Shropshire Community Health NHS
NHS Trust

Document Details	
Title	**Prevention and Management of Falls Policy**
Trust Ref No	1347-57229
Local Ref (optional)	NA
Main points the document covers	The policy details the measures to be taken to prevent and manage falls to patients, staff and others
Who is the document aimed at?	All staff
Owner	Lisa Manning
Approval process	
Who has been consulted in the development of this policy?	Debra Lane RGN Bridgnorth Hospital David Young Pharmacy Sue Chadwick Therapy Whitchurch, Andrea Windsor Falls Service Amanda Forty Rehab Tech Bridgnorth Hospital Cath Molineux Consultant Nurse Emily Peer Deputy Medical Director Leeanne Morgan Ward Manager Amber Bugler Ward Manager
Approved by (Committee/Director)	Clinical Policy Subgroup
Approval Date	21/10/2019
Initial Equality Impact Screening	Y
Full Equality Impact Assessment	N
Lead Director	Director of Nursing and Operations
Category	Clinical
Sub Category	All Clinical Services
Review date	21/10/2022
Distribution	
Who the policy will be distributed to	All staff
Method	Electronically to senior staff, all staff via the Trust website, Mandatory training
Document Links	
Required by CQC	Yes
Required by NHSLA	Yes
Keywords	Falls, Slips, Trips, Head injury, Prevention

Amendments History		
No	Date	Amendment
1	2011	Prevention and Management of Falls and Fracture Policy
2	May 2012	Prevention and Management of Falls Policy to reflect NHSLA requirements regarding the process for managing slips, trips and falls involving patients, staff and others.
3	January 2016	Amendment of Prevention and Management of Falls Policy to reflect NICE guidelines: Falls CG161, Head Injury CG176, NICE quality standards: Falls in older peopleQS86
4	October 2019	Updated

Contents

1 Introduction

The Trust recognises that minimizing the risk of falls and fall related injuries is an important safety and quality of care issue.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

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.

Patients admitted to Community Hospitals are at high risk of falls. Risk factors which exist in a patient's own home setting will be exacerbated through an admission to hospital. This is due to the increased incidence of confusion, confounding medical conditions, unfamiliar environment and fear of asking for assistance or "being a nuisance".

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency. Falls are the leading cause of accident- related death in people over 75 years of age.

Although the majority of falls are reported to result in no harm, even falls without injury can be upsetting and lead to loss of confidence, increased length of stay in hospital and increased likelihood of discharge to residential or nursing care home.

Preventing falls however must be balanced with patients' rights to dignity, privacy, independence, rehabilitation and their choices about the risks they are prepared to take.

Falls account for approximately 30% of all accidents to employees leading to time off work. Within the Trust between 20 and 40 staff falls occur each year, with 10% of these accidents leading to moderate or greater injury. Many of these accidents can be avoided by simple measures and ensuring that defects are promptly reported and dealt with.

Trust premises are used by many people including contractors and other NHS employees. The Trust owes the same duty to these people as it does to its employees.

2 Purpose

The purpose of the policy is to:

Provide guidance and awareness to Trust staff on falls related issues and thereby maximize staff and patient safety and quality of care

Guide clinical staff in identification of adult patients who have fallen or are at risk of falling and in implementation of multi- disciplinary multifactorial interventions required to reduce the risk of a fall or fall related injury for each individual

Standardise initiatives to prevent falls and fractures across the community services and hospitals

Identify environmental risks which have the potential to cause falls to patients and any other person who uses Trust premises and formulate actions to mitigate these risks

Identify work related tasks which increase the risk of slips trips and falls and formulate actions to mitigate these risks

3 Definitions

A fall is defined as:

"An unexpected event in which the participant comes to rest on the ground, floor or lower level" *[Prevention of Falls Network Europe (ProFaNE)]*

