SLIPS, TRIPS AND FALLS (PREVENTION AND MANAGEMENT) POLICY

This CLINICAL policy includes:

Protocol for Essential Care Following an Inpatient Fall
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
Physiological Observations Policy

<table>
<thead>
<tr>
<th>Version:</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of issue:</td>
<td>November 2018</td>
</tr>
<tr>
<td>This policy replaces all previous patient related falls policies.</td>
<td></td>
</tr>
<tr>
<td>Review date:</td>
<td>October 2019</td>
</tr>
<tr>
<td>Applies to:</td>
<td>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,</td>
</tr>
</tbody>
</table>

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
Amendments
2011 Revised in order to integrate mental health and community services.
2011/12 Updates included for work undertaken through relating to the South West SHA Patient Safety Improvement Programme
2012/13 Updated to reflect new/recent national guidance
Revised to include clinical audit standards and Updated Equality Impact assessment
2015 revision in response to updated national guidance, recommendations from Falls Audit
2014 and restructured to clinical policy only in order to support clinical practice.
2016 Audit Standards updated.
4.4 – April 2017 – Policy transferred to revised Trust Policy template.
4.5 - June 2017 – Inpatient leaflet and pain assessment appendix replaced with hyperlink.
5.1 - October 2018 - Post fall actions wording updated in line with duty of candour.

Approving body  Clinical Governance Group  Date: September 2016
Equality Impact Assessment  Impact Part 1  Date: September 2016
Ratification Body  Senior Management Team  Date: July 2017
Date of issue  July 2017 and November 2018
Review date  October 2019
Contact for review  Falls and Bone Health Coordinator
Lead Director  Director of Nursing and Patient Safety

CONTRIBUTION LIST Key individuals involved in developing the document

Contributor - Designation or Group
Falls Clinical Specialist Occupational Therapist
Falls and Bone Health Coordinator
Head of Division, East Somerset
Falls Best Practice Group
Clinical Governance Group
Clinical Policy Review Group
Senior Nurse Clinical Practice
<table>
<thead>
<tr>
<th>Section</th>
<th>Summary of Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doc</td>
<td>Document Control</td>
</tr>
<tr>
<td>Cont</td>
<td>Contents</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>Purpose and Rationale</td>
</tr>
<tr>
<td>3</td>
<td>Policy Statement</td>
</tr>
<tr>
<td>4</td>
<td>Definitions</td>
</tr>
<tr>
<td>5</td>
<td>Duties and Responsibilities</td>
</tr>
<tr>
<td>6</td>
<td>Assessment and Prevention of Falls in Older People</td>
</tr>
<tr>
<td>7</td>
<td>Management of individuals at risk</td>
</tr>
<tr>
<td>8</td>
<td>Action following a fall</td>
</tr>
<tr>
<td>9</td>
<td>Safeguarding</td>
</tr>
<tr>
<td>10</td>
<td>Monitoring Compliance and Effectiveness</td>
</tr>
<tr>
<td>11</td>
<td>Training and Competency Requirements</td>
</tr>
<tr>
<td>12</td>
<td>References, Acknowledgements and Associated documents</td>
</tr>
<tr>
<td>13</td>
<td>Appendices</td>
</tr>
<tr>
<td>Appendix A</td>
<td>Identification, assessment and management of falls for Inpatients</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Managing Falls for Community based Patients</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Somerset Falls Pathway</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Integrated Inpatient Falls Risk Assessment on RiO</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Guidelines for the use of Bedrails</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Falls Risk Assessment Tool (FRAT)</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Protocol for essential care after an inpatient fall</td>
</tr>
<tr>
<td>Appendix H</td>
<td>Process for learning from incidents</td>
</tr>
<tr>
<td>Appendix I</td>
<td>Rockwood Frailty Assessment Tool</td>
</tr>
<tr>
<td>Appendix J</td>
<td>Somerset Rehab Service Specialist Falls Assessments</td>
</tr>
<tr>
<td>Appendix K</td>
<td>Clinical Audit Standards</td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

1.1 Falls and fall-related injuries are a common and serious problem for older people and the causes of falls are broad and complex.

1.2 The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. (NICE QS86 March 2015)

1.3 In order to reduce the risk of falling and associated harm the individual’s individual risk factors for falling must be identified as soon as possible and appropriate action taken.

2. **PURPOSE AND RATIONALE**

2.1 This document is relevant to all clinical staff, including medical staff, nurses, and allied health professionals *(including Temporary, Locum, Bank, Agency, Contracted staff as appropriate).*

2.2 The purpose of the policy is to inform staff of their roles and responsibilities in relation to assessing, managing and reducing the incidence of falls and fall related injuries wherever possible by implementing a multi-faceted and multi-disciplinary approach.

2.3 It will provide guidance regarding risk assessment and the mitigation of risk and act as a resource for staff caring for individuals at risk of falling.

2.4 It will support a reduction in the incidence of falls and fall related injuries to residents of the Somerset Partnership NHS Foundation Trust where possible.

2.5 It will provide appropriate tools for the assessment and intervention for those people who have been identified as at risk of falling or have fallen.

2.6 It will raise awareness of the impact of falls and promote the falls prevention message.

2.7 It will provide a basis for further development across Somerset Partnership NHS Foundation Trust.

3. **POLICY STATEMENT**

3.1 The risks of falls and harm sustained from a fall remains due to the increasing complexity and frailty of patients.

3.2 Identification of those people at risk of falling, a multi-factorial assessment and an individualised care plan of interventions can reduce the risk of falls and falls with harm.

3.3 Slips, trips and falls incidents will be monitored to ensure learning is identified and disseminated both locally and at organisational level as appropriate.
3.4 To provide patients, their families and carers with information/education.

4. DEFINITIONS

4.1 A fall is defined as an unintentional/unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level [ach et al, 1991; Wolf et al, 1996].

5. DUTIES AND RESPONSIBILITIES

5.1 The Chief Executive Officer has a duty to care for patients receiving care and treatment from the Trust and has overall responsibility for procedural documents, and delegates’ responsibility as appropriate.

5.2 The Falls Best Practice Group has delegated responsibility to monitor falls incidents reported by Somerset Partnership NHS Foundation Trust staff. The role of the Falls Best Practice Group is to:

- ensure falls prevention is a key focus in the patient safety agenda;
- be informed about and respond to national guidelines and best practice;
- develop and monitor the overarching Falls Work Plan that reflects national guidance, learning from audit and incidents and sets key improvement objectives relating to falls prevention;
- monitor the falls incidents within the Somerset Partnership NHS Foundation Trust population reported on DATIX to identify trends or recurring themes and ensure action where there are areas of concern;
- ensure all falls resulting in significant harm – fractures, subdural haematoma - are investigated and lessons learned are disseminated widely and result in action to change practice where needed;
- it will actively support the development of services as resources allow and ensure that services are developed in collaboration with patients, stakeholders and partners.

5.3 The Risk Management Team will log all reported falls incidents and send to the Falls and Bone Health Coordinator for validation. Further information on Untoward Event Reporting can be obtained from the Untoward Event Reporting Policy and Procedure

5.4 The Manager / Practitioner in charge of clinical area/clinical team is responsible for

- ensuring that all staff are made aware of the requirements of this policy and comply with the safe systems that are contained within it;
- ensuring that the processes for risk avoidance, risk assessment and risk reduction are implemented within their area of responsibility, supporting and monitoring local compliance with the use of falls risk assessments and care plans;
ensuring that appropriate resources are available locally to meet identified needs, reporting any deficit in resources to their line manager (this includes the need for training);

ensuring that the Trust’s procedure for reporting and recording local risks using the Local Risk Register is followed, also ensuring falls that occur are reported on DATIX;

reviewing the number of falls and identifying areas of concern ensuring that local action plans are in place and implemented;

supporting staff awareness and engagement through Falls Local Action Groups (FLAG’s); awareness of local and individual patient risks by discussion at handover and team meetings; and ensure this is recorded within the minutes/notes of the meeting;

ensuring that staff receive instruction/training in the use of relevant equipment and risk assessment tools to enable them to utilise the appropriate safe systems for managing slips, trips and falls;

ensuring 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;

ensuring that Falls Risk Assessments are reviewed and updated when a fall (or falls) occurs.

5.5 Staff

For Inpatients see Appendix A and for Community based staff see Appendix B

5.5.1 Staff have a responsibility to ensure that all older people presenting within a health setting are routinely asked whether they have fallen in the past year and asked about the frequency, context and characteristics of the falls (NICE CG 161). They should identify and appropriately assess (or refer on) patients who are at risk of falling (and take action to reduce the risk of injury as a result of falling).

5.5.2 For the purpose of this policy, older people are

- all patients aged 65 years or older
- patients aged 50–64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

5.5.3 Where the patient is at risk of falls and a care plan developed a named person must be identified and agreed as responsible for overseeing and monitoring progress. This person may change as the patient progresses along the pathway.

5.5.4 On discharge the patient and carer should have information/contact details to access further support if required.
5.6 **Medical Assessment and Intervention**

- clinical examination to include identification of people who have fallen as a result of a collapse
- physical and cognitive assessment and history of falls
- review of drugs, particularly if the patient is on four or more medications and/or 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. Complete a FRAX (http://www.shef.ac.uk/FRAX/tool.jsp?country=1)
- review medication for osteoporosis and patient compliance
- onward referral for further investigations as required

5.7 **Registered Nurses are responsible for carrying out the falls risk assessment and appropriate Interventions. They are also responsible for ensuring this is documented appropriately.**

5.8 **Occupational Therapists and Physiotherapists providing rehabilitation services are responsible for**

- contributing to assessment of cognition and patient’s confidence in activities;
- contributing to the multifactorial falls risk assessment and any necessary interventions throughout the patient’s stay in hospital including frailty assessments;
- assessment of home environment, identifying possible hazards, so as to minimise risk at home and maximise independent living;
- providing appropriate equipment and/or adaptations;
- assessment of mobility/walking, to include gait and balance;
- providing treatment to improve safe mobility;
- assessment of suitability of walking/mobility aids;
- contributing to the falls prevention assessment and risk management care plan for patients who would otherwise not have therapy involvement, in order to reduce the risk of falls and injury from a fall.

