assistance required with relevant members of the health care team
- Ensuring documentation is consistent with the terms and abbreviations described within this guideline.

Unit managers are responsible for:

- Promoting awareness of this guideline and ensuring relevant staff have read and acknowledged it
- Ensuring that staff receive any training around the use of the approved terminology and are aware of their discipline-specific role
- Including the guideline and its contents as part of orientation for new staff and students
- Providing staff with access to this guideline via the Intranet and any other accepted means e.g. shared drives, printed copies.

Medical officers are responsible for:

- Clearly documenting weight bearing status, where relevant, in the medical record
- Understanding the terminology and abbreviations as described in this document.

Nurse educators and clinical nurse educators are responsible for:

- Including this guideline, where relevant, as part of the orientation of new staff and students
- Providing education, where needed, to nursing staff and students around the approved terms, their meaning and the implications for their interactions with patients.

Allied health student educators are responsible for:

- Including this guideline as part of the orientation of new students
- Ensuring students understand the approved terms, their meaning and the implications for their interactions with patients.

Patient support staff are responsible for:

- Adhering to these guidelines when delivering care to patients, providing at a minimum, the recommended level of assistance
- Understanding how recommendations about the amount of assistance that a patient requires with transfers and mobility relate to functional tasks e.g. if requires supervision with transfers and mobility, requires supervision in the toilet/shower.

Volunteers are responsible for:

Adhering to the statement of duties provided by the unit on which they volunteer.

Section 5 - Standardised mobility terminology for use across SESLHD

Independent

- No supervision or assistance, either physical or set-up, is required
- A walking aid may be used.

Supervision

- The patient is steady when mobilising but has an impairment e.g. cognitive or visual, or an attachment such as an IV pole that requires them to have someone there for verbal cues/prompting and/or to ensure a safe environment
- This level of assistance means that a patient is **not likely** to need any hands on assistance but proximity to the patient should be determined by the task and the individual patient requirements e.g. if a patient needs supervision for direction, being some distance away might be sufficient but if they need supervision to ensure they can safely access the bathroom, the staff member will need to be closer to the patient
- The patient must remain within view but not necessarily close to the person supervising
- Patients who are at high risk of falls and require supervision **should not be left unattended in the bathroom**, including during toileting and showering.

Stand by assistance

- The patient demonstrates **inconsistent performance and/or can be unsteady** when mobilising e.g. impulsive, impaired balance, unsteady gait, lower limb weakness
- The patient may need hands on assistance in the event that they lose their balance
- The staff member needs to be **standing directly next to the patient** at all times and **ready** to assist if needed
- Patients who are at high risk of falls and require standby assist **should not be left unattended in the bathroom**, including during toileting and showering
- Consider use of a transfer belt during mobility.

Minimal Assist (specify number of persons required)

- The patient requires a small amount of hands on assistance at times or throughout transfer, mobility and functional tasks
- The patient is able to assume all of his/her body weight but requires guidance for initiation, balance and/or stability during the activity e.g. standing, walking, toileting, showering
- Patients who are at high risk of falls and require minimal assistance **should not be left unattended in the bathroom**, including during toileting and showering
- Consider use of a transfer belt +/- equipment.

Moderate Assistance (specify number of persons required)

- The patient requires more help than guidance/touching
- Some lifting by assistant(s) required but within the safe lifting limits
- The patient can assume part of their body weight when initiating and performing the activity
- Patients who are at high risk of falls and require moderate assistance **should not be left unattended in the bathroom**, including during toileting and showering
- Always use a transfer belt +/- other equipment.

Maximal assistance (specify number of persons required)

- The patient contributes little or nothing toward the execution of the activity
- For transfers and mobility, consider mechanical lifter/hoist rather than maximal assistance. However, there will be cases where fostering patient improvement with transfers and mobility will require maximal assistance over hoist transfers
- Patients who are at high risk of falls and require maximal assistance **should not be left unattended in the bathroom**, including during toileting and showering
- Can be used as a descriptor of the amount of assistance required if more than what is recommended is given in an unpredicted event e.g. fall, acute deterioration or with unexpected performance in an assessment or treatment session.

