Somerset Partnership NHS
NHS Foundation Trust

SLIPS, TRIPS AND FALLS (PREVENTION AND MANAGEMENT) POLICY

This policy includes:
Protocol for Essential Care Following an Inpatient Fall and the Guidelines for the use of Bed Rails including Risk Assessment

This policy to be read in conjunction with the Serious Incident Requiring Investigations Policy, Medical Devices Policy

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Relevant Staff Groups:	Medical Staff, Registered Nurses, Students, Health Care Assistants, Allied Health Professionals, Social Workers and Social Care Staff, Housekeeping and Catering staff, Administrative Staff, Agency staff, Visiting Contractors

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DOCUMENT CONTROL

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Revised to include clinical audit standards and Updated Equality Impact assessment

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1 INTRODUCTION

1.1 Somerset Partnership NHS Foundation Trust is committed to ensuring the safety of patients in its care and that of staff and visitors. It is required to ensure policy guides clinical practice and monitors and addresses environmental factors that may contribute to slips, trips and falls. This policy will outline the responsibilities of all staff relating to:

- assessing the risk of falls
- reducing the incidence of slips, trips and falls by taking action to managing the risks
- reducing the severity of injury sustained as a result of falling.

1.2 A fall is defined as an unexpected event when the individual comes to rest on the ground from any level, this also includes falling on the stairs and onto a piece of furniture with or without a loss of consciousness (NICE, 2004).

2. PURPOSE & SCOPE

2.1 This policy applies to all persons working for the Somerset Partnership NHS Foundation Trust, to include bank / agency personnel and work experience / volunteer workers / social care staff and students

2.2 The purpose of this policy is to reduce the incidence of falls and fall related injuries wherever possible by implementing a multi-faceted and multi-disciplinary approach within the Somerset Partnership NHS Foundation Trust. This approach will include ongoing development and implementation of robust processes:

- To recognise the underlying factors that may contribute to falls
- To identify those people at risk of falling
- To identify and minimise environmental hazards
- To undertake multidisciplinary and multi-factorial assessment of the risks
- To provide appropriate intervention using a collaborative, multidisciplinary approach
- To reduce the severity of injury as a result of a fall
- To provide information/education for patients and carers
- To ensure staff training is in place and accessed appropriately
- To ensure appropriate untoward events reporting

- To monitor, review and investigate slips, trips and falls incidents to ensure learning is identified and disseminated, both locally and at organisational level as appropriate

- To support staff to participate in falls related audit

2.3 To work with patients and carers to achieve a balance between preventing falls and encouraging independence whilst ensuring privacy and dignity and enabling rehabilitation.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Chief Executive** of the Trust will take action to respond to any relevant National Guidance in relation to managing falls, including:

- NHS Operating Framework for the NHS in England 2012/13 (DOH)

- NHS Outcomes Framework 2012/13, particularly Domain 4 - Ensuring that people have a positive experience of care and Domain 5 - Treating and caring for people in a safe environment; and protecting them from avoidable harm

- The Chief nursing officers High Impact Actions - Staying safe-preventing falls: achieving year-on-year reductions in falls among older people in NHS-provided care

- The Royal College of Physicians (RCP) National Audits of Falls and Bone Health (2007 and 2010)

- NPSA/2011/RRR001 Essential Care after an Inpatient Fall (2011)

- The National Service Framework for Older People (2001),

- NICE guidelines CG 21 Falls (2004) ,

- The National Patient Safety Agency (NPSA) report of slips, trips and falls in hospital (2007)

- The How to Guide for Reducing Harm from Falls (2009)

- The How to Guide for Reducing Harm from Falls in Mental Health Inpatient Settings (NPSA)

- NICE Guidelines CG103 Delirium (2010)

3.2 It will actively support the development of services as resources allow and ensure that services are developed in collaboration with patients, stakeholders and partners.

Legal and Statutory Requirements

3.3 The NHS has a statutory and ethical duty to safeguard, so far as is reasonably practicable, the health and safety of staff at work. Slips and trips

cause three times more major injuries than manual handling and assault/violence

3.4 The **Management of Health and Safety at Work Regulations 1992 (amended in 1999)** specifies the legal requirements for risk assessments to be carried out, and for effective risk control measures to be implemented and enforced.

3.5 The **Workplace (Health, Safety and Welfare) Regulations 1992** require the floor surface to be suitable for purpose and kept free from hazard or obstruction which may cause a person to slip, trip or fall. Particular attention should be paid to:

- holes, bumps and uneven areas
- snow and ice on walkways
- arrangements for dealing with spillages
- hospital/building entrances
- obstructions to walkways

3.6 Contract workers working at height (e.g. Window or Gutter Cleaning, roof repair) must comply with the Work at Height Regulations, as amended by the **Work at Height (Amendment) Regulations 2007**. The Regulations apply to all work at height where there is a risk of a fall liable to cause personal injury. They place duties on employers, the self employed and any person who controls the work of others (e.g. facilities managers or building owners who may contract others to work at height) to the extent they control the work.

3.7 Head of Facilities Management

3.7.1 Will ensure that current good practice will be followed when introducing new or refurbished floor surfaces. Appropriate advice and guidance is followed with regard to flooring design, specification, procurement, construction, commissioning, and cleaning and maintenance regimes.

3.7.2 Shall prior to taking occupation of a building carry out risk assessments on common activities and hazards within the work environment these are then issued to individual sites and placed within the health and safety folder.

3.7.3 Will contribute proactively to Somerset Partnership NHS Foundation Trust health, safety and security management audits

3.8 Head of Corporate Services

3.8.1 Will ensure Health and Safety advice services are provided within the Trust

3.8.2 Will facilitate the Health, Safety and Security Management Audits and provide the Regulation Governance Group with an audit report

Management Responsibility

3.9 **Managers** are responsible for ensuring that steps are taken to implement the requirements of this policy. They have a responsibility:

3.9.1 To identify hazards and ensure the processes for risk avoidance, risk assessment and risk reduction are implemented within their area of responsibility. They can nominate competent staff to assist in this process, such as the Local Health & Safety Workplace Monitor.

3.9.2 To follow the Trust's procedure for reporting and recording local risks using the **Local Risk Register** via the Datix Risk Management System on the Trust Intranet.

3.9.3 To raise staff awareness of Local Risks by discussion at local team meetings and ensure this is recorded within the minutes/notes of the meeting.

3.9.4 To ensure that all staff are made aware of the requirements of the slips, trips and falls policy and comply with the safe systems that are contained within it.

3.9.5 To ensure that communications regarding falls are cascaded to all staff and that staff are involved in falls prevention activity

3.9.6 To ensure that staff receive instruction/training to comply with the requirements of this policy including use of relevant equipment, risk assessment tools to enable them to utilise the appropriate safe systems for managing slips, trips and falls.

3.9.7 To ensure that staff information and training is provided in formats which can be easily understood and which takes account of the diverse nature of the Trust workforce.

3.9.8 To ensure that Clinical Falls Risk Assessments are reviewed and updated when a fall (or falls) occur

3.9.9 To ensure that all Contractors carrying out maintenance/works on site are provided with a copy of the Health & Safety Site Rules for Contractors (accessible on the Trust intranet on the Home Page, click on Services, click on Central Services, click on Estates and Facilities. To ensure that contractors and sub-contractors are effectively monitored whilst on Trust premises in order to reduce slips and trips hazards which they may create.

3.9.10 To provide suitable equipment and encourage the use of relevant equipment where provided, ensuring that there is a procedure in place for cleaning, servicing and maintenance of all floor coverings, grounds and pathways.

3.9.11 To ensure maintenance records are held for all equipment (with specific reference to Medical Devices).

3.9.12 To ensure that wards and departments maintain accurate records of equipment sent for repair. Repeated malfunction of very old equipment may indicate a need for replacement.

3.9.13 To follow up all accidents, untoward events and near misses associated with slips, trips and falls to investigate their cause and to review control measures and required actions are carried out within the agreed timescales.

3.9.14 To monitor trends of sickness absence related to slips, trips and falls and ensure a RIDDOR form is completed where staff are absent for 7 days or more following an incident.

3.9.15 To ensure that appropriate action is taken when workplace inspections or general observation indicates the non-adherence to the required procedure for controlling slips, trips and falls in their area of responsibility.

Staff responsibility

3.10 **All staff** have a key role in providing a safer environment for patients, visitors to the Trust and other staff. Those at greatest risk are likely to be patients due to their clinical condition, however anyone is at risk of slipping, tripping or falling within the building or surrounding grounds.

3.10.1 All **employees** have a responsibility:

- To ensure that they undertake their duties in such a manner as not to produce a potentially hazardous situation which may lead to a slip trip or fall.
- Will ensure that any hazard which may lead to a slip trip or fall is reported to their line manager or Workbased Health and Safety Monitor immediately.
- To report all untoward events and near miss on DATIX in accordance with the Untoward Events Reporting Policy
- To wipe up spills on wet floors, or to identify the hazard and seek assistance to clean up the spill
- To avoid causing hazards by carrying drinks on a tray
- To report damaged flooring or external paths that could cause a slip or trip hazard
- To report and withdraw from use equipment that is faulty, particularly, but not exclusively beds, commodes etc with faulty brakes
- To avoid environmental clutter including ensuring safe placement of cables removing equipment from corridors etc.