5.9 **The role of the Pharmacist and Prescriber**

5.9.1 Medication review should be considered as part of a multifactorial assessment in patients at risk of falling (see NICE CG161)
5.9.2 **Polypharmacy** (When a patient is prescribed four or more drugs) - is a known risk factor for falls and potential harm in older people

- In particular, taking centrally sedating or blood pressure lowering drugs, is known to increase the risk of falls

- Sometimes medication has been prescribed that was necessary at the time but has not been discontinued when no longer needed

Pharmacy support can be requested in any setting to

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

- provide information/advice to staff re high risk medications on request

6. **ASSESSMENT AND PREVENTION OF FALLS IN OLDER PEOPLE**

6.1 **Assessment and Intervention**

6.1.1 **Staff Responsibilities**

- All patients (and their carers) must be educated about the risks of falls and given information in a format and language they may easily understand. All patients to be given Falls prevention in hospital: a guide for patients, their families and carers (RCP 2016) [https://www.rcplondon.ac.uk/file/4770/download?token=yT95Mlcz](https://www.rcplondon.ac.uk/file/4770/download?token=yT95Mlcz)

- Environmental clutter must be avoided, including ensuring safe placement of cables, removing equipment from corridors etc. In community settings this must be done following discussion and patient consent - involvement with care agencies / next-of-kin may also be applicable. Where capacity issues are identified action must be taken in the patient’s best interest and documented in the patient record taking into account capacity and consent policies.

- For patients presenting in community, MIU and outpatient settings identified as being at risk of falling, a multidisciplinary approach should be adopted and relevant clinicians involved, including the GP’s, integrated teams must be involved. See the Somerset Falls Pathway (Appendix C).

- To participate in any clinical audits as required

6.1.2 **Inpatients**

- All patients admitted to an Older Persons Mental Health Ward or Community Hospital must be assessed for their risk of falling. The admitting nurse must start a multifactorial falls risk assessment using the Integrated Inpatient Falls Risk Assessment on RiO (Appendix D) This should be completed within 6 hours for community Hospitals and 24 hours for older persons mental health ward timescale

- Transfers – patients should have a falls risk assessment completed within 6 hours of a transfer into a community hospital, from another community hospital.
- If the transferring hospital has completed an assessment less than 6 hours before the transfer and there is no change in the patient’s condition then this is sufficient. If an assessment was not completed or was completed more than 6 hours before transfer (i.e. arrival at new hospital) then the admitting hospital must complete an assessment.

- **NICE guideline (CG161 – June 2013) says:**
  ‘Ensure that any multifactorial assessment identifies the patient’s **individual risk factors** for falling in hospital that can be treated, improved or managed during their expected stay’. (*Do not use a fall risk prediction tool)*

- Completing the assessment can involve any other professional as needed to ensure a multifactorial approach e.g. medical, pharmacy and therapy staff.

- An evidence-based, personalised falls care plan must be developed and implemented in conjunction with the patient and/or family. This should take account of the patient’s goals, usual routine and coping strategies. Increased levels of observation must be implemented where appropriate.

- A review of the falls risk assessment and any resulting care/action plan must be undertaken weekly, following a fall, or if new risk factors are identified (e.g., administration of medication that increases the risk of falls, infection, delirium etc.) and prior to discharge.

- Any actions identified following a patient fall must be completed as soon as practicable such as removing environmental hazards, repairing damaged equipment, ensuring adequate supervision levels and appropriate placement of the patient.

- The use of bedrails must be considered if the benefit outweighs the risk (refer to the Guidelines for the use of Bed Rails including Risk Assessment, *(Appendix E)*

- In **other in-patient areas**, if a patient is deemed to be at risk of falling or has already fallen, a risk assessment must be completed as above and disseminated to all staff groups involved in the patient’s care.

- In **Adult Mental Health Wards** all patients must have a documented baseline assessment of their risk of falls within the risk screen which must be completed within 24 hours of admission. If the patient is identified as a moderate-high falls risk staff members need to then proceed with a falls risk assessment to be completed within 24 hours. A personalised falls care plan must be developed and implemented in conjunction with the patient and/or family.

- A review of the risk screen and/or falls assessment and any resulting care plan must be undertaken weekly, following a fall, or if new factors are identified (e.g. administration of medication that increases the risk of falls, infection, delirium etc.) and prior to discharge.

- Transfers – Prior to any transfer between **Mental Health Wards** the risk screen must be reviewed and updated to reflect the current presenting risks.
An effective handover of all relevant information relating to falls risk must be made at the point of discharge or transfer.

For each identified risk area, the precautions, actions taken and outcomes must be documented in the patients Falls Care Plan.

7. MANAGEMENT OF INDIVIDUALS AT RISK

Identification and assessment of risk factors should be undertaken (Falls Risk Assessment Tool - FRAT) (Appendix F)

8. ACTION FOLLOWING A FALL

Please see the Protocol for essential care after an inpatient fall. (Appendix G)

- An incident report form must be completed for all inpatient falls, and all witnessed falls which occur in other settings. All untoward events and near misses must be reported on DATIX in accordance with the Untoward Events Reporting Policy.

- In line with the Trust Record Keeping Policy all incidents must be recorded in the patient record.

- A more senior member of staff/manager must be made aware of any actions that may need to be initiated outside the concerned member of staff’s level of responsibility.

9. SAFEGUARDING

Somerset Partnership provides Level 1 and 2 Safeguarding Adults training as appropriate and as specified in the Safeguarding Training Strategy and Policy.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 Process for Monitoring Compliance

Audit of this policy is incorporated into the Trust’s Three Year Clinical Audit Plan, and will be appropriately prioritised according to an agreed system for determining the frequency of audit. The responsibility for undertaking the audit and signing off key recommendations is held by the appropriate Best Practice Group. Progress with any recommendations is included within the Best Practice Group report to the appropriate Divisional Governance Group.

All incidents, audits, complaints and feedback relating to falls will be reviewed by the Falls and Bone Health Coordinator, and discussed at the Falls Best Practice Group. A Falls Organisational Work Plan will be maintained by this group, and key risks, good practice, any shortfalls, action points and lessons learnt will be disseminated through the appropriate Best Practice Groups.

Local issues, including Inpatient Falls incidents will be monitored by the Ward Manager / Team Leader / Team Manager and discussed with staff to identify any learning points and actions taken to prevent/reduce the risk of further falls. Local
Action plans will be developed as appropriate See Process for learning from incidents (Appendix H)

In addition the Falls and Bone Health Coordinator will prepare:

- weekly run charts are prepared by location to monitor falls performance;
- monthly reports for Board Quality report – prepared by Risk Team and Falls and Bone Health Coordinator;
- quarterly reports to Clinical Governance Group identifying key risks, good practice, any shortfalls, action points and lessons learnt. This information is then disseminated to the Falls Best Practice Group and cascaded to other relevant best practice groups.

10.2 How will the resulting action plan be progressed and monitored?

- Local monitoring and reporting to be undertaken by Matrons / Ward Sisters / Unit Managers / Team Leaders / Integrated Team Managers.
- Inpatient Falls incidents are reviewed at Falls Local Action Group (FLAG) meetings to identify any learning points and actions taken to prevent/reduce the risk of further falls.
- Falls Local Action Plan must be reviewed at every FLAG meeting.
- Safety Thermometer returns monitored monthly by the patient safety team.
- Clinical audit standards relating to this procedural document are included as an appendix (Appendix K).

The audit of results will be provided to staff to raise awareness through “What’s on at Sompar”.

11. TRAINING AND COMPETENCY REQUIREMENTS

11.1 The Trust will work towards all staff being appropriately trained in line with the organisation’s Staff Mandatory Training Matrix (training needs analysis) (where mandatory training is indicated). Where no mandatory training is indicated all training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet. Falls training does not come under the mandatory training matrix.

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

11.3 A rolling programme of training will be delivered by the Falls and Bone Health Coordinator and the Clinical Specialist for Falls, to all staff groups.

11.4 A falls risk assessment eLearning training module is available to all staff from eLearning for health that can be accessed via Learning and Development intranet site
11.5 All staff must attend relevant mandatory patient handling/load management training which includes the use of equipment.

12. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

12.1 References

Health and Safety Executive (2006) Reducing Slip and Trip Accidents in the Health Services SIM 7/2006/06
Health and Safety Executive (2012) Preventing Slips and Trips at Work HSE Available at www.hse.gov.uk/slips
Health and Safety Executive (2013) Slips and Trips Hazard Spotting Checklist HSE

NHS Operating Framework for the NHS in England 2012/13 (DOH)
NICE Guidelines CG161 Falls (June 2013)
NICE Clinical knowledge summary-falls risk assessment (January 2014)
NICE Quality Standard QS63 Delirium in Adults (July 2014)
NICE Quality Standard QS86-falls in older people: Assessment after a fall and preventing further falls (March 2015)

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

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

The National Patient Safety Agency Essential Care after an inpatient fall (2011) NPSA/2011/RRR001

The National Service Framework for older people (2001)

The NHS Outcomes Framework 2015/16, 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 Audit of inpatient falls (2015)
The Royal College of Physicians (RCP) fall safe project (August 2015)

12.2 Cross reference to other procedural documents

Consent to Examination and Treatment Policy
Consent and Capacity to Consent to Treatment Policy
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 (within Policies and Procedures).

13. **APPENDICES**

13.1 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. This should include any relevant Clinical Audit Standards.