Term / Abbreviation	Explanation / Definition
BAPEN	British Association for Parenteral and Enteral Nutrition
BP	Blood pressure
CCS	Community Council of Shropshire
CMHN	Community Mental Health Nurse
CSP	Chartered Society of Physiotherapy
CXR	Chest X-ray
DAART	Diagnostics, Assessment and Access to Rehabilitation and Treatment
DEXA	Dual Energy X - Ray Absorptiometry
ECG	Electrocardiogram
ECT	Enhanced Care Team
ESC	European Society of Cardiology
FBC	Full blood count
FES-I	Falls Efficacy Scale-International
FPS	Falls Prevention Service
GCS	Glasgow Coma Scale
ICS	Integrated care Service
IDT	Inter Disciplinary Team
ILC	Independent Living Centre
IPCT	Integrated Primary Care Teams
LFT	Liver Function Test
MIU	Minor Injuries unit
NICE	National Institute for Health and Clinical Excellence
MCA	Mental Capacity Act
PBDU	Paul Brown Day Unit
POAM	Problem-oriented assessment of mobility (Tinnetti)

Term / Abbreviation	Explanation / Definition
RBG	Random Blood Glucose
SCHT	Shropshire Community NHS Health Trust
TSH	Thyroid Stimulating Hormone
U & E	Urea and electrolytes
UTI	Urinary tract infection
WHO	World Health Organisation

4 Duties

4.1 The Chief Executive

The Chief Executive Officer has overall responsibility for maintaining staff and patient safety and is responsible for the governance and patient safety programmes within the organisation.

4.2 Directors

Directors of Services are responsible for ensuring the safe and effective delivery of services they manage; this includes securing and directing resources to support the implementation of this policy. They are also responsible for ensuring a process is in place to effectively manage patient falls and that the organisation is compliant with the Care Quality Commission (CQC) and National Health Service Litigation Authority (NHSLA).

4.3 Line Managers and Service Leads

Managers and service leads must ensure that:

- A system is in place within the services they are responsible for, for the implementation of this policy and for monitoring its effectiveness
- Serious Incidents related to falls are investigated and lessons learnt to improve service delivery
- Ward managers must ensure that a Community Hospital Environment Assessment is completed (Appendix 7)
- Ward managers must liaise with domestic staff to ensure cleaning procedures / routines are carried out in a time and way so as to least likely impact on safety of patients
- Training is carried out in relation to falls according to their responsibilities detailed in 4.7 of the Mandatory (Risk Management) Training Policy and Procedure
- Risk assessments are carried out according to the requirements in this policy
- Where actions are identified by risk assessment they will identify who is responsible for making sure they are carried out and that they have been completed
- Defects/ hazards reported by staff are promptly resolved

4.4 Team Leaders

Team Leaders must ensure that clinical staff are competent in completing falls assessments and care plans through supervision and appraisal and a record kept.

4.5 All Staff

All staff must ensure that they:

- Comply with the arrangements in place to implement and maintain this policy within their areas of work
- Work within their professional codes of conduct (where applicable) and maintain professional competencies when completing assessments and providing interventions to reduce risks of falls
- Are aware of their work setting and implement relevant assessment and appropriate documentation
- Attend Falls Prevention training as indicated by the Mandatory Training Needs Analysis
- Report falls as incidents on DATIX
- Report hazards and defects promptly, and make areas safe where it is necessary to do so

4.6 Community Equipment Services

Community Equipment Services (CES) must ensure that:

- Sufficient stock is available to ensure prompt delivery of equipment ordered, including to satellite stores in some areas
- Any problems relating to procurement/ access to equipment are immediately raised with the responsible manager and Director

5 Prevention and Management of Slips, Trips and Falls (including falls from height) to patients

5.1 Identification of Patients at Risk of Falls

5.1.1 All community clinical staff must:

- Routinely (at least once a year) ask patients if they have fallen in the previous year. Ask about frequency, context and characteristics of fall and determine the need for further falls and bone health assessment by completing the Falls Referral Form and FRAX (Appendix 2) and following the advice

5.1.2 All community hospital nursing staff must:

- Ask Acute Trust Hospital Staff/ other referring organisation if the patient being referred has a history of recent falls at home or during hospital admission, the likely cause of the fall and any interventions in place to reduce risk of further falls
- Complete a Falls and Injury Risk Screening and Management Plan .(Appendix 3) Both sections are to be completed on all patients aged 65 years or older and patients aged 50 – 64 who are judged by a clinician to be at higher risk of falling because of an underlying condition.
    - The Falls Risk screening Tool must be completed on admission.