Section 6 – Documentation

In line with SESLHDPR/336 - Documentation in the Health Care Record, documentation in health care records must provide an accurate description of each patient/client's episode of care or contact with health care personnel. Additionally, only approved SESLHD abbreviations are permitted. Please refer to SESLHDPR/282 - Clinical Abbreviations procedure and the associated Clinical Abbreviations List.

A list of abbreviations relevant to this guideline has been included in *Appendix B.*

Clinical staff who assess patient transfers, mobility and/or functional tasks and make recommendations are required to document the outcome of their assessment in the clinical record. The minimum requirements for documentation include:

- Type of activity e.g. bed mobility, sit to stand, transfers, mobility, showering, dressing
- Level of assistance and abbreviation:
  - Independent: I
  - Supervision: S/V
  - Standby assistance: SBA
  - Minimal assistance: min. A
  - Moderate assistance: mod. A
  - Maximal assistance: max. A
- Type of assistance if not physical assistance e.g. patients who require supervision may need verbal cueing or set-up
- Number of people required to provide assistance. For example:
  - Minimal assistance of one person, abbreviated to min. A x 1
  - Maximal assistance of two people, abbreviated to max. A x 2
- Weight bearing status if relevant (see Section 3, Definitions)
- Equipment required such as walking aids, transfer belts, hoist
  - Walking stick and minimal assistance of one person, abbreviated to W/S + min. A x 1
  - Forearm support frame and moderate assistance of two people, abbreviated to FASF + mod. A x 2.

There will be circumstances where additional information is required to promote safe transfers mobility and functional tasks, such as different requirements for assistance during the day, compared with overnight. All relevant information should be documented in the health care record and included in clinical handover.

Local procedures may vary but mobility status should also be noted on the electronic journey board if in use and via other means such as bedside whiteboards.

Section 7 - Clinical handover

Accurate information during clinical handover is key to patient safety.

Information that should be included as part of clinical handover varies depending on the point of handover but may include:

- Type of activity such as bed mobility, sit to stand, transfers, mobility, showering, dressing
- Level of assistance and abbreviation include:
  - Independent: I
  - Supervision: S/V
  - Standby Assist: SBA
  - Minimal Assist: min. A
  - Moderate Assist: mod. A
  - Maximal Assist: max. A
- Type of assistance if not physical assistance e.g. patients who require supervision may need verbal cueing or set-up
- Number of people required to provide assistance
- Weight bearing status if relevant (see Section 3, Definitions)
- Equipment required such as walking aids, transfer belts, hoist.

Points of clinical handover include:

- Therapist to nurse/midwife after an assessment of the level of assistance needed has been completed
- Between nurses/midwives at shift handover so that commencing staff are aware of the level of assistance a patient requires
- Between therapists such as physiotherapists and occupational therapists when handing over care e.g. ward move, weekend/evening treatment or when asking for assistance with caseload
- Before or as soon as possible after transfer between units
- When transferring temporarily to other departments (e.g. for diagnostic procedures and operating theatres) to ensure an appropriate level of assistance is provided. This includes instructing porters/technical aids of the level of assistance required during transit
- Between nurses/midwives and patient support staff
- Multidisciplinary team meetings such as ward rounds, case conferences or whiteboard meetings.

Section 8 - References

1. Australian Commission on Safety and Quality in Health Care.2012. Safety and Quality Improvement Guide Standard 10: Preventing Falls and Harm from Falls. Sydney: ACSQHC; October 2012
2. Australian Commission on Safety and Quality in Health Care. Preventing Falls and Harm from falls in Older People: Best Practice Guidelines for Australian Hospitals. Sydney: ACSQHC; 2009
3. Uniform Data System for Medical Rehabilitation. The FIM System® Clinical Guide, Version 5.2. Buffalo: UDSMR; 2009
4. World Health Organisation. Falls [Internet]. 2016 [cited 2016 April 26]. Available from http://www.who.int/violence_injury_prevention/other_injury/falls/en/
5. Agency for Clinical Innovation. The Orthogeriatric model of care: Clinical Practice Guide Sydney; 2010.