- Appendix A Identification, assessment and management of falls for inpatients
- Appendix B Managing falls for community based patients
- Appendix C Somerset Falls Pathway
- Appendix D Integrated Inpatient Falls Risk Assessment on RiO
- Appendix E Guidelines for the use of Bedrails including risk assessment
- Appendix F Falls Risk Assessment Tool (FRAT)
- Appendix G Protocol for essential care after an inpatient fall
- Appendix H Process for learning from incidents
- Appendix I Rockwood Frailty Assessment Tool
- Appendix J Somerset Rehab Service Specialist Falls Assessment
- Appendix K Clinical Audit Standards
IDENTIFICATION, ASSESSMENT AND MANAGEMENT OF FALLS FOR INPATIENTS

All inpatients in Community Hospitals and Older Persons Mental Health Wards should have the inpatient falls risk assessment on Rio completed, with any risks identified incorporated in a Falls Care Plan. The care plan should be developed in conjunction with the patient and/or family carers as appropriate and a copy provided for their information.

The falls risk assessment should be reviewed/updated weekly, following a fall, or at any time if the patient’s status changes. The falls care plan should be updated in line with any changes and disseminated to the multidisciplinary team.

1 IDENTIFY RISKS

1a Record History of any falls in the last twelve months (an exception to this would be if the patient lacks capacity in which case family/carers can be involved) to include

- Details of fall(s) – When? Where? How? How many times / frequency?
- Any injuries sustained?
- Any pattern, e.g. at night?
- Coping strategies?
- Is the cause of fall(s) known/ been investigated

1b Fear of Falling

This is linked to increased risk/incidence of falls even if the patient has no history of falls. Establish patient goals, usual routine and coping strategies and increase levels of observation where appropriate.

1c Review of medicines

- Is the patient on multiple medications or medicines likely to increase risk of falling e.g. anti-depressants, Hypnotics, anti-hypertensive opiate analgesia, diuretics, anti-psychotics, benzodiazepines, laxatives? Consider risk when medicines are changed, newly prescribed, PRN.
- Be aware of medication linked to increased falls risk for all new prescriptions and PRN medications – alerts on MAR charts using falls symbol on stickers (where paper charts are in use). For electronic prescribing the fall alert should be activated on the alerts within Rio.


1d Mobility – Gait / Balance / Walking

Identify if there are problems and refer for rehabilitation assessment as needed.

1e Medical status

Has the patient any of the following conditions:

- Neurological impairment
- Infection
- Seizures
- Unstable diabetes
- New amputation or major surgery
- Pain ++ - Pain Assessment Tool [http://intranet.sompar.nhs.uk/a-z_directory/nursing.aspx](http://intranet.sompar.nhs.uk/a-z_directory/nursing.aspx)
- Cardiovascular symptoms/syncope (suspect if patient is unable to recall fall ‘just went’)

1f **Mental Health / Cognition**

- Patient is confused/agitated /presenting with challenging behaviours (including aggression) non-compliant, family report a change in cognition / behaviour
- Check for dementia diagnosis – refer to Dementia Toolkit
- Delirium assessment - Refer to Dementia / Delirium Toolkits for management strategies. [http://intranet.sompar.nhs.uk/a-z_directory/dementia.aspx](http://intranet.sompar.nhs.uk/a-z_directory/dementia.aspx)
- Use standardised cognitive assessments.

1g **Footwear**

- Check footwear for secure fit, non-slip sole, no trailing laces and patients ability to put on/take off safely
- Where possible, patients should wear their own footwear and be checked for signs of wear.
- Ask relatives for safer replacement if necessary
- If patients are wearing socks in bed, risk assess and agree action
- Check condition of feet
- In situations which alter the patient’s ability to wear their normal footwear, e.g. oedema, bandaging or podiatry intervention etc., alternative options and risks should be discussed with the patient/carer. Measures agreed to reduce risk should be implemented and clearly recorded

1h **Osteoporosis**

- Be aware of risk factors for osteoporosis and use FRAX assessment ([http://www.shef.ac.uk/FRAX/tool.jsp?country=1](http://www.shef.ac.uk/FRAX/tool.jsp?country=1)) – request medical review if risks identified and patient is not already taking medication for osteoporosis.

1i **Personal Care/ Toilet**

- Identify risks relating to Continence - Is falls risk linked to patient’s need to use toilet?
- Does the patient suffer from urgency/frequency, incontinence
- Does the patient take diuretics that cause urgency/frequency?
- Is the patient able to find the toilet or call for assistance appropriately?
- Is the patient avoiding drinking to avoid needing the toilet?

1j **Sensory - Hearing / Vision**

- Check availability/use of hearing aid if worn – identify alternative method of communication if required
- Check eyesight – (end of bed pen test) - ensure glasses are worn / clean / within reach.
1k  **Environmental Hazards**

- Clutter
- Floor surfaces
- Temperature – too hot or cold
- Lighting
- Noise

2  **MANAGEMENT OF INDIVIDUALS AT RISK**

2.1  **Falls Care Plan**

2.1.1 Following risk assessment a Falls Care Plan must be implemented on RIO via the care plan library.

2.1.2 A discussion with the patients’ family/carers/relative about the risk of falling is essential. Patients must be aware that the risk of falling cannot be completely eliminated despite preventative measures taken. Records of discussions held must be recorded in the patients’ records.

2.1.3 Involve other members of multidisciplinary team as needed to ensure a multifactorial approach.

2.1.4 Details of falls precautions should be communicated to all multidisciplinary team members:
- Ward rounds / board rounds / safety briefings etc.
- Magnets / alerts are in place
- Ensure falls risk is on patient risk profile – activate alert symbol on Rio
- Detailed falls care plan
- A fall in hospital must be taken into account when planning a patient’s discharge home or to a care setting (e.g. nursing/residential home). Discharge plans should include:
  - Implementation of interventions to reduce risk of falling again
  - Referral to Integrated Rehabilitation Team and, if appropriate a home safety assessment may be needed to identify adaptations and/or equipment to improve safety.

2.2  **Developing the Care Plan**

2.2.1  **Education / Information**

- Ensure that the patient is orientated to ward environment, location of toilets, call bell use.
- Discuss risks of falling in hospital with patient/ family and give ‘Falls prevention in hospital: a guide for patients, their families and carers’ booklet (RCP 2016)
  [https://www.rcplondon.ac.uk/file/4770/download?token=yT95Mlcz](https://www.rcplondon.ac.uk/file/4770/download?token=yT95Mlcz)
- Educate patient to specific risks and precautions

**Note** – record conversation in progress notes and remember that patients with reduced capacity may need repeated reminders
2.2.2 **Communication**

- Ensure patient is able to make needs known. Intentional Rounding must be implemented for patients at risk of falling in all inpatient settings.
- Ensure that the patient has access to and is able to use a means to call staff. If the patient has capacity, ensure the call bell is within reach and the patient knows how to use it. Consider alternative methods where patients are unable to recall use of call bell e.g. brass bell, move bed in sight of nurses’ station, use fall alarm, increase observations.
- Flexible use of observation/intentional rounding to monitor patient where they lack capacity and awareness to communicate their needs.

2.2.3 **Medicines**

- Check medications and request medical review if linked to increased falls risk (use medicines and Falls in Hospital: Guidance sheet for reference [www.drugsandfalls.com](http://www.drugsandfalls.com)).
- Reassess at any time when medication is prescribed or changed and reassess falls risk if indicated.
- Ensure correct timings of medication, such as drugs to treat Parkinson’s, are adhered to.

2.2.4 **Manage pain**

- Be aware of increased analgesia and falls risk.
- Use symbols if patient is unable to verbalise pain.
- Regular review and reassessment [http://intranet.sompar.nhs.uk/a_-_z_directory/nursing.aspx](http://intranet.sompar.nhs.uk/a_-_z_directory/nursing.aspx)

2.2.5 **Postural Hypotension**

**Check lying and standing blood pressure**

- Record lying and standing blood pressure twice daily.
- If patient has postural hypotension, advise patient to move slowly from lying to standing.
- Consider timing of anti-hypertensives.
- Request medical review/ECG.

2.2.6 **Screening for delirium**

- Should be repeated daily – NICE CG 103 delirium and QS 63.
- If result of screening suggests delirium – consider actions e.g. urine dip, medical review, blood tests.
  Refer to [http://intranet.sompar.nhs.uk/a_-_z_directory/dementia.aspx](http://intranet.sompar.nhs.uk/a_-_z_directory/dementia.aspx)

2.2.7 **Osteoporosis**

- Be aware of risk factors for osteoporosis.
- Complete FRAX if not already diagnosed ([http://www.shef.ac.uk/FRAX/tool.jsp?country=1](http://www.shef.ac.uk/FRAX/tool.jsp?country=1)).
- Check compliance with medication if diagnosed - GP review if non-compliant as alternatives are available.
- Ensure staff are aware of increased risk of injury if the patient falls.

2.2.8 **Continence**

- Urinalysis on admission, if patient deteriorates or delirium is suspected.
• Send MSU if positive to blood, nitrates or protein
• Implement bowel & bladder programmes – link to intentional rounding
• Fluid chart if patient is at risk of dehydration
• If high risk, supervision is required
• Consider toilet aids (raised toilet seat / rails)

2.2.9 Gait / Mobility / walking
Initial action to enable patient to mobilise within safe limits – may include provision of walking aid (patients should not be kept in bed pending therapy assessment). Therapy support may be needed to confirm level of supervision required to mobilise safely / use walking aids appropriately.

2.2.10 Environment
• Consider location on ward - close to nurses’ station – high visibility bed, close to toilet, quietest area (consider other patients’ needs)
• Ensure patient has access to and can safely reach drinks and personal belongings and remind patient to check for any spills before mobilising
• Ensure patient has access to and can reach, slippers/shoes, mobility aid
• Inform patient of any hazards e.g. toilet doors
• Lighting - older people require more light to see the same as they did when they were younger so consider whether bedside lamp needs to be left on, low level lighting at all times or night light in toilet.