- To use relevant hazard warning signs when floors are wet to ensure that the area is made as safe as possible by restricting access to the affected area

- To attend relevant training in line with the Mandatory Training Matrix

- To adhere to the Trust's Dress Code Policy and ensure they wear appropriate footwear

- To adhere to Trust policies

3.11 **Multi-disciplinary team members** have a responsibility to appropriately assess patients who are at risk of falling and to reduce the risk of injury as a result of falling. Dependent on their individual roles, responsibilities are as follows:

3.11.1 **Medical assessment and intervention**

- clinical examination

- physical and cognitive assessment

- review of drugs, particularly if the patient is on four or more medications and includes psychotropic/sedative medications.

- review of patients post fall, to exclude injury as a consequence of falls and to exclude medical deterioration as the underlying cause

- treatment or onward referral of acute medical problems causing the fall, unsteadiness or postural hypotension

- assessment of bone health and prescription of appropriate medication where need identified or following a fragility fracture

- onward referral for further investigations as required

3.11.2 **Nursing assessment and intervention**

- to complete a baseline assessment of each patient on admission

- to complete a falls risk assessment for all patients admitted to an older persons mental health ward or community hospital

- In other in-patient areas, if a patient is deemed to be at risk of falling or has already fallen, ensure risk assessment is carried out and disseminated to all staff groups involved in the patient's care

- to establish patient goals, usual routine and coping strategies and increase levels of observation where appropriate

- to consider use of bedrails if the benefit outweighs the risk (refer to the Guidelines for the use of Bed Rails including Risk Assessment, Appendix 1)

- to implement evidence based care plan for patients at risk of falls, identifying and recording individualised actions

- to ensure all information given to patients and their carers is in a format and language they may easily understand.

3.11.3 **Rehabilitation (Occupational therapy and Physiotherapy) assessment and intervention**

- assessment of activities of daily living and any necessary interventions throughout the patient's stay in hospital

- contribute to assessment of cognition

- assessment of home environment where appropriate, identifying possible hazards, so as to minimise risk at home and maximise independent living

- provision of appropriate equipment and/or adaptations

- Assessment of mobility, to include gait and balance

- Provision of treatment to improve safe mobility

- assess suitability of walking/mobility aids

3.11.4 **Pharmacy assessment and intervention**

- review prescribed medication to identify drugs that may increase risk of falls

3.12 Workbase Health and Safety Monitors

3.12.1 Will carry out an inspection of their site every month, which will include checking all walkways, exits and entrances and areas for slip, trip and fall hazards

3.12.2 Will raise local issues and generic risks at the Health, Safety and Security Management Group

3.13 Health Safety and Security Management Group

3.13.1 Will review incident reports with a focus to ensure any trends and learning are identified and appropriate action taken. Through review of workplace assessments the Group will also monitor updates of the slips, trips and falls generic risk assessments within the Trust.

3.14 Falls Best Practice Group

3.14.1 Will ensure actions identified for the annual falls clinical audit are included in the overarching Falls Action Plan. This group will monitor the actions and report to the Clinical Social Care and Effectiveness Group (CSCE) as required.

3.15 Lead Nurse for Slips, Trips and Falls (Mental Health) and Falls and Bone Health Coordinator (Community Health)

3.15.1 Will provide the Clinical Governance Group with an Annual Report (using the Governance Group reporting template) demonstrating progress throughout the year and highlighting where improvements have been achieved.

3.16 The role of the **Clinical and Social Care Effectiveness Group**, the **Clinical Governance Group** and the **Regulation Governance Group** is described within the monitoring section.

4. EXPLANATION OF TERMS USED

4.1 **Hazard** – something with the potential to cause harm

4.2 **RIDDOR** – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, this is a legal requirement. The information enables the Health and Safety Executive (HSE) and local authorities, to identify where and how risks arise, and to investigate serious accidents.

4.3 **RiO** - is the electronic patient records system currently used within the mental health directorate of the Trust. (Rio is undergoing a programme of roll out to the Community Directorate Services and this will be reflected in policy updates).

4.4 **DATIX** - the Trust's electronic risk management database used for recording the following data: PALS; Complaints; Untoward Events; Corporate and Local Risks; Medical Devices Register and CAS Alerts.

5 BACKGROUND AND GENERAL PRINCIPLES

5.1 Falls are a major cause of death and disability in people aged 75 and over. One third of people aged 65 years and over and half of those aged 85 years and over will fall at least once a year. The impact of this is huge to the individual in terms of disability, loss of independence, depression and sometimes death. Both health and social care services also incur high costs as a result of falls

5.2 The National Falls and Bone Health Audit (published by the Royal College of Physicians, 2007) reported an unacceptable degree of variation across the NHS, in the prevention of future falls and fractures. A subsequent audit in 2010 reported the following findings:

- People in England aged 65 and over spend 4 million days in hospital each year as the result of falls and fractures
- Injurious falls, including over 70,000 hip fractures annually, are the leading cause of accident-related death in older people

- The healthcare cost associated with fragility fractures, which are usually due to osteoporosis, is estimated at £2 billion a year

- Falls and fractures can lead to loss of confidence and increased difficulty in carrying out day-to-day activities both indoors and outdoors. This may result in increased dependency on families, carers and services, and lower quality of life.

- With many people living longer, the rate of falls and fractures is increasing and will continue to do so unless action is taken to address serious inadequacies in services currently provided.

6. STATEMENT OF POLICY

6.1 The Trust will have systems in place to ensure compliance with all relevant national guidance. Patient Safety Improvement Methodology will be implemented, including the use of rapid cycle testing, to ensure ongoing improvements and refinements are made to processes that improve patient safety. Therefore the tools included in the appendices will be subject to further development

Inpatients

6.2 Any patient who has fallen prior to admission to a Somerset Partnership inpatient setting, or who is considered to be at risk of falling, must be assessed. For mental health patients, the falls **risk assessment tool**, (Appendix 2) contained in the RIO risk management section should be used and for Community Health wards the **Inpatient Falls Risk Assessment** (Appendix 3) should be used.

6.3 On completion of the falls risk assessment, an individualised care plan/care action plan relating to falls must be implemented for patients at risk. In mental health settings using RiO, the care plan within the care plan library allows for adaptations of interventions as appropriate.

6.4 Discussion with the patient/carer/relative about the risk of falling and the potential interventions is essential and may be led by any member of the multi-disciplinary team. The patient and their family/carers where appropriate, should be included in the development of the falls prevention action plan. Patients need to be aware that the risk of falling cannot be completely eliminated despite preventative measures taken. Records of discussions held must be recorded in the patient's record.

6.5 Written information must be provided in a language and format easily understood by the patient or their carers. Use of an interpreter may also be necessary. All patients in community hospitals and older persons mental health wards should be given a 'Preventing Falls in Hospital' factsheet (Appendix 4). Any factors relating to their particular circumstances should be highlighted.

6.6 Intentional Rounding (Appendix 5 Mental Health Directorate Template) must be implemented for patients at risk of falling in all inpatient settings. The interval of the rounds is determined by the level of risk, with more frequent rounding for higher risk patients.

6.7 In the event of an inpatient fall occurring the Protocol for Essential Care following an Inpatient Fall must be implemented (NPSA (2010) (Appendix 6) and the post fall checklist completed. Where an unwitnessed fall has occurred, neurological observations must be undertaken with medical guidance before discontinuing. Details of the fall should be documented in the patient record For Community hospitals using the '4W's' sticker (Appendix 7)

6.8 Falls risk assessment must be repeated at weekly intervals and following a fall. All new actions must be documented, implemented and disseminated to the multidisciplinary team

Community patients/outpatients

6.9 For community patients, a Falls Risk Assessment Tool (FRAT) (Appendix 8) must be completed for every patient who has been identified as 'at risk'. This will include MIU's, outpatient clinics, community nursing services, community mental health teams, rehabilitation services and any other clinical service where contact is made with persons at risk of falling. The completed FRAT tool should be sent to the central point of referral for the Falls Service and a copy retained in the patient notes.

Reporting and investigation

6.10 Following a patient fall, a DATIX Untoward Event Report form (accessible on the home page of the Trust Intranet) must be completed and the appropriate action taken.

6.11 To assist in critical analysis of falls and provide information about the number of patient falls, a clear account of the incident must be given. To aid this process identification and documentation of contributing factors is essential. These factors may include:

- location of fall
- cognitive impairment
- during work with therapist
- from bed
- from commode/toilet
- on same level
- patient found on floor
- slipped on fluid
- steps/stairs
- time of fall

- any other relevant information

6.12 It is also essential to include information regarding actions taken as a result of reassessing risks.

6.13 These reports will be used for auditing purposes to monitor the incidence and causes of falls and their contributory factors. Reporting will be utilised from ward to board level.

7. DISCHARGE FROM HOSPITAL

7.1 A fall in hospital must be taken into account when planning a patient's discharge home. Interventions to reduce the risk of falling again must be implemented, to include referral to the community Falls Prevention Programme and/or ongoing support from the Community Rehabilitation Service. A home safety assessment may be needed to identify the need for adaptations and/or equipment to improve safety.

8. ENVIRONMENT AND EQUIPMENT

8.1 The availability of appropriate, fully maintained equipment is essential. The call bell system should be functioning correctly and the patient should be able to reach the call bell from the bed/chair/toilet.

8.1.1 Environmental factors to reduce the risk of falls must be considered, in particular floors in toilets and bathrooms, which benefit from a slip resistant surface. Hazards should be identified on an on-going basis and spills cleaned up immediately a cleaning regime will be established.