- File Falls and Injury Risk Screening and Management Plan within Risk assessment section of collaborative care document

5.2 Assessment and care planning of Patients identified to be at risk of Falls

5.2.1 All Adult Services must:

- Identify and manage falls risk factors.

  Falls Referral Form and FRAX (Example Appendix 2).

- Provide Multifactorial interventions as indicated from assessment with onward referrals as required.

  Common or Comprehensive Assessment Form (Rio – Adult Services)

- Devise a Falls Care / Action Plan agreed with patient and file in patient notes

5.2.2 Community Hospital Nursing Staff must:

- Complete Falls and Injury Risk Screening and Management Plan .(Appendix 3)
- The Falls Management Plan section must be completed within 24 hours of admission and should be reviewed thereafter weekly or following change in patients condition including change in medication or following a fall.
- Date and time of subsequent review(s) must be documented and any changes must be recorded on the Communication and Evaluation sheet and RiO progress notes.
- File Falls and Injury Risk Screening and Management Plan within Risk assessment section of collaborative care document

- The Falls Management Plan gives consideration to:
  - The patients physical condition e.g. orthostatic hypertension, cardiovascular status, mobility/ transfer problems
  - Urinary function- urgency/ frequency/ continence
  - Sensory function – poor eyesight
  - Bone health – risk of fracture due to osteoporosis
  - The patient’s cognitive function, ability to follow instruction, changes in behaviour/ causes of confusion
  - Pharmacology history- medication side effects/ interactions
  - Foot care and correct footwear
  - Use of appropriate aids and need for bed rails (refer to Bed Rails Policy)
  - Environment

5.2.3 Clinical Pharmacists must:

- Provide falls specific medication review on all patients admitted to Community Hospitals
- Highlight drugs of concern and make request for a medical review
- Ensure any changes to medication that are made are listed on Discharge Summary to GP
- Ensure the patient and their family or carers are educated about any medication changes and supplied with a "Compliance Chart" at discharge with current list of medication and is informed of changes.
- Refer to the Medicines Management Clinical Quality and Safety team on email meds.safety@nhs.net for patients where their medicines may have been a cause of the fall and Datix the incident.

5.2.4 All clinical staff in any setting must:

- Be aware of the organisation's Guidelines for the Integrated Management of Falls and Fracture Risk in Vulnerable People within Community Services and follow the referral pathway (Appendix 1)
- Be aware that changes in usual patient behaviour such as agitation, restlessness, listlessness may indicate delirium (Acute confusional state) - if present refer to Altered Behaviour Policy or refer to GP/ Shropdoc / DAART/ PBDU in Community Services (see *NICE Guidelines on Delirium, diagnosis, prevention and management (July 2010)*
- Be aware of suspected transient loss of consciousness (Blackout) (see *NICE Guidelines on Transient Loss of Consciousness ('Blackouts') management in adults and young people (September 2014) and* refer to Community Hospital GP/ GP/ Shropdoc / DAART/ PBDU

5.2.5 Orthostatic or Postural Hypotension

Postural hypotension / postural drop is said to be present if there is a systolic drop of more than 20 mm Hg or diastolic drop of more than 10 mm Hg on moving from lying to an upright position. See Appendix 1.Box 5 for guidance on measuring postural drop. It is to be noted that some patients may be symptomatic with systolic drop of much less than 20 mm Hg

- Refer to GP for medical review (medications or recent changes in medication, cardiac problems, Diabetic Neuropathy)
- Make sure patient is well hydrated
- Apply anti embolism stockings if practicable
- In hospital setting – ensure patient has access to call bell or alternative at all times and advise not to mobilize without assistance if they have symptoms
- Advise to move slowly from sitting to standing and activate muscles prior to standing
- Supply Postural Hypotension Patient Information Leaflet if appropriate

5.2.6 Use of High/ Low beds and Specialist Mattresses (Home and in a Community Hospital)

To prevent falls and injuries it may sometimes be necessary to use high/low beds or crash mats/mattresses to promote patient safety.

Patients should be individually assessed to determine if their use could prevent potential falls from bed. This would take into account their physical illness, their state of anxiety/ confusion, discomfort/ pain, disabilities/ capabilities, patient wishes, previous accidents and injuries and any variation in condition over the past 24 hours e.g. nocturnal confusion.