2.2.11 Equipment
• Consider need for: Hi/Lo bed – ensure bed is set at appropriate height
• Fall alarm - use of pager if alarm at bedside distresses patient. Check alarm is in place and activated
• yellow bracelet;
• bedside fall mat;
• Mobility Aid
• Bedrails – risk assessment must be completed before use and may need frequent review as patient’s status changes and following a fall. Ensure team know outcome of assessment
• symbol/magnet in place
• Ensure patient knows risks if bedrails are contraindicated but patient has capacity and requests rails to be up - record in progress notes
• Ensure armchair is suitable height and provides effective postural support

2.2.12 Specialist Equipment - Mental Health inpatient wards:
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. An example of these types of protective devices is helmets.

Helmets are to be considered when there is significant risk of head injury.

2.2.13 Medical Assessment and Intervention
• clinical examination (to include identification of people who may have fallen as a result of a collapse)
• physical and cognitive assessment and history of falls
• review of medicines, particularly if the patient is on four or more medications and/or 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
• review medication for osteoporosis and patient compliance
• There are other significant risk factors e.g. medical status, neurological conditions / cardiovascular concerns
• onward referral for further investigations as required

3. FOLLOWING A FALL
• The ‘Protocol for essential care following an inpatient fall’ must be followed (Appendix G)
• The fall must be reported on DATIX

4. REVIEW AND EVALUATION OF FALLS
DATIX incidents are reviewed in the first instance by the ‘handler’ named on the DATIX incident report and subsequently at FLAG meetings to consider the following:

• That the patient’s clinical condition had been evaluated and individual fall risk factors for falling had been identified
• The Care plan implemented interventions that were consistent with the person’s needs and goals, and the recognised standards of practice
• Changes to the patients status had been monitored/evaluated and changes made to the falls care plan as needed to mitigate the identified risks
• That the patient did not have awareness or capacity to comply with strategies to improve safety/reduce the risk of a fall and could not have been made any safer
• the patient did not adhere to prevention strategies in spite of education and/or understanding of the consequences of not complying

Where omissions or alternative strategies are identified that may have prevented the fall or indicate local changes to improve practice, learning is identified and actions are put in place
COMMUNITY PATIENTS AND OTHER CLINICAL SERVICES
IDENTIFICATION, ASSESSMENT AND MANAGEMENT OF FALLS RISK FACTORS

All older people presenting within a health setting are routinely asked whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s (NICE CG 161).

Where risks are identified for community patients and those presenting to MIU and outpatient settings a Falls Risk Assessment Tool (FRAT - Appendix F), or an appropriate risk assessment or referral to the Integrated Rehabilitation Team (IRT) should be completed for further specialist assessment and submitted in line with the instructions on the FRAT template. Exceptions to this are if the patient refuses referral to IRT, bedbound patients and end of life patients. Note. This may be subject to change during the lifetime of this policy in line with organisational changes – refer to the Somerset Falls Pathway (Appendix C).

1 IDENTIFY RISKS

1.1 History of falls – is a predictor for more (see Inpatient Management Appendix A)

1.2 Medical status
Conditions as below or multiple pathologies are risk factors for falling
- Neurological impairment
- Infection
- Seizures
- Unstable diabetes
- New amputation or major surgery
- Pain ++ - Pain Assessment Tool [http://intranet.sompar.nhs.uk/a_z_directory/nursing.aspx](http://intranet.sompar.nhs.uk/a_z_directory/nursing.aspx)
- Cardiovascular symptoms/syncope (suspect if patient is unable to recall fall - 'just went')
- Recent illness or discharge from hospital – is patient more frail? Complete frailty assessment if not already done (Rockwood Frailty Score Appendix I)

Does the patient need a medical review?

1.3 Fear of Falling
This is linked to increased risk/incidence of falls even if the patient has no history of falls. Establish patient goals, usual routine and coping strategies.

1.4 Medicines / Polypharmacy

See Inpatient management (Appendix A) [www.drugsandfalls.com](http://www.drugsandfalls.com)
1.5 **Mobility – Gait / Balance / Walking**

Identify if there are problems and refer for specialist assessment as needed. Therapist assessment - include actions specific to reducing falls mobility risk in care plan.

1.6 **Mental Health / Cognition**

See Inpatient Management (Appendix A)

1.7 **Footwear**

See Inpatient Management (Appendix A)

1.8 **Osteoporosis**

Not a risk factor for falling in itself but increases the risk of injury from a fall and must be considered as part of the specialist falls assessment.

1.9 **Personal Care**

Identify risks relating to:

- Continence - Is falls risk linked to patient’s need to use toilet?
- Does the patient suffer from urgency/frequency, incontinence?
- Does the patient take diuretics that cause urgency / frequency?
- Is the patient able to access and use the toilet independently?

1.10 **Sensory - Hearing / Vision**

See Inpatient Management (Appendix A)

1.11 **Environmental Hazards**

- Clutter
- Floor surfaces
- Temperature – too hot or cold
- Lighting
- Steps / stairs
- Does the patient require a home hazard assessment?

2 **MANAGEMENT OF INDIVIDUALS AT RISK**

2.1 Record **History** of any falls in the last **twelve months** to include

- Details of fall(s) – When? Where? How? How many times / frequency?
- Any injuries sustained?
- Any pattern, e.g. at night?
- Coping strategies?
- Is the cause of fall(s) known / been investigated

2.2 **Education / Information**

Involve / engage patient / family in understanding falls risk and actions to reduce the risk.
Where appropriate patient and family information leaflets can be downloaded and provided www.csp.org.uk (Get up and Go- a guide to staying steady) and www.healthysomerset.co.uk/resources (ageing well) For the Somerset Falls stop booklet.

- Note: record conversation in progress notes
- Complete a detailed Falls Care Plan
- Where available include the details of Falls Care Plan.

2.3 **Fear of Falling**

- This is linked to increased risk/incidence of falls even if the patient has no history of falls. Patient will need strategies to address and reduce the fear.
- Consider referal for balance and safety class
- Refer to Integrated Rehabilitation teams for home hazard assessment and modification
- Implement strategies to prevent a long lie www.csp.org.uk (Get up and Go - a guide to staying steady)
- Consider referal to social services for package of care assessment.

2.4 **Mental Health / Cognition**

- Patient is confused/agitated / non-compliant, family report a change in cognition/ behaviour
- Check for dementia diagnosis – refer to Dementia Toolkit
- Delirium assessment - Refer to Dementia / Delirium Toolkits for management strategies
- Perform standardised cognitive assessments.
- Consider involving Older Persons Community Mental Health Team

2.5 **Footwear**

See Inpatient Management (Appendix A)

2.6 **Medicines / Polypharmacy**

See Inpatient Management (Appendix A)

2.7 **Medical status**

2.7.1 **Nursing Assessment / Intervention**

- clinical assessment/observations
- review of drugs as below
- check whether patient is on medication for osteoporosis (and patient compliance) (to include identification of people who have fallen as a result of a collapse)
- If concerned Request GP review

2.7.2 **GP review**

- review of patients post fall, to exclude injury as a consequence of falls and to exclude medical deterioration as the underlying cause
- clinical examination to include identification of people who have fallen as a result of a collapse
- 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 Bone Health navigator app is available to GPs
- consider other significant risk factors e.g. medical status, neurological / cardiac conditions
- onward referral for further investigations as required.

2.8 Therapy intervention

A Specialist Falls Assessment must be completed (Appendix J)
- Therapists to continue specialist falls assessment started by referrer
- Intervention to be personalised to reflect risks identified to include signposting to other services such as podiatry, continence service, community groups. Or minimisation of home hazards and evidence based exercises (at home or part of a group).
- Upon receipt of a Falls Risk Assessment Tool (FRAT), the Integrated Rehabilitation Team (IRT) will contact the patient regarding future assessment and interventions

2.9 Manage pain

See Inpatient Management (Appendix A)

2.10 Postural hypotension

- Record lying and sitting BP
- If patient has postural hypotension, advise patient re slow movement lying to standing
- consider timing of anti-hypertensives
- request GP review / ECG

2.11 Screening for delirium

See Inpatient Management (Appendix A)

2.12 Osteoporosis

- Be aware of risk factors for osteoporosis
- Complete FRAX if not already diagnosed
- Check (compliance with) medication if diagnosed - GP review if non-compliant - Alternatives are available
- Be aware of increased risk of injury if the patient falls

2.13 Continence

- Discuss bowel & bladder programmes
- Identify functional difficulties of accessing/safe use of toilet and consider need for toilet aids (seat height/rails)
- Encourage patient to monitor fluid intake if at risk of dehydration – patients with mobility problems/loss of confidence may restrict fluid intake to avoid need to go to the toilet
- May need specialist continence assessment.
2.14 Gait / Mobility / Balance / Walking
If problems are identified request rehabilitation therapy assessment.

2.15 Sensory - Hearing / Vision
- Check availability / use of hearing aid if worn – identify alternative method of communication if required
- Vision assessment and correction of impaired vision - pen test - ensure glasses are worn / clean / within reach. If patient has not had an eye test in the past twelve months advise the patient to make an optician appointment.

2.16 Environment
- Consider hazards such as access, clutter, poor lighting, flooring etc. OT assessment may be required.
- Lighting - consider whether bedside lamp needs to be left on, night light in toilet.
- Discuss hazards eg Keep paths free of debris and ensure they are well maintained with no cracks in paving, clear up spills immediately and consider installation of safety rails.