8.1.2 Installation of handrails within patient environments can improve patient safety and reduce falls and injuries.

8.1.3 Patients at high risk of falls due to impaired mobility should not have to walk far to reach the toilet.

8.2 Specialist Equipment (Mental Health inpatient wards)

8.2.1 Mobility should be promoted with all patients in order to avoid complications associated with immobilisation as well as improving functional ability, dignity and quality of life. However, increased mobility may result in an increase in the incidence of falls. Protective devices are designed to reduce the likelihood of a fall related injury where falls cannot be prevented. Examples of these types of protective devices include hip protectors and helmets.

8.2.2 Hip protectors -The majority of hip fractures occur as a result of a fall impact to the greater trochanter. Hip protectors attenuate the fall impact forces on this prominent and vulnerable bone. Hip protectors must be accessible on all older persons' wards.

8.2.3 Helmets - Falls have been identified as the second leading cause of brain injury in older people and helmets are a consideration where there is significant risk.

8.3 Telecare

8.3.1 Electronic alarms alert staff when high risk patients are moving from bed/chair/toilet and enable the appropriate response. Alarms should be considered as a risk reduction measure and care planned accordingly.

8.4 Bed Rails

8.4.1 Bed rails should only be used in accordance with the Guidelines for the use of Bed Rails including Risk Assessment (Appendix 1) and a risk assessment completed prior to their use. Regular reviews must be undertaken as specified and following a fall at the bedside. The decision to use bed rails must be documented and all staff aware.

8.5 Height Adjustable Beds

8.5.1 Beds should be left in the position most appropriate for the patient. Patients at high risk of falling from the bed should have the bed set on the lowest setting or a special low bed used if available. The risks of falling must be carefully assessed as injuries can occur even if the bed is very low.

8.6 Specialist Seating

8.6.1 Chairs should be selected to provide effective postural support and optimise safe transfers. Time spent sitting must form part of the care plan, be time limited where indicated and be reviewed on a regular basis. Specialist chairs may be required as part of an individual patients treatment regime to promote safe sitting, minimise distress or prevent the infliction of harm. The chair must not constitute a form of restraint.

8.6.2 The named nurse is responsible for ensuring the core risk assessment contained in RiO and care plan are completed when using specialist chairs (Mental Health Directorate)

8.6.3 Patients being nursed in a specialist chair, who are unable to mobilise independently, must be mobilised or their position changed at regular planned intervals, to be specified in their care plan, and records maintained to this effect.

8.6.4 Specialist seating would include:

- tilt in space chairs
- recliner chairs
- low level chairs
- wheelchairs
- chairs with elevated leg rests

8.6.5 Restraining straps should only be used in extreme circumstances under guidance, when the individual is at risk of severely injuring themselves (mental health wards)

9 HAZARD AWARENESS, PREVENTION AND MANAGEMENT OF SLIPS, TRIPS AND FALLS IN THE WORKPLACE TO ENSURE THE SAFETY OF STAFF AND VISITORS

9.1 The Trust pro-actively identifies and implements controls to prevent the risk of slips trips and falls (including falls from height) involving staff and others.

9.2 Prior to taking occupation of a building the Health and Safety Manager will carry out risk assessments on common activities and hazards within the work environment these will be shared with the relevant Managers and advice and support will be provide by the Head of Estates and Facilities when required.

9.3 All Managers will receive training in how to undertake and complete risk assessments on DATIX Risk in line with the Risk Management Policy and Procedure.

9.4 Managers will undertake risk assessments and formulate action plans within the environment following a significant change or following an incident, following the HSE five steps to risk assessment:

Step 1: Identify hazards
Step 2: Decide who might be harmed and how
Step 3: Evaluate the risks and decide on precautions - controls and actions
Step 4: Record your findings and implement actions
Step 5: Review your assessment and update if necessary

9.5 Managers will discuss local risks raise staff awareness within local team meetings (which will be minuted to ensure this information can be shared with staff not in attendance).

9.6 Actions to manage slips and trips at work (HSE Preventing slips and trips at work) are described in Appendix 10, this will assist staff and managers in identifying hazards associated with a slip and trip risk and assessment for their area.

9.7 Local Workbased Health and Safety Monitors will carry out an inspection of the ward/team area every month, which will include checking all walkways and areas for slip, trip and fall hazards. If repair works are required to remove the hazard then they should report the fault to the helpdesk of their Local Maintenance Provider (LMP). The LMP can then log the fault and contact a local contractor to visit site and repair the hazard.

9.8 Snow and Ice Management Plan Action Cards - Each site has a snow and ice action plan card which has a site plan on the reverse to show location of salt bin and areas of priority of clearance. The action cards are usually held in the main reception and are to give the site managers, nurse in charge or Health and Safety monitors guidance in what areas to clear first using local staff and resources. However, if this is not possible the site manager or

nurse in charge will contact their Local maintenance provider who can help co-ordinate a local contractor to respond and carry out any snow or ice clearance. The site plan is to help staff and Contractor understand which areas to clear first to limit any confusion and to make best use of the contractors time on site. Site managers, nurse in charge or Health and Safety monitors also need to check salt bins to ensure they are full, and request more salt (supplies permitting) through their Local Maintenance Providers. They should also erect appropriate hazard signs on external doors to main entrances etc, to remind persons of conditions outside when they leave the building.

9.9 The Head of Corporate Services will facilitate the annual Health, Safety and Security Management Audit and on completion will provide a report to the next Health, Safety and Security Management Group and subsequently the Regulation Governance Group. Areas of concern and significant risk will be escalated to the Integrated Governance Group were recommendations and agreed actions have not been completed within the agreed timescale.

10 TRAINING REQUIREMENTS

10.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

10.2 The Trust will work towards staff working with older people and other vulnerable patient groups being appropriately trained in falls risk assessment and management.

10.3 All staff caring for patients at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.

10.4 Training will be delivered to all older persons' in-patient wards on the management and prevention of slips, trips and falls. This will include use of the risk assessment and care planning within the patient record.

10.5 A Falls Awareness training DVD is available to raise awareness of falls risk. The DVD focuses on actions that can be taken by all staff groups working with vulnerable people to prevent/reduce falls. The DVD provides an introduction to falls prevention and is suitable for use in all clinical and care settings.

10.6 All staff must attend relevant mandatory patient handling/load management training, which includes use of equipment.

10.7 Recording, reporting and follow-up of non attendance at Mandatory Training is described within the Learning Development and Mandatory Training policy (accessible on the Trust Intranet).

11. PATIENT INFORMATION

11.1 A self help guide to reduce your risk of falling booklet provides information and advice and is widely available within the Trust for patients and carers to

promote independence and safe mobility. Additional copies are available from the Health Promotion Manager (Public Health). This may be used in conjunction with targeted, individual education and advice as a core component of a holistic falls management plan.

11.2 Other information leaflets/booklets are available through www.ageuk.org.uk.

11.3 Information provided to patients, relatives or significant others in regard to falls prevention should be documented in the patient record.

12. EQUALITY IMPACT ASSESSMENT

12.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

13. COUNTER FRAUD

13.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

14. MONITORING COMPLIANCE AND EFFECTIVENESS

14.1 **Patient Falls**

Overall monitoring will be by the Falls Best Practice Group who will ensure actions identified for the annual falls clinical audit are included in the overarching Falls Action Plan. This group will monitor the actions and report to the Clinical Social Care and Effectiveness Group (CSCE) as required. The Lead Nurse for Slips, Trips and Falls (Mental Health) and Falls and Bone Health Coordinator (Community Health) will provide the Clinical Governance Group with an Annual Report (using the Governance Group reporting template) demonstrating progress throughout the year and highlighting where improvements have been achieved.
Falls Prevention forms part of the trust wide audit plan and audits will be facilitated by the Clinical Effectiveness Team.

14.2 **Falls data relating to Staff and Others**

The Corporate Governance team will monitor incident reporting and provide a report relating to Slips, Trips and Falls to the Health, Safety and Security Management Group. Where deficiencies are identified action plans will be developed and implemented. The Health, Safety and Security Management Group will provide a quarterly progress report to the Regulation Governance Group using the Governance Group reporting template. Areas of concern and risk issues will be escalated to the Regulation Governance Group.

14.3 **Methodology to be used for monitoring**

- internal audits- Clinical audit standards are attached –Appendix 9
- compliance with national guidelines
- complaints monitoring
- untoward events reporting

14.4 **Frequency of monitoring**

- quarterly Slips, Trips and Falls reports to the Clinical Governance Group
- quarterly reports to the Health, Safety and Security Management Group

14.5 **Process for reviewing results and ensuring improvements in performance occur.**

Audit results will be presented to the Falls Best Practice Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

Actions will be included in the overarching falls action plan, monitored through the Falls Best Practice Group

Lessons learnt will be included in the Quarterly Reports to the Clinical Governance Group with feedback at relevant Best Practice Groups

A briefing of the audit will be provided to staff to raise awareness through the Somerset Partnership Improving Clinical Effectiveness (SPICE) newsletter with a hyperlink to the Audit Report.

15. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

15.1 The standards and outcomes which inform this procedural document, are as follows:

Section	Outcome	
Information and involvement	1	Respecting and involving people who use services
	2	Consent to care and treatment
Personalised care, treatment and support	4	Care and welfare of people who use services
	6	Cooperating with other providers
Safeguarding and safety	10	Safety and suitability of premises
	11	Safety, availability and suitability of equipment
Suitability of staffing	12	Requirements relating to workers
	14	Supporting workers
Quality and management	15	Statement of purpose
	16	Assessing and monitoring the quality of service provision
	17	Complaints

	20	Notification of other incidents
	21	Records
Suitability of management	28	Notifications – notice of changes

Relevant National Requirements

Department of Health (2001) National Service Framework for Older People. Details of Standard 6 are available www.dh.gov.uk/

National Institute for Clinical Excellence. (2004) CG21 Falls. The Assessment and Prevention of Falls in Older People Clinical Guideline. Available at: www.nice.org.uk/

National Institute for Clinical Excellence (2004) CG21 Falls: The Assessment and Prevention of Falls in Older People – Quick Reference Guide. Available at: www.nice.org.uk/

NHSLA Risk Management Standards 2012-2013 for NHS Trusts providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS Providers of NHS Care

16. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

16.1 References

The Royal College of Physicians (RCP) National Audits of Falls and Bone Health (2007 and 2010)

National Patient Safety Agency The third report from the Patient Safety Observatory: Slips, trips and falls in hospital (2007)

National Patient Safety Agency) Slips, trips and falls data. For acute and community hospitals and mental health units in England and Wales - Putting patients First. June 2010.

Patient Safety Observatory “Slips, trips and falls in hospital” (2007)

National Patient Safety Agency safer practice notice: Using bedrails safely and effectively (2007).

Health & Safety Commission (2000) Revitalising Health and Safety HSC

Health & Safety Executive (2006) Reducing Slip and Trip Accidents in the Health Services SIM 7/2006/06

Health & Safety Executive (2003) Preventing Slips and Trips at Work HSE. Available at www.hse.gov.uk

NHS Operating Framework for the NHS in England 2012/13 (DOH)

NHS Outcomes Framework 2012/13, particularly Domain 4 - Ensuring that people have a positive experience of care and Domain 5 - Treating and caring for people in a safe environment; and protecting them from avoidable harm

The Royal College of Physicians (RCP) National Audits of Falls and Bone Health (2007 and 2010)

NPSA/2011/RRR001 Essential Care after an Inpatient Fall (2011)

The National Service Framework for Older People (2001),

NICE guidelines CG 21 Falls (2004) ,

The National Patient Safety Agency (NPSA) report of slips, trips and falls in hospital (2007)

The National Patient Safety Agency “The How to Guide for Reducing Harm from Falls” (2009)

The National Patient Safety Agency “The How to Guide for Reducing Harm from Falls in Mental Health Inpatient Settings”

NICE Guidelines CG103 Delirium (2010)

16.2 **Cross reference to other procedural documents**

Admission, Transfer and Discharge Policy

Claims Handling Policy and Procedure

Cleaning of Equipment and Decontamination Policy

Clinical Assessment & Management of Risk of Harm to Self and Others

Consent to Examination or Treatment Policy

Counter Fraud Policy

Dress Code Policy

Health and Safety Policy

Learning Development and Mandatory Training Policy

Medical Devices Policy

Medicines Policy

PALS and Complaints Policy

Physical Assessment and Examination of Service Users Guidance

Physiological Observations Policy

RCPA Policy

Risk Management Policy and Procedure

Serious Incidents Requiring Investigation Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

Training Prospectus

Untoward Events Reporting Policy

All current Trust Policies and Procedures are accessible to all staff on the home page of the Intranet, click Policies and Procedures. Guidance can be found on the homepage of the Trust Intranet by clicking Information, then Local Guidance.

17. APPENDICES

17.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix 1	Guidelines for the use of Bedrails, including risk assessment
Appendix 2	RiO Falls Risk Assessment (Mental Health)
Appendix 3	Inpatient Falls risk assessment for Community Health
Appendix 4	Inpatient Preventing Falls Factsheet
Appendix 5	Intentional Rounding Tool (Mental Health)
Appendix 6	Protocol for Essential Care following an Inpatient Fall
Appendix 7	4W's template
Appendix 8	Falls Risk Assessment Tool – FRAT
Appendix 9	Clinical Audit Standards
Appendix 10	Action to Manage Slips and Trips at Work

APPENDIX 1

GUIDELINES FOR THE USE OF BED RAILS INCLUDING RISK ASSESSMENT

1 INTRODUCTION

1.1 Somerset Partnership NHS Foundation Trust (hereafter referred to as the Trust) aims to take all reasonable steps to ensure the safety and independence of its patients and respects the rights of patients to make decisions about their care within the limits of their capacity.

1.2 Patients in hospital may be at risk of falling from bed for many reasons including poor mobility, dementia or delirium, visual impairment and the effects of their treatment or medication.

1.3 These guidelines provides additional information regarding the risks of bedrail use in relation to falls risk management, and forms part of the Slips, Trips and Falls (prevention and management) Policy.

1.4 The only appropriate use of bedrails is to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed

1.5 Bedrails will not prevent a patient leaving their bed and falling elsewhere and should not be used for this purpose. Bedrails are not intended as a moving and handling aid.

1.6 The use of bedrails is not appropriate for all patients. For patients who can mobilise without help from staff, bedrails would create a barrier to independence. They may create a greater risk of falls and injury for patients who are both confused enough and mobile enough to climb over them

1.7 This guidance has been produced to ensure compliance with the National Patient Safety Agency Safer Practice Notice – Using bedrails safely and effectively (2007).

2. PURPOSE

2.1 The purpose of these guidelines is to reduce harm to patients caused by falling from beds or becoming trapped in bedrails.

2.2 To support staff to make informed clinical decisions around the risks of using or not using bedrails in order to reduce harm.

2.3 To enable patients, and their families where appropriate, to be active partners in decisions about their care in hospital

3. SCOPE

3.1 This protocol applies to all persons working for the Trust to include bank/agency/personnel and work experience/volunteer workers, Social Care Staff and students

4. RESPONSIBILITY FOR DECISION MAKING

4.1 Decisions about the use of bedrails need to made in the same way as decisions about other aspects of treatment and care as outlined in the Trust's Consent to Examination or Treatment Policy. This means:

- The patient should decide whether or not to have bedrails if they have capacity. Capacity is the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to the patient.

4.2 If the patient lacks capacity, staff have a duty of care and must decide if bedrails are in the patient's best interest. Discussions with the patient's relatives/carers should also take place, however, relatives or carers can **not** make decisions for adult patients (except in certain circumstances where they hold a Lasting Power of Attorney, extending to healthcare decisions under the Mental Capacity Act 2005).

4.3 The Trust does not require written consent for bedrail use, but discussions and decisions should be documented by staff in the patient's notes and on the bedrail risk assessment form.

5. INDIVIDUAL PATIENT ASSESSMENT

5.1 An inpatient bedrail assessment (Appendix 6A) **must** be undertaken if the use of bedrails is considered for an individual patient. This is to be used in conjunction with the professional judgement of clinical staff to consider the risks and benefits.

5.2 If the patients medical condition is likely to be variable, the use of bedrails should be monitored daily and the outcome documented in the patient record.

5.3 The use of bedrails should also be documented on the patient's care plan, updated as necessary and evaluated within the patient's notes.

5.4 The use of bumper covers should also be documented if used.

6. USING BEDRAILS

6.1 The NHS Trust will take steps to comply with MHRA advice through ensuring that all unsafe bedrails (e.g. two-bar bedrails, bedrails with internal spaces exceeding 120mm, bedrails not in matched pairs and bedrails in poor condition or with missing parts) are removed or destroyed.

6.3 All community bedrails or beds with integral rails have an asset identification number and are regularly maintained.

7. REDUCING RISKS

7.1 Any patient with a high risk of falls having regular intentional rounding, safety/ comfort rounds should have the bedrail checked as an integral part of this.

7.2 When bedrails are in place, it is the responsibility of the staff member raising them to ensure that they are functioning correctly.

8. TRAINING

8.1 The Trust will ensure that:

- All staff who make decisions about bedrail use, or advise patients on bedrail use, and supply and fit bedrails have the appropriate knowledge to do so.

- All staff caring for patients at risk of falling should develop and maintain basic professional competence in falls assessment and prevention

9. SUPPLY, CLEANING, PURCHASE AND MAINTENANCE

9.1 The Trust aims to ensure that bedrails, bedrail covers and special bedrails can be made available for all patients assessed as needing them.

9.2 For routine decontamination, please refer to the 'Cleaning of Equipment and Decontamination Policy'.

9.3 Bedrail maintenance is the responsibility of the Estates Department.

10. REPORTING INCIDENTS

10.1 Any incident/near miss involving a bedrail should be reported using DATIX.

11. MONITORING

11.1 Compliance with the completion of Bedrail Audits will be included in the Falls audit programme. See also monitoring section of the Slips, Trips and Fall Policy.