Decision must be recorded in clinical nursing records. Use of equipment to be reviewed as per care plan.

5.2.7 Bed Rails (Home and in a Community Hospital)

If bed rails are indicated refer to Bed Rails Policy & completion of risk assessment. Decision and rationale must be documented in the clinical records and care plan.

5.2.8 Equipment for Management of Falls

Basic low level equipment should be accessible to Community Hospital, Interdisciplinary/ Integrated Care / Falls Prevention Teams including emergency access to walking frames (Appendix 6). Community Equipment Loan Stores/ Specialist Equipment Nurse and Interdisciplinary Teams/ Integrated Care Teams are available for expert advice and support.

5.2.9 Patient Falls from Height (Home and in a Community Hospital)

All patient areas should consider the possibilities of patients falling from height. Where risks are identified these should be recorded within the departmental risk assessment, along with any identified controls which are followed in the area, and any actions that need to be taken to introduce further controls.

The following risks will need to be considered:

- Stairs and landings

Stairs and landing are a risk associated with everyday living. The risk associated with them will need to be considered more carefully where vulnerable patients e.g. elderly and children are present. Areas that will need to be considered are:

  - Stairs with particular hazards, e.g. steep and twisting

Where these pose risks to all persons redesign or marking will be necessary. Where there are vulnerable patients restricting access or other means of controlling access may be necessary

  - Stairs and landings in general

The level of protection in general will need to be considered. The provision of support e.g. handrails. Where vulnerable patients are required to access stairs and landings staff assistance may be necessary. Restricting access e.g. stairgates with children may need to be considered. Heights of barriers are crucial, especially with children. Footholds and location of furniture will also need to be considered

- Windows

There have been a number of serious incidents, which includes fatalities, related to patients or other persons falling from windows. This may result from accidents, a patient being confused or as an act of deliberate self harm.

All Trust properties should have patient area windows restricted to an opening of 100mm as recommended in Health Technical Memorandum 55. This must be checked on a regular basis, at least annually, as part of the environmental checklist included in Appendix 7.

5.3 Assessment and Management following a Fall

5.3.1 Post Fall Protocol

- Any patient who has fallen (including fall from height) should be managed according to the Post Fall Flow Chart for Health Professionals Actions (Appendix 4 Page 4)
- On wards Laminated copies of Post Fall Flow Chart for Health Professionals Actions should be displayed where visible to all staff
- Any patient who has fallen during a hospital stay must be checked for signs or symptoms of fracture and potential for spinal injury before they are moved
- Any patient who has fallen during a hospital stay and has signs or symptoms of fracture and potential for spinal injury must not be moved. Emergency services must be called to ensure safe manual handling methods are undertaken
- Any patient showing signs of serious injury, being highly vulnerable to injury or who has been immobilised should have a fast- track medical examination. This may be achieved in collaboration with emergency services.
- If patient in community setting, and not identified as Medical emergency requiring 999, a Level 1: Falls referral form and FRAX (Appendix 2) should be completed/ actioned and referral made to appropriate agency / service with patients consent
- Community Hospital clinical staff must complete Post Fall Incident Form (Appendix 4) on any patient who falls in Community Hospital setting and follow recommendations.

5.3.2 Head Injuries

A Head Injury is defined by NICE as “any trauma to the head other than superficial injuries to the face”.

- Community Hospital Staff should follow recommendations and guidance in Post Fall Incident Form (Appendix 4)
- If fall occurs in patient’s own home, recommended frequency and duration of neurological observations are unlikely to be possible, but, community staff should follow Post Fall Flow Chart for Health Professionals Actions.