2.17 Equipment
- Chair is suitable height and provides effective postural support
- Falls alarm
- Lifeline
- Request IRT assessment if needed

2.18 Monitoring / Review
Communicate falls precautions to all multidisciplinary team members

2.19 Ensure falls risk is on patient risk profile – activate alert symbol on RiO

3. FOLLOWING A FALL in the community / patients home
If a patient falls while staff member is present;
- Vital signs
- Check for injuries
- Make patient comfortable if unable to get up
- First aid
- If uninjured promote self assist to get up
- Escalation to team leader and emergency services if patient unable to get up/injuries suspected eg any fractures or head injury.
- Inform GP

4. REPORTING and Evaluation of Falls
- Include patients description of what happened
- Determine cause of fall where possible
- Did the patient have a falls care plan that had addressed modifiable risks?
- Were there risks that had not been considered / addressed?
- Could the fall have been prevented or the outcome changed?
- The fall could be deemed unpreventable if the patient fell even though
• Their clinical condition and individual falls risk factors had been identified and addressed where possible
• They were monitored to evaluate the effectiveness of the falls care plan and changes made where necessary
  OR
• the individual person did not have awareness or capacity to comply with strategies to improve safety / reduce the risk of a fall
• the individual person refused to adhere to prevention strategies in spite of education and/or understanding of the consequences of not complying.
SOMERSET FALLS PATHWAY

LESS THAN 50yrs
but frequent
faller – refer to
GP

OVER 50
Use a FRAT (Falls Risk Assessment
Tool) including if there is concern of
a recurrence, or fear of falling
signpost
(LINK to FRATis and next steps
guidance)
(i)

FALL

OVER 65
[Presentation in any
healthcare setting
should be asked if
fallen in previous 12
months (NICE LINK)]

Multifactorial health assessment
(Integrated Rehab Teams [IRT]
or acute)
Consider Frailty (Rockwood Tool
link)
Specialist Assessment includes
therapy recommendations
(i)

REPORT SENT TO GP
and patient with
recommendations

Consider referral to secondary
care outpatients and/or
telehealth (link to referral
form)

Signpost (LINKS to Somerset Choices
and Living Well for
Stronger Bones)

Yes – see Bone Health
Pathway (link)

If No but bone
health a concern
– refer via GP to
Bone Health
Pathway At Risk
Section (LINK)

Consider discussion
with Pharmacist
and/or referral to
GP to rule out
medicine induced

Signpost (LINKS to Somerset Choices
and Living Well for
Stronger Bones)

RESOURCES:
NICE Quality Standards
Patient.co.uk
Somerset Choices
Zing Somerset (activity)
RCP Falls Assessment
Falls Stop Booklet
FRATis

Key: Blue = Primary care; green = secondary care; orange = community services; beige = information

SOMERSET DIRECT for social
needs assessment including
home adaptations (see
eligibility criteria [i])
(0300 123 2224)

SOMERSET FALLS PATHWAY

IRT: West – westirthub@sompar.nhs.uk
0300 323 0029 (Taunton,
Bridgwater, North
Sedgemoor, West
Somerset)
East – eastirthub@sompar.nhs.uk
0300 323 0028 (Yeovil,
South Petherton,
Langport, Chard,
Crewkerne, Ilminster,
Wincanton, Frome,
Shepton Mallet, Wells,
Less than 50yrs
but frequent
faller – refer to
GP

Slips, Trips and Falls (Prevention and Management) Policy
V6
November 2018
INPATIENT FALLS RISK MANAGEMENT

1 IMPLEMENT UNIVERSAL PRECAUTIONS (for all inpatients in Community Hospitals and Older Persons Mental Health Wards, plus any other inpatient who is likely to be at risk of falling due to their diagnosis/presenting problems)

Medication Review - Answer yes if the patient is on multiple medications or medicines likely to increase risk of falling e.g. anti-depressants, Hypnotics, anti-hypertensive opiate analgesia, diuretics, anti-psychotics, laxatives. Consider risk when medicines changed, newly prescribed, PRN.

Footwear - Check condition of feet? Check footwear 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

Communication – use of call bell – ensure the call bell is within reach and the patient knows how to use it. Consider alternative strategies where patients are unable to recall use

Education

2 INITIAL FALLS RISK ASSESSMENT

Has the patient fallen in the last twelve months? Yes No

HISTORY - Details of fall(s) – When? Where? How? How many times / frequency? Any injuries sustained? Any pattern, e.g. at night? Coping strategies? Is the cause of fall(s) known/investigated

3 FALLS RISK FACTORS

A fall was the reason for Admission? YES NO The patient is known to be a frequent faller? YES NO

The patient has fallen since admission? YES NO Patient has expressed a fear of falling? YES NO

There are other significant risk factors e.g. medical status, mental health status, neurological / cardiac conditions YES NO

FALLS RISK ASSESSMENT

If answer is YES to any question, continue to section 3 - Falls Risk Assessment

Note: For each identified risk area, precautions, actions taken and outcomes should be included in the patients care plan.
<table>
<thead>
<tr>
<th>RISK CATEGORY</th>
<th>Is this a Risk area?</th>
<th>Take action and record in care plan – suggestions in column below</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication changes</td>
<td>Yes No</td>
<td>• Be aware of medication linked to increased falls risk for all new prescriptions and PRN medications – alerts on MAR charts.</td>
<td></td>
</tr>
<tr>
<td>MEDICAL STATUS - Has the patient any of the following conditions:</td>
<td></td>
<td></td>
<td>Hyperlinks to:</td>
</tr>
<tr>
<td>Neurological impairment</td>
<td>Yes No</td>
<td>• Check medications and consider medical review if linked to increased falls risk – check any new prescriptions and reassess falls risk if indicated.</td>
<td>Physical obs chart</td>
</tr>
<tr>
<td>Infection</td>
<td>Yes No</td>
<td>• Educate patient to specific risks and precautions</td>
<td>Medicines reconciliation</td>
</tr>
<tr>
<td>Seizures</td>
<td>Yes No</td>
<td>• Manage pain (be aware of increased analgesia and falls risk)</td>
<td>Pain assessment</td>
</tr>
<tr>
<td>Unstable diabetes</td>
<td>Yes No</td>
<td>• Check lying and sitting BP and record - If patient has postural hypotension, advise patient to slow movement lying to standing, consider timing of anti-hypertensives.</td>
<td>MAR chart</td>
</tr>
<tr>
<td>New amputation or major surgery</td>
<td>Yes No</td>
<td>• Request medical review/ECG</td>
<td></td>
</tr>
<tr>
<td>Pain ++ Cardiac symptoms/syncope (suspect if patient is unable to recall fall 'just went')</td>
<td>Yes No</td>
<td>• Refer to Osteoporosis Society Guide</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis (Risk factors include: age-75+, female, low BMI, previous fracture, smoker, alcohol intake high, family history)</td>
<td>Yes No</td>
<td>• Complete FRAX if not already diagnosed. Check (compliance with) medication if diagnosed, GP review if non-compliant. Alternatives</td>
<td>Link to FRAX assessment</td>
</tr>
<tr>
<td>Any other condition that may increase risk</td>
<td>Yes No</td>
<td>• Ensure staff are aware of increased risk of injury if the patient falls</td>
<td></td>
</tr>
<tr>
<td>specify</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERSONAL CARE / SENSORY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence</td>
<td>Yes No</td>
<td>• Urinalysis on admission, if patient deteriorates – delirium is suspected</td>
<td>Hyperlink to fluid chart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Send MSU if positive to blood, nitrates or protein</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implement bowel &amp; bladder programmes – link to intentional rounding</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fluid chart if patient is at risk of dehydration</td>
<td></td>
</tr>
<tr>
<td>Toilet</td>
<td>Yes No</td>
<td>• Is falls risk linked to patient's need to use toilet? On diuretics – urgency/frequency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If high risk, supervision is required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider toilet aids (seat height/rails)</td>
<td></td>
</tr>
<tr>
<td>Gait/Mobility/balance</td>
<td>Yes No</td>
<td>• Ensure therapist is involved - include actions specific to reducing fall risk in mobility care plan. Patient needs supervision to mobilise safely</td>
<td>Link to therapy assessment - Tinetti Balance and Gait assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use walking aids appropriately</td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Yes No</td>
<td>• Check availability/use of hearing aid if worn</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Alternative method of communication if required</td>
<td></td>
</tr>
<tr>
<td>Eyesight,</td>
<td>Yes No</td>
<td>• Check eyesight - pen test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure glasses are worn/ clean/ within reach.</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Yes No</td>
<td>• Ensure patient is able to make needs known</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teach use of call bell or alternative</td>
<td></td>
</tr>
<tr>
<td>ENVIRONMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location on ward</td>
<td>Yes No</td>
<td>• Close to nurses’ station – high visibility bed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Close to toilet</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Quietest area (consider other patients’ needs)</td>
<td></td>
</tr>
<tr>
<td>Environmental Hazards</td>
<td>Yes No</td>
<td>• Free of clutter. Water etc. in reach, remind patient to check for any spills before mobilising</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inform patient of any hazards e.g. toilet doors</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>Yes No</td>
<td>Consider need for:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hi/Lo bed; Fall alarm; yellow bracelet; crash mat; Mobility Aid; Floor Pressure Pad; Hip</td>
<td></td>
</tr>
<tr>
<td>RISK CATEGORY</td>
<td>Is this a Risk area?</td>
<td>Take action and record in care plan – suggestions in column below</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Bed</td>
<td>Yes No</td>
<td>• Set bed to suitable height for patient</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consider use of special low bed</td>
<td></td>
</tr>
<tr>
<td>Bedrails</td>
<td>Yes No</td>
<td>• Assess need – use risk assessment template for bedrails</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure team know outcome of assessment – symbol/magnet in place</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure patient knows risks if bedrails are contraindicated but patient has capacity and requests rails to be up</td>
<td></td>
</tr>
<tr>
<td>Chair</td>
<td>Yes No</td>
<td>• Assess suitability of chair for postural support/stability, correct height – request therapist assessment</td>
<td></td>
</tr>
<tr>
<td>Lighting</td>
<td>Yes No</td>
<td>• Consider whether bedside lamp needs to be left on ,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Night light in toilet,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other - specify</td>
<td></td>
</tr>
<tr>
<td>EDUCATION / INFORMATION</td>
<td>Yes No</td>
<td>Check this was implemented at 1</td>
<td></td>
</tr>
<tr>
<td>ANY OTHER ACTIONS – SPECIFY</td>
<td></td>
<td>Engage patient /family in details of Falls Care Action Plan</td>
<td></td>
</tr>
</tbody>
</table>

### 4 COMMUNICATE FALLS PRECAUTIONS TO ALL MULTIDISCIPLINARY TEAM MEMBERS

- Handover sheet
- Magnets / alerts are in place
- Ensure falls risk is on patient risk profile – activate alert symbol
- Detailed falls care plan

Action confirmed – timed and signed

<table>
<thead>
<tr>
<th>Hyperlinks to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care plan</td>
</tr>
<tr>
<td>Risk profile</td>
</tr>
</tbody>
</table>

### 5 REVIEW/UPDATE RISK MANAGEMENT PLAN WEEKLY, FOLLOWING A FALL OR IF THE PATIENT’S STATUS CHANGES

Ensure falls management plan and precautions are communicated at each handover
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 be 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 patient’s 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.
# BEDRAILS ASSESSMENT

<table>
<thead>
<tr>
<th>Mental state</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is confused and disorientated</td>
<td>Patient is very immobile (bedfast- or hoist-dependent)</td>
</tr>
<tr>
<td>Patient is drowsy</td>
<td>Use bedrails with care</td>
</tr>
<tr>
<td>Patient is orientated and alert</td>
<td>Bedrails recommended</td>
</tr>
<tr>
<td>Patient is unconscious</td>
<td>Bedrails recommended</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Bedrails recommended (circle)</th>
<th>Comment if necessary</th>
<th>Sign</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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’)
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.