Somerset Partnership NHS
NHS Foundation Trust

BEDRAILS ASSESSMENT

Patients Name: ……..…… DoB……..…… NHS No.....		Mobility		
		Patient is very immobile (bedfast- or hoist-dependent)	**Patient is neither independent nor immobile**	**Patient can mobilise without help from staff**
Mental state	**Patient is confused and disorientated**	Use bedrails with care	Bedrails **not** recommended	Bedrails **not** recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails **not** recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails **not** recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A

Use the risk matrix above in combination with nursing judgment, remembering:

- Patients with capacity can make their own decisions about bedrail use.
- Patients with visual impairment may be more vulnerable to falling from bed.
- Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers

Date	Time	Bedrails recommended (circle)	Comment if necessary	Sign	Print Name
		Yes No With Care			
		Yes No With Care			
		Yes No With Care			
		Yes No With Care			
		Yes No With Care			
		Yes No With Care			

Ensure you know how to fit bedrails correctly, including assessing any potential entrapment gaps

- **Use the risk matrix with professional judgement**
- **Ensure assessment decision is known by all multidisciplinary team members**
- **Refer to full bedrails guidelines or seek advice if in doubt**

(Taken from the National Patient Safety Agency's safer practice notice 'Using bedrails safely and effectively')

Somerset Partnership NHS Foundation Trust

RIO FALLS RISK ASSESSMENT (Mental Health only)

Use this assessment on admission, at each review/w…

Mobility	- None -
Sensory deficit	- None -
Falls history	- None -

Medication, *check all that apply*

Hypnotics	☐
Tranquilizers	☐
Hypotensives	☐
Diabetes	☐
Confusion/agitation	☐
Seizures	☐
Incontinence	☐
Inability to cooperate	☐
Hypotension	☐
Total score	0

Scoring
3 - 8 = Low risk
9 – 12 = High risk, make an entry in Care Plan,
13+ = Very high risk, make an entry in Care Plan and add an Alert

Click here to go to Care Planning. If score is greater than 9 use Care Plan Library, type 'Falls' in the search box. Amend the problem/need text to suit the client and select interventions that are appropriate, amending text as needed.

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST **APPENDIX 3**

COMMUNITY HOSPITAL INPATIENT FALLS RISK ASSESSMENT

Patient Details	**Community Hospital**	**Ward**
	Date of admission	
Risk Assessment form number 1 2 3 4 5 6 (please circle) **(Review Weekly or Following a Fall)**		

		Date of assessment	**Completed by**	**Date of assessment**	**Completed by**	**Date of assessment**	**Completed by**
Has the patient fallen recently?		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Details of fall(s) – When, where, how?							
UNIVERSAL PRECAUTIONS (every patient, every time)							
1	**Medication review needed?** e.g. anti-depressants, Hypnotics, anti-hypertensive opiate analgesia, diuretics, anti-psychotics, laxatives	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
		Outcome		**Outcome**		**Outcome**	
2	**Footwear is suitable?** Check for secure fit, non-slip sole, no trailing laces. Ask relatives for safer replacement if necessary. If patients are wearing socks in bed, risk assess and agree action	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
		Action taken		**Action taken**		**Action taken**	
3	**Call bell is within reach and the patient knows how to use it?** Consider alternatives where patients unable to recall use of call bell e.g. brass bell, move bed in sight of nurses' station	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
		Action taken		**Action taken**		**Action taken**	
4	**Education** Provide Falls Factsheet to patient/ family -discuss risks Orientate patient on ward	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**

FALLS RISK FACTORS						
A fall was the reason for Admission?	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
The patient is known to be a frequent faller?	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
The patient has fallen since admission?	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Patient has expressed a fear of falling?	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
There are other significant risk factors from the MDAR e.g. medical status, neurological / cardiac conditions	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
If answer is **YES** to any question, **complete Falls Care Action Plan overleaf**						

FALLS CARE ACTION PLAN

Review risk factors below and update weekly or following a fall (Use √ or N/A**)**	**Date**	**Signature**	**Date**	**Signature**	**Date**	**Signature**
If patient is at risk of falling IMPLEMENT INTENTIONAL ROUNDING - state frequency						
Fall alert symbol is in use						
Patient is confused/agitated /non-compliant Delirium assessment, involve family /carers in care plan, Avoid moves within ward						
Urinalysis. On admission and if pt deteriorates Send MSU if positive to blood, nitrates or protein						
Blood Pressure/ Cardiac symptoms Check lying and sitting BP and record Advise pt re slow movement lying to standing Request medical review						
Multidisciplinary Team involved in assessment Ensure everyone is aware of level of risk, frequency, nature, seriousness of falls and **actions to be implemented**.						
Communication Ensure patient is able to make needs known -Teach use of call bell or alternative						
Hearing Check availability/use of hearing aid if worn Alternative method of communication if required						
Gait/Mobility/balance – physiotherapist involved Patient needs **supervision** to mobilise safely Use walking aids appropriately						
Eyesight, Check eyesight - pen test Ensure glasses are worn/ clean/ within reach.						
Bed and bedrails Assess need Ensure team know Set bed to suitable height for patient Consider use of special low bed						
Location on ward Close to nurses' station – high visibility bed Close to toilet Quietest area (consider other patients' needs)						
Toilet Falls risk linked to patient's need to use toilet? If high risk, supervision is required						
Continence Implement bowel & bladder programmes – link to intentional rounding						
Lighting Bedside lamp to be left on , Night light in toilet, Other - specify						
Environmental Hazards Free of clutter. Water etc. in reach, Inform patient of any hazards e.g. toilet doors						
Fall prevention equipment Assess/use TABs monitor / pressure pad/ crash mat etc.						
Education / Information Engage patient /family in Falls Care Action Plan						
Any other actions – specify						

FACT SHEET – Community Hospital

Somerset Partnership NHS
NHS Foundation Trust

Preventing falls in hospitals

Information for patients

Name .....

When you are in hospital you may be at increased risk of falling for a variety of reasons, including

- being in unfamiliar surroundings
- weakness and poor balance due to your illness
- being less active or mobile than usual
- because of changes in your medication

Unfortunately, it is not always possible to prevent every fall but there are a number of things that can help. We want to work in partnership with you and your family/carers to reduce the risk of falling

Things that you can do to prevent falls

- familiarise yourself with the ward layout and location of toilets so that you know where to go
- take extra care when you stand up. If you feel unsteady, please sit down and call for someone to help you
- If you are not sure how to use the nurse call bell, ask someone to show you
- keep your walking stick or other walking aid within easy reach
- take your time when moving around
- try to anticipate your need for help (for example, going to the toilet) and ring for assistance - don't wait until you are desperate
- wear shoes or slippers that fit properly. You will be safer and feel more confident on your feet
- wear your glasses. Ask a relative or friend to bring them in if you have left them at home
- wear comfortable clothes that are not too loose. Gentlemen should use a belt or braces if necessary. Ladies should avoid long nightdresses
- don't walk where hazard signs indicate wet floors and alert staff to any spills
- share this information with your family or carers so they can support you in staying safe

Somerset Partnership Adult Services

APPENDIX 5

General Observation Form – Level One – General Observations Form

**** NURSE IN CHARGE TO BE INFORMED IMMEDIATELY IF A PATIENT CANNOT BE ACCOUNTED FOR.** PLEASE ENTER CODE TO INDICATE WHERE PATIENT IS WHEN CHECKS ARE CARRIED OUT**

ROOM NO.	PATIENT'S NAME	FALL RISK	PRESSURE DAMAGE RISK	07 30	08 30	09 30	10 30	11 30	12 30	13 30	14 30	15 30	16 30	17 30	18 30	19 30	20 30	21 30	22 30	23 30	30 30	01 30	02 30	03 30	04 30	15 30	06 30
1																											
2																											
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23																										
24																										
	Nurse's initials																									

L **– open lounge**	B **- bathroom**	BA **– bedroom awake**	OT **– groups/ADL**	O **- out**	D **– dining room**
I **– interview room**	BS **– bedroom asleep**	C **– corridor**	AW **- AWOL**	FL **– female only lounge**	M **– meeting room**
S **– shower room**	A **– activity room**	G **- garden**	OL **– on leave**	C **– comfort check**	PAC **– pressure area care (skin bundle)**

One incoming and outgoing member must do checks together at handover times

07.30hrs handover Incoming staff ……. Outgoing staff ……..

13.30hrs handover Incoming staff ……. Outgoing staff ……..

20.45hrs handover Incoming staff ……. Outgoing staff ……..

Comfort check – to be completed where fall risk if 9+

check pain, thirst, call bell available, need the toilet

Pressure area care - where Waterlow score is 10+

S surface (eg mattress, cushion)

K keep moving (reposition if necessary)

I incontinence

N nutrition (offer drink, snack)

Somerset Partnership NHS
NHS Foundation Trust

Appendix 6

PROTOCOL FOR ESSENTIAL CARE AFTER AN INPATIENT FALL

To be read in conjunction with the Slips, Trips and Falls (Prevention & Management) Policy Moving and Handling Policy; the Physiological Observations Policy and the Pain Assessment Tool

Version:	2
Ratified by:	Senior Managers Business Group
Date ratified:	November 2012
Title of originator/author:	Falls and Bone Health Co-ordinator
Title of responsible committee/group:	Director of Community Health Services
Date issued:	**November 2012**
Review date:	**October 2012**
Relevant staff groups:	All Somerset Partnership NHS Foundation Trust clinical staff working in inpatient settings All visiting clinical staff in ward settings

This document is available in other formats, including easy read summary versions and other languages upon request. Should you require this please contact the Equality and Diversity Lead on 01278 432000

DOCUMENT CONTROL

Reference Number SO/Nov12/ECAIFP	**Version** 2	**Status** Final	**Author** Falls and Bone Health Coordinator
Amendments	This document is based on existing Guidelines first issued in September 2008. Amendment to Flow chart following feedback from Mental Health Directorate		
Document objectives: This protocol details standards for physical assessment and safe management of service users on inpatient wards following a fall, in order to achieve compliance with NPSA/2011/RRR001, Essential Care after an Inpatient Fall.			
Intended recipients: Clinical staff on inpatient units			
Committee/Group Consulted: Clinical Policy Group, Clinical Governance Group			
Monitoring arrangements and indicators: Include quarterly Falls Reports to Clinical Governance Group, Monitoring and review of Falls incidents on DATIX Annual internal clinical Audit			
Training/resource implications: Training requirements include specialist falls prevention training as identified in the Falls Prevention Policy and NICE CG21 Falls. Safe handling following a fall is now included in mandatory Moving and Handling training			
Approving body and date	Clinical Governance Group	Date: May 2012 Date: October 2012	
Formal Impact Assessment	Impact Part 1	Date: October 2012	
Clinical Audit Standards	Yes	Date: November 2012	
Ratification Body and date	Senior Managers Business Group	Date: June 2012 Date: November 2012	
Date of issue	**November 2012**		
Review date	**October 2015**		
Contact for review	Falls and Bone health Coordinator		
Lead Director	Director of Community Health Services and Mental Health		

CONTRIBUTION LIST Key individuals involved in developing the document

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All group members	Clinical Working Group
All group members	Clinical Governance Group (formerly SQUID)
Judith Brown	Director of Community Health Services
Diana Rowe	Director of Mental Health and Social Care

CONTENTS

1. INTRODUCTION

1.1 When a serious injury occurs as a result of an inpatient fall, safe manual handling, prompt assessment and treatment is critical to the patient's chances of making a full recovery.