5.3.3 Multidisciplinary Teams in all settings, Including Medical Staff must:

- Consider further investigation for recurrent unexplained falls or syncope. Refer to Hospital GP, GP, Diagnostic, Assessment and Access to

Rehabilitation and Treatment (DAART) or Consultant Falls Clinic depending on locality and status in – Shropshire, or Paul Brown Day Hospital –Telford

- Consider referring older people who have a history of recurrent falls and who live in their own homes or sheltered housing schemes for strength and balance training delivered by appropriately trained staff. See referral pathway in Level 1 Falls Referral Form and FRAX (Appendix 2)
- Patients who are admitted to hospital after having a fall should be offered a home hazard assessment and safety interventions. See example of locally validated Home Safety Check Booklet on http://www.shropshire.nhs.uk/Care-and-Treatment/Out-of-Hospital-Services/Falls-Prevention-Service/

6 Falls to staff and other persons

6.1 Risk Assessment

Risk Assessment

All departmental risk assessments will have an entry for slips trips and falls. This entry must be reviewed annually. There will be 2 sections to this

6.1.1 Environment

For patient areas the risks identified as part of compliance with section 5 should be included. Any significant risks identified when completing the assessment at appendix 7 should also be included.

All areas, patient and non patient should identify any significant areas of concern, e.g. where ground levels, flooring, changes in level, lighting and other aspects give concern, both internal or external. Remedial actions should be put into place where possible. If not possible, the assessment should include how the risk is going to be managed or controlled. This will include stairs and landings where not covered as part of the patient risks, and where there are significant findings.

The assessment will need to take into account outdoor/indoor thresholds, and how water transfer will be avoided.

These assessments must be reviewed annually

6.1.2 Risks Associated with Work

The risk assessment must include any activity where there is an increased risk of falling. The following activities are examples of this

Working from ladders or steps (e.g changing curtains, cleaning large items of furniture

Possible controls

- Good quality appropriate access equipment
- Equipment inspected and maintained according to manufacturer's instructions
- Training on the use of the access equipment (when indicated by the risk assessment

Working in wet conditions (e.g. in kitchens, and where there is risk of spillages)

Possible controls

- Ensuring that spillages are dealt with promptly
- Signing wet areas
- Ensuring floor areas are of the appropriate type
- Selection of footwear

Cleaning activities

Cleaning activities will potentially pose a risk to staff, patients and any other person who uses the area.

Possible controls

- Choosing a time where there is less activity
- Choice of cleaning methods and materials
- Signing areas

6.2 Actions resulting from the Risk Assessment

The purpose of the risk assessment is to establish the hazards, who will be affected, what the level of risk is and whether or not existing measures to control the risk are sufficient.

Where additional control is required an action plan will be formulated including what is to be done, who is to do it and by when. Regardless of who carries out the assessment the line manager will be informed of the outcome, including any actions necessary to improve the management of falls risks. They are responsible for ensuring that any actions identified are carried out.

The above will apply to all general risk assessments for patients, staff and other, including the environmental assessment detailed in Appendix 7.

6.3 Reporting hazards and defects

All staff must report any hazards or defects that they identify. Examples of the types of hazards are

- Unlevel or broken paving slabs
- Potholes
- Damaged flooring
- Lifting carpets
- Damaged gratings or gullies
- Leaks
- Trailing cables

- Inappropriately placed furniture or equipment

And any other trip hazards

Where the hazard poses an immediate risk the member of staff should take remedial action immediately e.g. marking or cordoning the area off. In all cases the defect should be reported to the line or other appropriate manager as soon as is reasonably practicable.

The manager should take further action, including actioning with Estates as appropriate.

6.4 **Reporting and learning from incidents**

Slips trips and falls incidents should be reported according to the Incident Reporting Policy. Incidents are forwarded to a nominated manager for investigation. For slips trips and falls this will normally be at the least a visit to the area and conversation with the staff involved. For serious incidents this will mean a Root Cause Analysis investigation will be undertaken.

There will be circumstances where an isolated incident occurs which does not warrant any further action at the time, but subsequent incidents will point to an unidentified underlying problem. An analysis of past incidents is a useful tool in identifying these circumstances.