**Criteria For Integrated Rehabilitation Service**

- Medical reasons for falls are eliminated/ stabilised prior to referral
- Consent
- Over 18 (flexible with Acquired Conditions)
- Patient is willing to engage in rehabilitation process
- Potential to recover from illness or injury that requires registered professional involvement
- Potential to maximise independence/ self-management requiring registered professional involvement

Integrated Rehabilitation Service **does not** accept referrals for:

- Requests for equipment or adaption only
- Reduction in package of care
- Confidence building/ reduced ability to cope or starting to struggle where there is a package of care in situ
ASSESSMENT OF FALLS RISK IN OLDER PEOPLE

ASSESSMENT TOOL – (FRAT)

Please Note this service is for patients with a Somerset GP only

Name_________________________ Date of Birth ______________________

Address_____________________________ Tel No ______________________

________________________________ NHS no or equivalent________________

GP/ Surgery _______________________________________________________

Patient Consent to Referral and Visit from a Therapist?

People who have collapsed – “just went” require medical review and stabilisation before Integrated Rehabilitation Teams can assess.

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

Please add further comments

Name of Referrer______________________ Title_________________________

Signature____________________________ Contact_______________________

Service Provided____________________ Date of Referral___________

Referral to Integrated Rehabilitation Teams for 3 or more positive responses:

**EAST:** Tel: 0300 323 0028

<table>
<thead>
<tr>
<th>Option</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><a href="mailto:YeovilIRT@sompar.nhs.uk">YeovilIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>2</td>
<td><a href="mailto:ChardIRT@sompar.nhs.uk">ChardIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>3</td>
<td><a href="mailto:FromeIRT@sompar.nhs.uk">FromeIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>4</td>
<td><a href="mailto:MendipIRT@sompar.nhs.uk">MendipIRT@sompar.nhs.uk</a></td>
</tr>
</tbody>
</table>

**WEST:** Tel: 0300 323 0029

<table>
<thead>
<tr>
<th>Option</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><a href="mailto:TauntonIRT@sompar.nhs.uk">TauntonIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>2</td>
<td><a href="mailto:BridgwaterIRT@sompar.nhs.uk">BridgwaterIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>3</td>
<td><a href="mailto:WestSomersetIRT@sompar.nhs.uk">WestSomersetIRT@sompar.nhs.uk</a></td>
</tr>
<tr>
<td>4</td>
<td><a href="mailto:NorthSedgemoorIRT@sompar.nhs.uk">NorthSedgemoorIRT@sompar.nhs.uk</a></td>
</tr>
</tbody>
</table>
# SUGGESTIONS FOR FURTHER ASSESSMENT, REFERRAL OPTIONS AND INTERVENTIONS

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

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

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 sway 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).
GUIDELINES FOR ESSENTIAL CARE AFTER AN INPATIENT FALL

GUIDELINES

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:

- 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

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

- 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.

- Timescales for medical examination following a fall must include fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised. Examination by medical staff i.e. OOH doctors, GP’s or hospital doctors must occur within 12 hours of a fall, and in the event of a fast track, within 30 minutes. If the delay is deemed too long in
relation to the patients assessed condition, then urgent advice should be sought via 999 system.

- The post-fall protocol is easily accessible by all clinical staff and the ‘Flowchart for Actions following a Fall’ (Appendix 1) is available in laminated versions at nursing stations
- The staff has access to clear guidance and formats for recording neurological observations using a 15 point version of the Glasgow Coma Scale (GCS) and is trained and competent to use them. Also ensuring that changes in the GCS and National Early Warning Score (NEWS) that should trigger urgent medical review are highlighted
- 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 achieve this in collaboration with the ambulance services
- 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

- 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.

5.3.6 Neck/back injury

- Elderly or frail patients can have back and neck fractures from a relatively insignificant fall.
- If a patient complains of pain, or appears to have pain, in their back or neck do not move the patient – ensure they are warm and comfortable – ask for MIU or doctor review if available.
- If there is no one available to review patient call an ambulance via 999.

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 1)

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 1** and the post fall checklist (**Appendix 2**) which includes all actions that must be followed.

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

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.

11. **REFERENCES**


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


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 One – Flow Chart for Actions after an Inpatient Fall
- Appendix Two – Post Fall Checklist
Appendix 1

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

Fracture, neck/head injury is obvious or

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

If head injury or unconscious commence neuro obs
- Call onsite medical/MIU support for review within 30 minutes.
- If support not available immediately **CALL 999**
- Give pain relief/first aid
- Carry out ABC observations (BP, P, O₂ Stats, RR, ECG)
- NEWS Score

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
- In line with duty of candour family/carers to be informed

Urgent review of patient by medical staff within 12 hours or the next day if fall happened during the night
Review by medical team after 24 hours if previously assessed post fall in hours

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
- In line with duty of candour family/carers to be informed
- Review/reassess if condition changes

**Note:** ALL FALLS

Undertake **urgent** review if patient deteriorates - ↓GCS or ↑NEWS score
APPENDIX 2

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST
COMMUNITY HEALTH DIRECTORATE

POST FALL CHECKLIST

<table>
<thead>
<tr>
<th>Patients</th>
<th>Completed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ..................................</td>
<td>Name (PRINT)..................................</td>
</tr>
<tr>
<td>Date of Birth.........................</td>
<td>Signature......................................</td>
</tr>
<tr>
<td>NHS No.</td>
<td>Date .............. Time...................</td>
</tr>
</tbody>
</table>

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 ................................................................................................................. □

If there is any suspicion of a head injury, commence neurological observations and National Early Warning Score (NEWS) scoring

¼ hourly for the first 2 hours.................................................................................................................. □

½ hourly for 2 hours ................................................................................................................................. □

1 hourly for 2 hours ................................................................................................................................. □

2 hourly for 4 hours ................................................................................................................................. □

4 hourly to 24 hours post-fall .................................................................................................................. □

Request an immediate medical review.................................................................................................. □

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 and care plan ........................................................................................................ □

In line with duty of candour family/carers to be informed................................................................. □

Complete an incident form ...................................................................................................................... □

If the patient has sustained injuries, a reflective review should be undertaken with relevant staff and a post fall evaluation sheet completed ........................................................................................................ □

Document everything in the patient’s evaluation record ........................................................................ □

Ensure that the patient’s fall and any other preventative actions to be implemented are communicated to all other staff on duty and those due to come on shift .................. □
Flow chart for investigating and learning from incidents resulting in serious or SIRI reportable injuries

1. Incident resulting in injury – DATIX completed
   - Patient is transferred to Acute Hospital for further investigations/surgery
   - Diagnosis is confirmed
   - 72 hour report completed
   - 1st staff debrief and local action plan to address identified areas of concern.
     - Author of 72 hour report invites investigator
       - Note. Human factors approach is used
     - Timescale - 42 days

2. Incident is logged and investigator is allocated
   - RCA/Level 2 investigation completed and submitted as final draft to risk team without LAP
   - Formal debrief with investigator and staff.
     - Initial action plan updated and amended to include new recommendations from investigation report

3. Learning points widely disseminated at relevant meetings
   - CHBPG
   - Sisters Forum
   - FLAG meetings

4. Learning points from Investigation and LAP discussed at Falls BPG Meeting

5. Investigation report and action plan considered/approved by SIRI Group

6. LAP progress monitored at local FLAG meetings and FBPG meeting

7. All actions complete and evidence in action plan
   - Learning is embedded into practice

8. LAP on agenda for SIRI Group for final sign off

Timescale 2 weeks?
Clinical Frailty Scale*

1. **Very Fit** — People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well** — People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. **Managing Well** — People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. **Vulnerable** — While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5. **Mildly Frail** — These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail** — People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7. **Severely Frail** — Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. **Very Severely Frail** — Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally III** — Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.


© 2007-2009, Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.
## Slips, Trips and Falls (Prevention and Management) Policy

### Patients Name | NHS No.
--- | ---

### FALLS HISTORY

**History Of Last Fall**
- Can patient remember the last fall?
- History of stumbling but not falling:
  - Any: loss of consciousness?
  - Dizziness? Palpitations?
  - Any pattern to the injuries?
  - Can patient remember the fall?
  - Where did they fall and at what time?
  - What were they doing at the time of the fall?
  - Carer’s knowledge?