1.2 A rapid response report by the National Patient Safety Agency aims to ensure that local protocols and systems help staff to consistently achieve this.

1.3 National Reporting and Learning System (NRLS) data from across England and Wales indicate that approximately 208,000 falls are reported in acute hospitals every year, with over 36,000 reported from mental health wards and 38,000 from community hospitals. A significant number of these falls result in death, severe or moderate injury, including around 840 fractured hips, 550 other types of fracture, and 30 intracranial injuries. Even for the less serious falls the human cost of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers and hospital staff.

1.4 This protocol details the recommendations in NPSA/2011/RRR001, Essential Care after an Inpatient fall.

2. PURPOSE & SCOPE

2.1 Somerset Partnership NHS Foundation Trust will ensure that appropriate guidance is provided to enable clinical staff working with inpatients in community hospitals and mental health inpatient wards to recognise the signs and symptoms of fracture or potential for spinal injury

2.2 This protocol applies to all clinical staff working with inpatients in Community Hospitals and Mental Health Wards, including Temporary, Locum, Bank, Agency and Contracted staff

2.3 The purpose of the Protocol is to consistently achieve compliance with the recommendations in the Rapid Response Report, NPSA/2011/RRR001

3. DUTIES AND RESPONSIBLITIES

3.1 Duties in respect of the requirements of this document are as follows

- The **Trust Board** has overall responsibility for procedural documents and delegates responsibility as appropriate
- The **Lead Director** is the Director of Community Services
- The **Identified Lead (Author)** is the Falls and Bone Health Coordinator, who will be responsible for producing written drafts of the document and for consulting with others and amending the draft as appropriate.
- **Service Managers/Heads of Service** Responsibility for implementing the guidance is devolved to Clinical Directors and Heads of Service.

- The **Head of Corporate Governance** has responsibility for holding the central database of procedural documents including this guidance and for providing review reminders. The team also has responsibility for dissemination of the final document and archiving old versions.

- **All Medical and inpatient clinical staff** including temporary staff are individually responsible for their actions including complying with these guidelines.

- **Consultation and Communication with Stakeholders.** The process for consultation and communication with stakeholders is summarised in the Document control front sheet and the Contribution list.

- **Approval of the Guidelines.** This document is approved by the Clinical Governance Group and ratified by the Senior Managers Business Meeting

4. EXPLANATIONS OF TERMS USED

Any definitions of terms required are included in the text of the guidelines and are not separately stated here

5 GUIDELINES

5.1 Background

- The causes of falls are complex. Hospital patients are particularly vulnerable to falling due to medical conditions including delirium, cardiac, neurological or muscular-skeletal conditions, side effects from their medication, or problems with their balance, strength or mobility.

- Problems like poor eyesight or poor memory can create an even greater risk of falls when someone is out of their normal environment on a hospital ward, as they are less able to spot and avoid any hazards. Continence problems can mean patients are vulnerable to falling while making urgent journeys to the toilet.

- In hospital settings falls can also be an ominous ‘red flag’ symptom indicating the patient’s underlying medical condition may have deteriorated, and may merit urgent medical review regardless of injury.

- Prevention of falls is an important patient safety challenge for healthcare settings. What happens after a fall is as important as detecting and treating injury from the fall itself in order to reduce the degree of harm caused to the patient. This is particularly critical for injuries such as subdural haematoma that may progress to irreversible brain damage if not detected early and fractured hip, where minimising the time elapsed between fracture and surgery is vital to reducing mortality and disability.

5.2 Practice Objectives/Standards

Community Hospitals and Mental Health Wards with inpatient beds should ensure that:

5.2.1 Checks by clinical/nursing staff for signs or symptoms of fracture or potential for spinal injury are undertaken following a fall before the patient is moved

5.2.2 Safe manual handling methods are used for patients with signs or symptoms of fracture or potential for spinal injury*

5.2.3 Frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (e.g. unwitnessed falls) are based on National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 56: Head Injury – see Appendix 6A.

5.2.4 Timescales for medical examination following a fall to include fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised. Time to assessment will be determined by availability of medical staff i.e. OOH doctors, GP's or hospital doctors and if the delay is deemed too long in relation to the patients assessed condition then urgent advice should be sought via 999 system.

5.2.5 The post-fall protocol is easily accessible by all clinical staff and the 'Flowchart for Actions following a Fall' (Appendix 6A) is available in laminated versions at nursing stations

5.2.6 The staff have access to clear guidance and formats for recording neurological observations using a 15 point version of the Glasgow Coma Scale (GCS) and are trained and competent to use them. Also ensuring that changes in the GCS and Patient at Risk (PAR) scoring that should trigger urgent medical review are highlighted

5.2.7 The staff have access at all times to special equipment (e.g. hard collars, flat-lifting equipment, scoops)* and colleagues with the expertise to use it, for patients with suspected fracture or potential for spinal injury - *Community hospitals and mental health wards without the equipment or expertise will to achieve this in collaboration with the ambulance services

5.2.8 Systems are in place allowing inpatients injured in a fall access to investigation and specialist treatment* that is equal in speed and quality to that provided in emergency departments and conforms to NICE Clinical Guideline 56: Head Injury

5.3 Recognising Signs and Symptoms of Fracture

Signs and symptoms of common fractures following a fall:

5.3.1 Hip Fracture

- The patient with a hip fracture will usually have pain over the outer upper thigh or in the groin. There will be significant discomfort with any attempt to flex or rotate the hip.
- If the bone has been weakened by disease (such as a stress injury or cancer), the patient may notice aching in the groin or thigh area for a period of time before the break.
- If the bone is completely broken, the leg may appear to be shorter than the non-injured leg.
- The patient will often hold the injured leg in a still position with the foot and knee turned outward (external rotation).

5.3.2 **Fractured Humerus / Elbow**

Symptoms include:

- Pain (primary suspicion will be pain and decrease in function) that worsens with movement, or inability to move the arm, with signs of bruising and swelling.

- The shoulder may be painful and stiff and the patient may complain of numbness and tingling in the arm and hand of the affected side.
- Deformity and or bone tenderness may be present at the shoulder, upper arm or elbow.
- Abnormal capillary refill may indicate poor circulation as a result of arterial involvement.

5.3.3 **Fractured Wrist**

- Pain, deformity, swelling and loss/decrease function are the primary indicators of possible wrist fracture.
- The two common forms of wrist fracture are Scaphoid and Colles fractures. Scaphoid fracture is often difficult to diagnose until the fracture starts to heal and can then be seen on x-ray. The signs are pain in the 'anatomical snuff box'. A Colles fracture causes a "dinner fork" deformity, wrist swelling and an inability to use the wrist and hand.
- The patient may hold the affected wrist towards their body in an effort to protect it. Diagnosis is confirmed by an x-ray.

5.3.4 **Fractured Pelvis**

- In elderly people the most common cause of a fractured pelvis is a fall from a standing position.
- Any history of significant blunt trauma, such as a fall, should raise the consideration of a pelvic fracture.
- Tenderness, bruising, swelling and crepitus of pubis, iliac bones, hips and sacrum are indications of fracture.
- No attempt should be made to assess stability of the pelvis as this is unreliable and may cause additional haemorrhage or injury.
- A thorough assessment for associated wounds and other injuries is essential. Others significant signs of pelvic fracture include haematuria and rectal bleeding.

5.3.5 **Head and neck injury**

- A common site of injury, that usually results in obvious external evidence of trauma, i.e. wounds, bruising and/or soft tissue swelling and may, or may not, result in a decreased level of consciousness at time of injury.
- Any decrease in level of consciousness, and / or associated neck pain warrants referral for formal emergency care evaluation.
- All patients who are anti-coagulated with an associated blunt head injury should be managed in line with NICE guidance.

5,4 Safe Manual Handling

5.4.1 Following a fall a careful and thorough clinical examination should be undertaken before any attempt is made to move the patient. If obvious signs of fractures or neck/ head injury are present, **DO NOT MOVE THE PATIENT and call for further support** (see appendix 6A)

5.4.2 Appropriate manual handling techniques must be adopted at all times and if there is any cause for concern then staff must call a medical clinician for a more thorough assessment.

5.4.3 In some circumstances patients with an undisplaced fracture will not display any signs or symptoms of that fracture, especially fractures of the hip. Moving these patients inappropriately may cause the fracture to displace, resulting in further injury and an increased level of harm. In some circumstances this could be fatal.