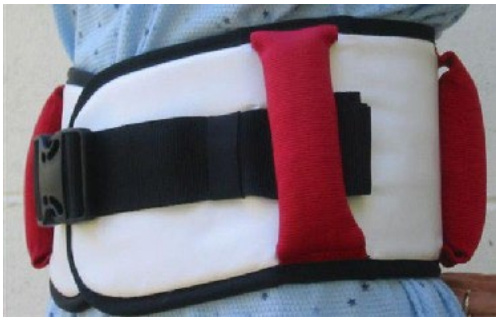
Revision and Approval History

Date	Revision no:	Author and approval
June 2016	Draft	Draft guideline prepared and published on Draft for Comment
January 2017	Draft	Endorsed by Executive Sponsor
February 2017	0	Approved by Clinical and Quality Council
March 2020	1	Update to Executive Sponsor. Published by Executive Services.
March 2022	2	Minor review. Update hyperlinks. Approved by Executive Sponsor.

Appendix A: Commonly used transfer and mobility aids

Item of equipment: Abbreviation	Image
Walking stick: W/S	
Quad stick:QS	
Canadian crutch or elbow crutch	
Axillary crutch	

Item of equipment: Abbreviation	Image
Pick up frame: PUF	
Rollator frame **A. 2 wheels: RF** **B. 4 wheels: 4WF**	**A**  **B** 
Wheeled walker **A. 2 wheels: 2WW** **B. 4 wheels: 4WW**	**A**  **B** 
Forearm support frame: FASF	 

Item of equipment: Abbreviation	Image
Transfer belt: T/F belt	
Wheelchair **A. Manual wheelchair: MWC** **B. Power wheelchair: PWC**	**A**  **B** 
Stand up hoist	
Hoist	 

Appendix B: CEC videos demonstrating correct use of walking aids

The following links lead to videos demonstrating correct use of various walking aids. The videos were developed by the Clinical Excellence Commission, NSW Falls Prevention Program.

These **do not** instruct health professionals how to prescribe walking aids but aim to ensure that staff are aware of important factors such as correct height, safe transfers with walking aids and how to best assist patients using these aids.

1. Forearm support frame
2. Rollator frame and pick up frames
3. Wheeled walkers
4. Walking sticks

Appendix C: Relevant approved clinical abbreviations

Please refer to SESLHDPR/282 - Clinical Abbreviations procedure and the associated Clinical Abbreviations List for the complete list of SESLHD approved abbreviations

Assistance	A
Forearm support frame	FASF
Four-wheeled walker	4WW
Independent	I
Manual wheelchair	MWC
Maximum	Max.
Minimum	Min.
Moderate	Mod.
Non weight bearing	NWB
Over toilet aid	OTA
Partial weight bearing	PWB
Physiotherapy	P/T
Pick up frame	PUF
Power wheelchair	PWC
Quad stick	QS
Rollator frame (2 wheels)	RF
Rollator frame (4 wheels)	4WF
Sit to stand	STS
Sit out of bed	SOOB
Standby assistance	SBA
Supervision	S/V
Touch weight bearing	TWB
Transfer	T/F
Two-wheeled walker	2WW
Walking stick	W/S
Weight bearing	WB
Weight bearing as tolerated	WBAT

Appendix D: Case scenarios and self-assessment

The following case scenarios are based on SAC 2 fall events. Refer to Page 23 for suggested responses to case scenarios and rationale.

Scenario 1

A 92 year old female is admitted to a rehabilitation unit after a fall and fractured distal radius. She has a history of congestive cardiac failure, chronic kidney disease, recurrent falls and glaucoma. She is assessed by the physiotherapist as needing a walking stick and 1 person present at all times with transfers and mobility due to occasional unsteadiness. She does not require physical assistance.

Question 1: Based on the information provided, the recommended level of assistance would be? Why? Include the accepted abbreviations you may use when writing the notes for this patient

a. Independent: I
b. Supervision :S/V
c. Stand by assistance: SBA
d. Minimal assist of one person: min. A x 1

Question 2: The patient scored 7 on the Ontario Modified Falls Risk Screen (6 points for a recent fall and 1 point due to her impaired vision). Which of the following statements best reflects the information provided in the case scenario?

a. The patient is not at risk of falls in hospital as she did not score ≥9 on the falls risk screen
b. The patient may be at risk of falls and my clinical judgement overrides the falls risk screen

Question 3: The patient walks to the toilet with a physiotherapy student. Which of the following statements is most accurate?

a. The physiotherapy student can leave the patient in the bathroom once they are seated on the toilet and instruct the patient to press the call bell when finished
b. The physiotherapy student should go and find a nurse to assist the patient
c. The physiotherapy student should remain with the patient at all times in the bathroom, unless there is someone else present to help the patient e.g. nursing staff

Scenario 2

An 80 year old male presents to an Emergency Department (ED) with new right-sided weakness. He was previously independent with mobility without a walking aid and independent with all activities of daily living. His only documented past medical history is hypertension.