**Coping Strategy:**
- Were they able to get up?
- Ability to summon help?
- Lifeline/ falls monitor/ telecare in situ?

**History Of Previous Falls:**

**Alcohol taken:**
- More than 3 units per day? Yes/No
- Alcohol History:

**Smoker:**
- Smoking History Yes/No

**Condition Of Feet:**

**Clothing Hazard:**

**Signature......................................................**
**Date ...........................................................**

**Amendments**
**Signature......................................................**
**Date ...........................................................**
# Adult Rehabilitation Service
## Specialist Falls Assessment

### Patients Name | NHS No.
--- | ---

<table>
<thead>
<tr>
<th><strong>Has the patient already been diagnosed with osteoporosis?</strong> <em>(if yes, no need to calculate risk)</em></th>
<th><strong>Do you have 20 mins exposure to sunlight per day?</strong> <em>(Bare arms/ face- April to Oct)</em>? Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are they taking their medication?</strong></th>
<th><strong>How many dairy products do you have per day( a pint of milk per day or the equivalent in dairy products?)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

If so, proceed to

## Osteoporosis Risk

<table>
<thead>
<tr>
<th><strong>Weight:</strong></th>
<th><strong>Height:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weight Loss:</strong></td>
<td><strong>Height Loss:</strong></td>
</tr>
<tr>
<td><em>(height loss &gt; 2” may indicate osteoporosis)</em></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BMI:</strong></th>
<th><strong>BMD:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(BMI &lt; 22 indicates osteoporosis risk)</em></td>
<td></td>
</tr>
</tbody>
</table>

### Osteoporosis:

Previous medical history of:

<table>
<thead>
<tr>
<th><strong>Rheumatoid Arthritis?</strong></th>
<th><strong>Yes/No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Fracture?</td>
<td><strong>Yes/No</strong></td>
</tr>
</tbody>
</table>

Did your parents:

<table>
<thead>
<tr>
<th><strong>have Osteoporosis?</strong></th>
<th><strong>Yes/No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>break their hip?</td>
<td><strong>Yes/No</strong></td>
</tr>
</tbody>
</table>

Did you have an early menopause?

Has your adult weight ever dropped below 6 stone?

*(Periods starting 16+, early menopause (< 46), amenorrhea may indicate osteoporosis risk)*

Fracture Risk Assessment *(FRAX)*:

http://www.shef.ac.uk/FRAX/tool.jsp?locationValue=1

<table>
<thead>
<tr>
<th><strong>Do you take/ buy calcium supplements?</strong></th>
<th><strong>Yes/No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What dose?</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Do you take/ buy vitamin D tablets?</strong></th>
<th><strong>Yes/No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What dose?</strong></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever taken steroids? *(refer to generic screening, 5mg for more than 3 months)*

Yes/No

< 65 yrs may need Dexa Scan

> 65 Bisphosphonates, Calcium and Vit D)

<table>
<thead>
<tr>
<th><strong>Do you use or receive any other anti-osteoporosis treatment?</strong></th>
<th><strong>Yes/No</strong></th>
</tr>
</thead>
</table>

### Self-Medicates?

Yes/No

### Dosette Box?

Yes/No

How do they take their bisphosphonate *(if on them?)*

Refer to G.P re compliance? Yes/No

### 10 year probability (%)

| **Major osteoporotic fracture =** |
| --- | --- |
| **Hip fracture**= |

## Observations

<table>
<thead>
<tr>
<th><strong>Date:</strong></th>
<th><strong>Lying Blood Pressure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standing Blood Pressure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temperature</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Radial Pulse</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B.M.</strong></td>
<td></td>
</tr>
</tbody>
</table>

## Urinalysis

<table>
<thead>
<tr>
<th><strong>Amendments</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Signature..................................................</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Date....................................................</strong></th>
</tr>
</thead>
</table>

Slips, Trips and Falls (Prevention and Management) Policy

V6

- 46 -

November 2018
# Adult Rehabilitation Service
**Specialist Falls Assessment**

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>NHS No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Continence
- How much do you drink per day?
- Do you suffer from urgency, Stress, night time incontinence or loose bowels?

## Continence Issues?
- Do you receive Pads?
- Do you see anybody re continence issues?

*When were you last assessed?*

## Vision:
- Patients Assessment of Own Sight:
  - Vision is satisfactory
    - Yes [ ]
    - No [ ]
  - Date eyes last tested:
  - Patient is wearing Current Prescription glasses
    - Yes [ ]
    - No [ ]
  - Patient is wearing bifocal/ varifocal glasses
  - Patient has double vision or a squint
  - Does patient report a visual field defect
  - Registered Blind:
    - Left: [ ]
    - Right: [ ]
  - Registered Partially Sighted:
    - Left: [ ]
    - Right: [ ]

## Abbreviated Mental Test Score: /10
- Age [ ]
- Address*: [ ]
- Name of institution/ Place [ ]
- Date Of Birth [ ]
- Name of Queen [ ]
- Time [ ]
- Year [ ]
- Recognise 2 people or recognise pen and watch [ ]
- Year of first world war [ ]
- Count back 20 – 1 [ ]

* (42 West Street)

## Signature

<table>
<thead>
<tr>
<th>Amendments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>NHS No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## HOME FALLS AND ACCIDENTS SCREENING TOOL (HOME FAST)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are walkways free of cords and other clutter?</td>
<td></td>
</tr>
<tr>
<td>Are floor coverings in good condition?</td>
<td></td>
</tr>
<tr>
<td>Are floor surfaces non slip?</td>
<td></td>
</tr>
<tr>
<td>Are mats and rugs securely fixed?</td>
<td>N/A</td>
</tr>
<tr>
<td>Can the person get up from their lounge chair easily?</td>
<td></td>
</tr>
<tr>
<td>Are the outside paths, steps and entrances well lit at night?</td>
<td></td>
</tr>
<tr>
<td>Is the person able to get on and off the toilet easily and safely?</td>
<td></td>
</tr>
<tr>
<td>Is the person able to get in and out of the bath easily and safely?</td>
<td></td>
</tr>
<tr>
<td>Is there an accessible/sturdy grab rail/s in the shower or beside the bath?</td>
<td></td>
</tr>
<tr>
<td>Are all the lights bright enough for the person to see clearly?</td>
<td></td>
</tr>
<tr>
<td>Can the person switch a light on easily from their bed?</td>
<td></td>
</tr>
<tr>
<td>Are the outside paths, steps and entrances well lit at night?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the person able to get on and off the toilet easily and safely?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is the person able to get in and out of the bath easily and safely?</td>
<td>N/A</td>
</tr>
<tr>
<td>Is there an accessible/sturdy grab rail/s in the shower or beside the bath?</td>
<td></td>
</tr>
<tr>
<td>Are the outside paths, steps and entrances well lit at night?</td>
<td></td>
</tr>
<tr>
<td>Can the person switch a light on easily from their bed?</td>
<td></td>
</tr>
<tr>
<td>Are the outside paths, steps and entrances well lit at night?</td>
<td></td>
</tr>
<tr>
<td>Is the person able to get on and off the toilet easily and safely?</td>
<td></td>
</tr>
<tr>
<td>Is the person able to get in and out of the bath easily and safely?</td>
<td></td>
</tr>
<tr>
<td>Is there an accessible/sturdy grab rail/s in the shower or beside the bath?</td>
<td></td>
</tr>
<tr>
<td>Are the outside paths, steps and entrances well lit at night?</td>
<td></td>
</tr>
</tbody>
</table>

**Signature..................................................**

**Date ........................................................................**

**Amendments**

**Signature..................................................**

**Date ........................................................................**
## Confidence in Maintaining Balance

<table>
<thead>
<tr>
<th>Question</th>
<th>Date:</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How confident are you that you can sit <strong>down in a chair</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident - 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How confident are you that you can <strong>get up from a chair</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident - 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. How confident are you that you can <strong>pick up something from the floor</strong> without losing your balance- not holding on to any support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident - 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. How confident are you that you can <strong>stand unsupported for about 5 minutes</strong> without losing your balance- not holding onto anything for support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How confident are you that you can <strong>walk without support for about 10 metres indoors</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How confident are you that you can <strong>walk up a gentle slope indoors</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. How confident are you that you can <strong>walk down a gentle slope indoors</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. How confident are you that you can walk <strong>over an uneven pavement</strong> without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How confident are you that you can <strong>go down stairs indoors, not using the handrail</strong>, without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident – 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. How confident are you that you can <strong>go up stairs indoors, not using the handrail</strong>, without losing your balance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not confident -3 Slightly Confident – 2 Confident - 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Amendments**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Adult Rehabilitation Service**  
**Specialist Falls Assessment**

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>NHS No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TINETTI BALANCE ASSESSMENT**

<table>
<thead>
<tr>
<th>Sitting balance</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leans or slides in chair = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady, safe = 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arises</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable without help = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able, uses arms to help = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able without using arms = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arises</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable without help = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able, requires &gt; 1 attempt = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to rise, 1 attempt = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immediate standing balance (first 5 secs)</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsteady (stagger, moves feet, trunk sway) = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady but uses walker or other support = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady without walker or other support = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standing balance</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsteady = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady but wide stance (heels &gt; 4&quot; apart &amp; uses a stick) = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narrow stance without support = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nudged (feet as close together as possible, 3 light pushes on the sternum)</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begins to fall = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagger, grabs, catches self = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes closed (feet as close together as possible)</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsteady = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady = 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Turning 360 degrees</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsteady (grabs, -stagger) = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discontinuous steps = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sitting down</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe (misjudged distance, falls into chair) = 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses arms or not a smooth motion = 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe, smooth motion = 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total:</th>
<th>Date:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>/16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature..................................................**  
**Amendments**  
**Signature..................................................**  
**Date .................................................................**  
**Date .................................................................**
## TINETTI GAIT ASSESSMENT

**Initiation gait (immediately after told to go)**
- Any hesitancy or multiple attempts to go = 0
- No hesitancy = 1

**Step Length and Height**

a) **Right foot swing**
   - Does not pass left stance foot with step = 0
   - Passes left stance foot = 1
   - Right foot does not clear floor completely with step = 0
   - Right foot completely clears floor = 1

b) **Left swing foot**
   - Does not pass right stance foot with step = 0
   - Passes right stance foot = 1
   - Left foot does not clear floor completely with step = 0
   - Left foot completely clears floor = 1