5.5 Physiological and Neurological Observations

5.5.1 Observations and pain assessment must be commenced immediately following the flow chart at Appendix 6A and the post fall checklist (appendix 6B) which includes all actions that must be followed.

5.5.2 Patients who are subsequently ambulant after a fall to be closely observed by ward staff and any subsequent extremity pain evaluated by appropriate clinician (ENP, medical practitioner, ECP)

5.6 Infection Control

5.6.1 Although a patient fall is always managed as a high priority and may constitute an emergency situation, infection control procedures should be followed and hands should always be decontaminated prior to instigating assistance.

6 TRAINING REQUIREMENTS

6.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff MandatoryTraining Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

6.2 Moving and handling training has been updated to take account of this guidance and to provide information regarding the actions to be taken following a fall. The updated training is available through the mandatory training process and Falls training road shows and workshops, delivered at all community hospital sites to ensure staff have the additional knowledge.

6.3 Physiological observations training is supported by the clinical practice team.

6.4 ALERT training, to recognise the deteriorating patient, has been commissioned for all community hospitals.

6.5 Falls risk assessment training is now included in the mandatory training matrix for nurses and allied health professionals. The Falls and Bone Health Coordinator provides regular, locally based falls training and ward based

registered clinical staff should undertake the national e-learning module Fallsafe Preventing Falls in Hospital

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Document Lead (author) who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 Compliance and effectiveness

This protocol will be ratified at the Clinical Governance Group. It will be reviewed every three years or sooner if guidance changes.

Routine monitoring of DATIX incidents will be undertaken by the Falls and Bone Health Coordinator and areas of concern reported locally and at the Falls Best Practice Group

Overall monitoring will be by the Falls Best Practice Group with lessons learned included in the quarterly report

8.2 Responsibilities for conducting the monitoring

Matrons/Local teams will be responsible for monitoring falls occurring in their clinical area, overseen by the Falls Best Practice Group

8.3 Methodology to be used for monitoring

- Internal audits
- Incident reporting and monitoring
- Clinical effectiveness monitoring

8.4 Frequency of monitoring

- Quarterly reports to the Clinical Governance Group

8.5 Process for reviewing results and ensuring improvements in performance occur.

Audit results will be presented to the Falls Best Practice Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

Lessons learnt will be included in the Falls Quarterly Report. The report will be forwarded to the Head of Clinical Effectiveness to be made accessible to all staff on the Trust Intranet and hyperlinked into SPICE newsletter to raise awareness.

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

The standards and outcomes which inform this procedural document, are as follows:

Section	Outcome	
Information and involvement	1	Respecting and involving people who use services
	2	Consent to care and treatment
Personalised care, treatment and support	4	Care and welfare of people who use services
	6	Cooperating with other providers
Safeguarding and safety	7	Safeguarding people who use services from abuse
	10	Safety and suitability of premises
	11	Safety, availability and suitability of equipment
Suitability of staffing	12	Requirements relating to workers
	13	Staffing
	14	Supporting workers
Quality and management	15	Statement of purpose
	16	Assessing and monitoring the quality of service provision
	20	Notification of other incidents
	21	Records

Relevant National Requirements

- See references, below

11. REFERENCES

11.1 References

National Patient Safety Agency, *Rapid Response Report - Essential Care after an Inpatient fall. (NPSA/2011/RRR001)* January 2011

National Institute for Health and Clinical Excellence, NICE Clinical Guideline 56 Head Injury, September 2007

TeasdaleG, Jennet B*: Assessment of coma and Impaired consciousness. A Practical Scale.* Lancet 2:81-84 1974

Morgan, R.J.M.,F. Williams et al (1997). *"An early warning system for detecting developing critical illness*." Clinical Intensive Care. 8(2):1

11.2 Cross reference to other procedural documents

Development & Management of Procedural Documents

Learning Development and Mandatory Training Policy

Moving and Handling Policy

Risk Management Policy and Procedure

Slips, Trips and Falls Prevention and Management Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

The Pain Assessment Tool

The Physiological Observations Policy

Training Prospectus

Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible to all staff on the Trust intranet (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet (on the home page, click on Information, then Local Guidance).

12. APPENDICES

12.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

- Appendix 6A – Flow Chart for Actions after an Inpatient Fall
- Appendix 6B – Post Fall Checklist

FLOW CHART FOR ACTIONS AFTER AN INPATIENT FALL

Patient fall
Witnessed or un-witnessed
DO NOT MOVE PATIENT

Patient conscious

Patient unconscious

Regains consciousness

Undertake a **thorough clinical examination** to check for Injury and select ongoing pathway from options below

Attempt to rouse patient, ABC

Fracture, neck/head injury is obvious or suspected

Fracture not suspected but pt. is injured and/or fall **unwitnessed**

If patient **remains unconscious**

If head injury or unconscious commence neuro obs

- Call onsite medical/MIU support
- If support not available immediately **CALL 999**
- Give pain relief/first aid
- Carry out ABC observations (BP, P, 0_2 Stats, RR, ECG
- PAR Score
- GCS as per neurological observations chart guidelines

Fall was **witnessed** and there are **no** obvious signs of injury

- Reassure patient
- Review/update falls risk assessment
- Request medical advice
- Review/update care plan
- Complete DATIX
- Inform relatives/carers as soon as practical
- Review/reassess if condition changes

- Carry out ABC, Observations (BP, P, 0_2 Sats, RR, ECG, PAR Score, GCS)
- If the fall was unwitnessed or a head injury is suspected, complete neurological observations (as per neuro obs chart guidelines) - Only cease on medical advice
- Give pain relief/first aid
- Call medical Support - OOH GP Service if out of hours and no MIU
- Carry out treatment plan as advised by medical/MIU Team
- Review and update Falls Risk Assessment
- Update Care Plan
- Complete DATIX Incident report
- Inform Relatives/carers of events as soon as practicable

Urgent review of patient by medical staff next day if fall happened during the night

Review by medical team after 24 hours if previously assessed post fall in hours

Note: **ALL FALLS**

Undertake **urgent** review if patient deteriorates - ↓GCS or ↑PAR score

Appendix 6B

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
COMMUNITY HEALTH DIRECTORATE

POST FALL CHECKLIST

Patients Name: ……	**Completed by:** **Name (PRINT)…….**
Date of Birth……	**Signature…….**
NHS No. ……	**Date ……..… Time.....**

If a patient sustains a fall, the following actions MUST be completed

Assess patient for injury ..... ☐

If you are satisfied that no serious injury/fracture has been sustained, assist them back to the chair or bed using the most appropriate method for that situation..... ☐

Complete a set of observations and Patient at Risk (PAR) score ..... ☐

If there is any risk of a head injury, commence neurological observations as below:
Note: only discontinue neurological observations on medical practitioner advice

- ..... ½ hourly for the first 2 hours until GCS 15 - **Note:** if GCS 15 is not met, continue half hourly, only proceed to 1 hourly when GCS 15 is met ..... ☐
- ..... 1 hourly for 4 hours..... ☐
- ..... 2 hourly thereafter ..... ☐

Request a medical review – urgent if patient is injured, or advice only if fall was witnessed and patient has no apparent injury ..... ☐

Be vigilant if a patient is on anticoagulants, particularly in the presence of a head injury ☐

Dress any wounds if required..... ☐

Consider any other measures that could be implemented to prevent a further fall and update the falls risk assessment, action plan and care plan ..... ☐

Complete a 4 W's sticker and document all relevant information in the patient's evaluation record..... ☐

Submit DATIX incident form ..... ☐

Ensure that the patient's fall and **preventative actions to be implemented** are communicated to all other staff on duty and those due to come on shift..... ☐

Inform patient's relatives (with consent) and document in patient record..... ☐

Date:
What? (happened)

DATIX incident number	
Fall number	

When?

Where?

Why?

New action(s) (nursing/therapy)

Signature
Print name

Date:
What? (happened)

DATIX incident number	
Fall number	

When?

Where?

Why?

New action(s) (nursing/therapy)

Signature
Print name

Date:
What? (happened)

DATIX incident number	
Fall number	

When?

Where?

Why?

New action(s) (nursing/therapy)

Signature
Print name

Date:
What? (happened)

DATIX incident number	
Fall number	

When?

Where?

Why?

New action(s) (nursing/therapy)

Signature
Print name

Somerset Partnership NHS
NHS Foundation Trust

ASSESSMENT OF FALLS RISK IN OLDER PEOPLE (FALLS RISK ASSESSMENT TOOL – FRAT)

Multi-professional guidance for use by the primary health care team, Hospital staff, care home staff and social care workers.

This guidance has been derived from longitudinal studies of factors predicting falls in older people and randomised controlled trials that have shown a reduction in the risk of falling. (adapted for local use but originally designed by Queen Mary College, University of London).

Definition Fall – An event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness (NICE 2004).

Notes for Users:

1. Complete assessment form on the next page. The more positive factors, the higher risk for falling.

2. If there is a **positive response to three or more of the questions on the form, then please see over** for guidance for further assessment, referral options and interventions for certain risk factors.

3. Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.