Approximately one hour after arrival in ED, the patient requests to go to the toilet. The nurse advises the patient he is not safe to walk to the toilet as he has not yet had a physiotherapy assessment and gives him a urine bottle. The patient becomes distressed and states he can't use the bottle lying down. The nurse assists the patient to sit up on the edge of the bed and the patient then demands privacy.

Question 1: Given the information provided, what would you do if placed in a similar situation? What factors did you consider when making your decision?

Scenario 3

A 76 year old male is admitted to an aged care ward with a respiratory tract infection. He has a history of dementia. He was previously independently mobile without a walking aid and has not previously had a fall.

On assessment, you note be steady mobilising without a walking aid and not needing any physical assistance. His son reports his walking to be the same as it is at home. The occupational therapist walks the patient to the toilet and notes he needs some verbal prompting to find the bathroom and to sit on the toilet instead of the shower chair, which was also in the bathroom.

Question 1: Based on the information provided, what level of assistance would you recommend is provided to this patient during transfers? Why?

a. Independent: I
b. Supervision :S/V
c. Stand by assistance: SBA
d. Minimal assist of one person min. A x 1

Question 2. Based on the information provided, what level of assistance would you recommend is provided to this patient during mobility? Why?

a. Independent: I
b. Supervision :S/V
c. Stand by assistance: SBA
d. Minimal assist of one person : min. A x 1

Appendix E: Suggested responses to case scenarios and rationale

Scenario 1

Question 1

Answer: c. Standby assistance: SBA
The accepted abbreviation to describe the level of assistance required by this patient is W/S + SBA

Rationale: Occasional unsteadiness with mobility means staff will need to stand directly next to the patient at all times and be ready to assist if needed. This level of assistance is called standby assistance.

Question 2

Answer: b. The patient may be at risk of falls and my clinical judgement overrides the falls risk screen

Rationale: The falls risk screen is a guide for staff and does not replace clinical judgement. If staff judge an inpatient to be clinically at risk of a fall, this always overrides an individual risk score. A comprehensive assessment and management plan is required in these cases.

The patient's recent fall and fracture, unsteady gait and poor vision are risk factors for a fall during her rehabilitation stay. Clinical judgement is required regarding the need for a falls risk assessment and management plan addressing her individual risk factors.

Question 3

Answer: c. The physiotherapy student should remain with the patient at all times in the bathroom, unless there is someone else present e.g. nursing staff

Rationale: Patients who require standby assistance and are at risk of falls should not be left unattended in the bathroom, including during toileting

Scenario 2

Question 1

- Prioritise patient safety over privacy in this situation
- Gently but firmly explain the reasons behind needing to remain in the room with the patient
- Factors to consider: only presented to ED one hour prior with new right sided weakness, no formal assessment of cognition, no formal assessment by physiotherapy or occupational therapy, risk of falls clinically high even in absence of falls risk screen

Scenario 3

Question 1

Answer: b. Supervision: S/V

Rationale: He needs verbal prompting to carry out some tasks safely e.g. toileting. The need for verbal prompting whilst toileting means the patient needs supervision with transfers. The patient should remain within view at all times and must not be left alone in the bathroom. Due to the patient's history of dementia, he will be at high risk of falls in an unfamiliar hospital environment.

Question 2

Answer: b. Supervision: S/V

Rationale: He is not unsteady when mobilising and does not need physical assistance. However, due to his history of dementia and need for verbal prompting, he will require supervision. This so may not need a staff member within arm's reach at all times. This will require the judgement of the clinician and is dependent on the task. Due to the patient's history of dementia, he will be at high risk of falls in an unfamiliar hospital environment.