**Step symmetry**
- Right & left step length not equal (estimate) = 0
- Right & left step appears equal = 1

**Step continuity**
- Stopping or discontinuity between steps = 0
- Steps appear continuous = 1

**Path deviation**
- Marked deviation = 0
- Mild to moderate deviation or uses a walking aid = 1
- Straight without walking aid = 2

**Trunk**
- Marked sway or uses a walking aid = 0
- No sway, flexion of knees or back pain or spreads arms out while walking = 1
- No sway, no flexion, no use of arms and no walking aid = 2

**Walk stance**
- Heels apart = 0
- Heels almost touching = 1

**Comments:**

**Gait score: /12**

**Balance and Gait score: /28**

**Signature:**

**Date:**

**Amendments**

**Signature:**

**Date:**
## Summary/ Action Plan

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>NHS No.</th>
</tr>
</thead>
</table>

### Date

<table>
<thead>
<tr>
<th>Problems identified by patient</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Problems identified from assessments</th>
<th>Signature</th>
</tr>
</thead>
</table>

### Possible Medical Concerns

<table>
<thead>
<tr>
<th>Date</th>
<th>Postural Hypotension</th>
<th>Abnormal Urine</th>
<th>Multiple Medications</th>
<th>Calcium/ Vitamin Deficiency</th>
<th>Osteoporosis Risk</th>
<th>Alcohol Intake</th>
<th>Smoker</th>
<th>Abnormal Pulse</th>
</tr>
</thead>
</table>

### Action Plan

1. Refer to Medical Falls Clinic [Yes/ No] | **Unexplained fall, suspicion of medical cause**
2. Refer to Balance/ Safety Group [Yes/ No] | **Reason:**
3. Individual Therapy [Yes/ No] | **Reason:**
4. Home Hazard Assessment [Yes/ No] | **Reason:**
5. Refer to GP [Yes/ No] | **Reason:** (see above for medical concerns)
6. Refer to Social Services [Yes/ No] | **Reason:**
7. Refer to District Nurse [Yes/ No] | **Reason:**
8. Refer to Practice Nurse [Yes/ No] | **Reason:**
9. Refer to Community Exercise group [Yes/ No] | **Reason:**
10. Refer to Dietician [Yes/ No] | **Reason:**
11. Refer to Podiatrist [Yes/ No] | **Reason:**
12. Refer to Optometrist/ Ophthalmologist? [Yes/ No] | **Reason:**
13. Refer to Continence Service [Yes/ No] | **Reason:**

**Signature.............................................**  **Date ..................................................**

**Amendments**

**Signature.............................................**  **Date ..................................................**
SLIPS, TRIPS, AND FALLS (PREVENTION AND MANAGEMENT)
CLINICAL AUDIT STANDARDS

08/09/2016

Service area(s) to which standards apply:

<table>
<thead>
<tr>
<th>MH Inpatient (CAMHS)</th>
<th>Community CAMHS</th>
<th>X</th>
<th>CH Specialist Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>MH Inpatient (Adult)</td>
<td>C &amp; YP Integrated Therapy</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>MH Inpatient (Older)</td>
<td>School Nursing</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>MH Rehab &amp; Recovery</td>
<td>Health Visitors</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>Community Hospital</td>
<td>X</td>
<td>CH Rehab</td>
</tr>
<tr>
<td>X</td>
<td>MIU</td>
<td>X</td>
<td>Musculo-Skeletal</td>
</tr>
</tbody>
</table>
# SLIPS, TRIPS, AND FALLS (PREVENTION AND MANAGEMENT)

## CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Policy/Document Reference</th>
<th>Compliance (%)</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td></td>
<td>100%</td>
<td>None</td>
<td>Recorded in RiO via: <strong>Community Hospitals</strong>: Assessments Menu\Multi-disciplinary Assessment Record\Complete within 2 hours of Admission\Inpatient Falls Risk Management. (Sections 1 Universal Precaution and 2, Initial Falls Risk Assessment). <strong>Mental Health Older Adult wards</strong>: Risk &amp; Safety\Inpatient Falls Risk Management. (Sections 1 Universal Precaution and 2, Initial Falls Risk Assessment), within 24 hours of admission. The falls risk assessment should be completed within 6 hours of admission for community hospitals and older persons mental health wards. Transfers – patients should have a falls risk assessment completed within 6 hours of a transfer into a community hospital, from another community hospital. If the transferring hospital has completed an assessment less than 6 hours before the transfer then this is sufficient. If an assessment was not completed or was completed more than 6 hours before transfer (i.e. arrival at new hospital) then the admitting hospital must complete an assessment.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Policy 2.2.1</td>
<td>100%</td>
<td>Patient refused Patient lacked capacity</td>
<td>Any factors relating to their particular circumstances should be highlighted. Evidence in section 1 Falls Risk Assessment.</td>
</tr>
</tbody>
</table>

Admission: Community Hospitals and Older Persons Mental Health Wards

An inpatient falls risk assessment should be completed for all patients admitted to an older persons mental health or a community hospital.

All patients in community hospitals and older persons mental health should be given a “Preventing Falls in Hospital” factsheet.

---

**Slips, Trips and Falls (Prevention and Management) Policy**

V6

- 54 -

November 2018
<table>
<thead>
<tr>
<th>Standard</th>
<th>Policy/document Reference</th>
<th>Compliance (%)</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</th>
</tr>
</thead>
</table>
| 3        | Policy 5.1.2               | 100%           | None       | Core Assessments\Risk & Safety\Risk Screening.  
To be completed within 24 hours of admission  
Transfers – patients should have a falls risk assessment completed within 24 hours of a transfer into a mental health ward, from another mental health ward.  
If the transferring ward has completed an assessment less than 24 hours before the transfer then this is sufficient. If an assessment was not completed or was completed more than 24 hours before transfer (i.e. arrival at new ward) then the admitting ward must complete an assessment |
| 4        | Policy 5.1.2               | 100%           | None       | “At risk” = serious/significant entry for falls on the risk Screen. Recored in Core Assessments\Risk & safety link to ‘Inpatient Falls Risk Management’.  
Nice = all patients 65+ as well as all patients aged 50 and above who have dementia, stroke, vision or hearing problems and other underlying conditions, to be at a high risk of falling over while in their care. |

All patients admitted to adult mental health wards should have a baseline assessment of their risk of falls carried within the risk screening on admission.  
A falls risk assessment should be completed for any other patient admitted to mental health adult inpatient wards who have been identified at risk of falls.
## Slips, Trips, and Falls (Prevention and Management) Clinical Audit Standards

### INPATIENTS ONLY

<table>
<thead>
<tr>
<th>Standard</th>
<th>Policy/document Reference</th>
<th>Compliance (%)</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ONWARD MANAGEMENT: ALL INPATIENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A falls risk assessment must be repeated at weekly intervals for all patients and for any patient following a fall</td>
<td>Policy 5.1.2</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>6</td>
<td>Intentional Rounding must be implemented for patients at risk of falling in all inpatient settings</td>
<td>Appendix A 2.2.2</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>7</td>
<td>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</td>
<td>Appendix A 2.1</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>8</td>
<td>The patient should be included in the development of the care plan/care action plan and made aware of ways to stay safe. Wherever possible and appropriate, family and carers should also be included</td>
<td>Appendix A 2.1</td>
<td>100%</td>
<td>No carers/family Patient choice/lacked capacity Family/Carer refused</td>
</tr>
<tr>
<td>9</td>
<td>In the event of an inpatient fall occurring, the Protocol for Essential Care Following an Inpatient Fall Flowchart must be followed</td>
<td>Policy 7 Protocol Appendix G</td>
<td>100%</td>
<td>None</td>
</tr>
</tbody>
</table>
### SLIPS, TRIPS, AND FALLS (PREVENTION AND MANAGEMENT)
#### CLINICAL AUDIT STANDARDS

<table>
<thead>
<tr>
<th>Standard</th>
<th>Policy/ document Reference</th>
<th>Compliance (%)</th>
<th>Exceptions</th>
<th>Definitions (e.g. any interpretations, directions, or instructions on where/how to find information, plus relevant service where applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ONWARD MANAGEMENT: ALL PATIENTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>All falls should be reported via the DATIX reporting system</td>
<td>Policy 3.2</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>11</td>
<td>Upon receipt of a Falls Risk Assessment Tool (FRAT), the Integrated Rehabilitation Team (IRT) will contact the patient regarding future assessment and interventions</td>
<td>Policy Appendix B 2.8</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td><strong>DISCHARGE FROM HOSPITAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 12 | A fall in hospital must be taken into account when planning a patient’s discharge home | Appendix A 2.1.4 | 100% | Patient refusal | Discharge plans should include:  
- Implementation of interventions to reduce risk of falling again  
- Referral to Integrated Rehabilitation Team and, if appropriate:  
  - Home safety assessment may be needed to identify adaptations and/or equipment to improve safety |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Policy/document Reference</th>
<th>Compliance (%)</th>
<th>Exceptions</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13</strong></td>
<td>Older patients in other clinical services should be asked if they have fallen in the previous 12 months to establish their risk of falls</td>
<td>Appendix B 1.1 100%</td>
<td>Patient lacks capacity</td>
<td>Response or refusal to respond to be recorded in the patient record. Mental Health: recorded and assessed within risk screen on RiO Patients who have fallen in the last 12 months are deemed as “at risk” of falls.</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>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”</td>
<td>Appendix B 100%</td>
<td>Patient refuses referral to IRT Patient bedbound Patient receiving end of life care</td>
<td>Patients scoring 3 or more on the FRAT tool should be referred to Local Integrated Rehabilitation Team and a copy retained in the patient notes (scanned into RiO)</td>
</tr>
</tbody>
</table>