4. Consider which referral would be most appropriate given the patient's needs and local resources.

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NHS Foundation Trust

ASSESSMENT OF FALLS RISK IN OLDER PEOPLE
FALLS RISK ASSESSMENT TOOL – (FRAT)

Name_____ Date of Birth _____

Address_____ Tel No_____

_____ NHS no or equivalent_____

		YES	NO
1	Is there a history of any fall in the previous year? **How assessed?** Ask the person		
2	Is the patient/client on four or more medications per day? **How assessed?** Identify number of prescribed medications.		
3	Does the patient/client have a diagnosis of stroke or Parkinson's Disease? **How assessed?** Ask the person.		
4	Does the patient/client report any problems with his/her balance? **How assessed?** Ask the person.		
5	Is the patient/client **unable** to rise from a chair of knee height? **How assessed?** Ask the person to stand up from a chair of knee height without using their arms.		

Referred to the Adult Rehabilitation Service (Falls Service) Yes/No (please circle)

Date of Referral

Send to: Falls single Point Of Access, Rehabilitation Department, West Mendip Hospital, Old Wells Road, Glastonbury. BA6 8JD. **Fax: 01458 836468, or e mail:** somersetrehabfallsreferrals@sompar.nhs.uk

Please add further comments

Name of Referrer_____ **Title** _____

Signature_____ **Contact** _____

Service Provided_____

SUGGESTIONS FOR FURTHER ASSESSMENT, REFERRAL OPTIONS AND INTERVENTIONS

Assessment by health professional – please complete as much information as you are able

Risk factor present	Further assessment	Interventions	Action Taken/ Comments
1. History of falling in the previous year	• Review incident(s), identifying precipitating factors	• Discuss fear of falling and realistic preventative measures	
2. Four or more medications per day	• Identify types of medication prescribed • Ask about symptoms of dizziness	• Review medications, particularly sleeping tablets (see Discuss changes in sleep patterns normal with ageing, and sleep promoting behavioural techniques	
3. Balance and gait problems	• Can they talk while walking? (1) • Do they sway significantly on standing? (2) • Do basic balance test such as Timed Up and Go test	• Teach about risk. And how to manoeuvre safely, effectively and efficiently. • Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises. • Transfer exercises. • Evaluate for assistive devices. • Consider environmental modifications (a) to compensate for disability and to maximise safety, (b) so that daily activities do not require stooping or reaching overhead.	
4. Postural hypotension (low blood pressure)	Two readings taken 1. After rest five minutes supine 2. 1 minutes later standing Drop in systolic BP ≥ 20mmHg and or drop in diastolic ≥ 10mmgHg or more	• Offer extra pillows or consider raising head off bed if severe. • Review medications • Teach to stabilise self after changing position and before walking. • Avoid dehydration	
5. Fragile Bones	Ask patients questions from the Frax: http://www.shef.ac.uk/FRAX/tool.jsp?country=1	• further information on questions and how to interpret outcomes ofn website	

1. While the patient is walking ask them a question but keep walking while you do so. If the patient stops walking either immediately or as soon as they start to answer, they are at higher risk of falling.

2. The patient stands between the assessor and the examination couch (or something they can safely hold on to). First assess if the person sways significantly (raises arms or compensates foot placement) while standing freely. Then ask the person to take their weight on to one leg and try to lift the other foot off the floor by about an inch (allow a few practice attempts).

Somerset Partnership NHS
NHS Foundation Trust

Appendix 9

SLIPS TRIPS AND FALLS (PREVENTION AND MANAGEMENT) CLINICAL AUDIT STANDARDS

02/11/2012

Service area(s) to which standards apply:

	MH Inpatient (CAMHS)		Community CAMHS	X	CH Specialist Services
X	MH Inpatient (Adult)		C & YP Integrated Therapy	X	MH Specialist Services
X	MH Inpatient (Older)		School Nursing	X	MH Community Adult
X	MH Rehab & Recovery		Health Visitors	X	MH Community Older
X	Community Hospital	X	CH Rehab	X	Learning Disabilities
X		X	Musculo-Skeletal	X	District Nurses

SLIPS TRIPS AND FALLS (PREVENTION AND MANAGEMENT) CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
Inpatients				
1	All patients should have a baseline assessment of their risk of falls carried out on admission *(Policy 3.10)*	100%	None	To be considered and recorded as part of the usual admission assessment process, within 24 hours. Any audit should ascertain time taken, and future review of policy should state timescales.
2	An inpatient falls risk assessment should be completed for all patients admitted to an older persons mental health or a community hospital *(Policy 3.10)*	100%	None	CH: use the Inpatient Falls Risk Assessment MH: use the falls risk assessment tool within the RiO Risk Management section
3	A falls risk assessment should be completed for any other patient admitted to mental health inpatient wards who have been identified at risk of falls *(Policy 3.10/6.2)*	100%	None	Recorded within the falls risk assessment tool within the RiO Risk Management section
4	For those patients who have been identified as being at risk of falls, an individualised care plan/care action plan relating to falls must be completed and implemented *(Policy 6.3)*	100%	None	CH: Falls Care Action Plan within patient's nursing folder MH: RiO care plan, utilising the care plan library
5	The patient should be included in the development of the care plan/action plan and made aware of ways to stay safe. Wherever possible and appropriate, family and carers should also be included. *(Policy 6.4)*	100%	Where there are no carers or family involved Patient choice	Records of discussions held must be recorded in the patients record

SLIPS TRIPS AND FALLS (PREVENTION AND MANAGEMENT) CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
6	Intentional Rounding must be implemented for patients at risk of falling in all inpatient settings *(Policy 6.6)*	100%	None	The interval of the rounds is determined by the level of risk with more frequent rounding for higher risk patients MH use the Intentional Rounding template CH use individual recording processes
7	In the event of an inpatient fall occurring, the flowchart within the Protocol for Essential Care following an Inpatient Fall must be followed, and the post fall checklist completed *(Policy 6.7)*	100%	None	Details of the fall should be documented in the patient record. Community hospitals use the '4W's' sticker
8	A falls risk assessment must be repeated at weekly intervals and following a fall *(Policy 6.8)*	100%	None	All new actions must be documented, implemented and disseminated to the multidisciplinary team
9	All patients in community hospitals and older persons mental health should be given a "Preventing Falls in Hospital" factsheet *(Policy 6.5)*	100%	None	Any factors relating to their particular circumstances should be highlighted Documented in the falls risk assessment (CH) or progress notes (MH)
10	All falls should be reported via the DATIX reporting system. *(Policy 6.11/6.12)*	100%	None	Documented in patients evaluation record (CH) or progress notes (MH) These reports will be used for auditing purposes to monitor the incidence and causes of falls and their contributory factors. Reporting will be utilised from Ward to Board level
Discharge from hospital				

SLIPS TRIPS AND FALLS (PREVENTION AND MANAGEMENT) CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
11	A fall in hospital must be taken into account when planning a patient's discharge home *(Policy 7.1)*	100%	None	Interventions to reduce the risk of falling again must be implemented, to include referral to the community Falls Prevention Programme and/or ongoing support from the Community Rehabilitation Service. A home safety assessment may be needed to identify the need for adaptations and/or equipment to improve safety
Community/Outpatients				
12	For older patients in other clinical services a falls risk assessment tool (FRAT) must be completed for every patient who has been identified as "at risk". *(Policy 6.9)*	100%	None	"At risk" is determined by: CH: older patients being asked if they had fallen in the previous 12 months (included on each service assessment form) MH: recorded and assessed within Risk Screen on RiO This will include MIU's, outpatient clinics, community nursing services, rehabilitation services, Specialist Services, Professional Clinical Services and Mental Health (community) The completed FRAT tool should be sent to the central point of referral for the Falls Service and a copy retained in the patient notes (scanned into RiO)

SLIPS TRIPS AND FALLS (PREVENTION AND MANAGEMENT) CLINICAL AUDIT STANDARDS				
Ref No	**Standard**	**Compliance**	**Exceptions**	**Definitions** *(e.g. any interpretations, directions, or instructions on where/how to find information, **plus** relevant service where applicable)*
13	Upon receipt of the FRAT, the Rehab team will contact the patient regarding future assessment and interventions *(Policy 6.9)*	100%	None	The Falls Service routinely report referrals received to the Falls Best Practice Group.

Appendix 10

Action to manage slips and trips at work

Hazard	Suggested Action
Spillage of wet and dry substances Bodily fluids	Clean up spills immediately Ensuring suitable cleaning agents are used Whenever there is a wet floor after cleaning, use appropriate hazard warning signs to tell people the floor is still wet and arrange alternative routes. Access to materials as appropriate.
Unsuitably trained staff	Ensure appropriate training to carry out the required duty eg knowledge of cleaning processes and chemicals. Staff awareness of Health and Safety related policies and procedures during Corporate and Local Induction.
No Appropriate Risk Assessments	Risk assessments should be completed or reviewed at regular intervals and incidents must be reported and control measures put in place to minimise the risk.
Miscellaneous items stored or discarded in access routes (broken equipment, chairs etc)	Keep area clear; remove rubbish and do not allow area to build up with equipment etc
Slippery surfaces	Assess the cause and treat accordingly, with appropriate measures that could include mats, cleaning methods, new flooring
Poor lighting	Improve lighting levels and placement of light fittings to ensure more even lighting of all floor areas
Changes of level	Improve lighting, consider high visibility tread nosing
Slopes	Improve visibility, provide handrails and use floor markings
Unsuitable footwear	Ensure employees choose suitable footwear (in line with Dress Code Policy) particularly with the correct type of sole for the work undertaken
Training cables	Position equipment to avoid cables crossing pedestrian routes, use cable covers to securely fix to surfaces, restrict access to prevent contact. Consider use of cordless tools. Remember that contactors will also need to be managed.
Rug/Mats	Ensure mats are securely fixed and do not have curling edges.