7 Consultation

Policy circulated via: E- mail contact with:

Debra Lane RGN Bridgnorth Hospital

David Young Pharmacy

Sue Chadwick Therapy Whitchurch,

Andrea Windsor Falls Service

Amanda Forty Rehab Tech Bridgnorth Hospital

Cath Molineux Consultant Nurse

Emily Peer Deputy Medical Director

Leeanne Morgan Ward Manager

Amber Bugler Ward Manager

8 Dissemination and Implementation

This policy will be disseminated and implemented by the following methods:

8.1 **Dissemination**

- Directors/Service Leads/Key personnel to receive copy electronically via Datix safety alert system – to disseminate to relevant staff within their areas
- Published to the staff intranet and on the public website
- Mandatory Falls Prevention training programme provided by the Falls Prevention Service
- Awareness raising by the Falls Champions

8.2 **Implementation**

8.2.1 Advice

For further information contact:

Lisa Manning
Team Lead
Shropshire Falls Prevention Service
Tel No: 01743 730035
E- mail : Lisa.manning7@nhs.net

8.2.2 Awareness

- The Falls Prevention in Hospital Leaflet will be issued to patients and carers / relatives to promote awareness of falls risks and assessments undertaken in hospital. Other leaflets which may be useful for patients/ families to access are available from Falls Prevention Service and a range of leaflets from Age UK.
- For additional Falls information and leaflets see Falls website: http://www.shropshire.nhs.uk/Care-and-Treatment/Out-of-Hospital-Services/Falls-Prevention-Service/
- Falls Champions are identified in each area of community services whose role is to attend a quarterly Falls Champion Forum to be led by Falls Prevention Service. The Forum will provide opportunity to gain feedback of best practice in each area, disseminate new information/ research for cascade back to their teams. The Forum will develop links and network opportunities between health, social, independent and voluntary sector to promote the prevention of falls including taking part in Falls Awareness Events.

8.2.3 Training

- Staff awareness will be promoted by training. The training to be carried out is detailed in the Training Needs Analysis which forms part of the Mandatory (Risk Management) Training Policy and Procedure
- Refer to the Trust Mandatory (Risk Management) Training Policy and Procedure.

9 Monitoring Compliance

This policy will be reviewed and updated every two years or as changes in best practice standards, guidance or legislation occurs.

Compliance with this policy will be monitored according to the template below

	Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
1	**Duties (Patients Staff and Others)**	Falls lead, Risk Manager	Falls risk assessments	At least annually	Reporting to line manager	Risk Manager will verify that required risk assessments are carried out, that controls are being applied as described and any identified actions are applied Falls lead will ensure that patient assessments and controls are being applied in line with the policy	A written report will be submitted to line managers, for dissemination as appropriate
2	**How organization assesses the risk of slips, trips and falls involving patients (including falls from height)**	Risk Manager	Risk assessment records	Annually for summary report, monthly for individual records	Reporting to Line/service managers and summarily to Q&S Operational group	Quality check on entries as part of risk moderation process Summary report on findings	Feedback to lines managers and to service heads via Q&S Operational Group

3		Service managers	Quality review of Falls risk Assessments and Falls Care/ Action plans	Monthly	Results fed back to Lead for Quality and Safety. The Lead is expected to read and interrogate the report to identify deficiencies in the system and act upon them.	Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
4		Service managers	Report Falls to National Safety Thermometer	Monthly	Results fed back to Lead for Quality and Safety, Safecare Shropshire Project Board and Commissioners	Required actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
5	**How the organization trains staff in line with the training needs analysis (Patients staff and others)**	Refer to the Trust Mandatory (Risk Management) Training Policy and Procedure.				Actions will be identified and completed in a specified timeframe.	Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where

							appropriate. Lessons will be shared with all the relevant stakeholders
6	**How organization raises awareness about preventing and reducing the number of slips, trips and falls involving patients**	Risk Manager/Falls Lead/Service Managers	Incident reports Current initiatives	Quarterly Annually	The Risk Manager will issue quarterly reports to all areas. Service managers will raise with their staff the issues arising out of incidents Fall lead will review mandatory training, which includes staff awareness, annually Service Managers will share falls results from quality reviews to staff	Service Managers will initiate actions where necessary Using local and national information Service Managers will initiate actions where necessary	Lessons will be shared via local arrangements e.g. team meetings Through staff training sessions Information shared through local forums according to service type and structure
7	**How the organisation assesses the risk of staff and others (including falls from height**	Risk Manager	Risk assessment records	Annually for summary report, monthly for individual records	Reporting to Line/service managers and summarily to Q&S Operational group	Quality check on entries as part of risk moderation process Summary report on findings	Feedback to lines managers and to service heads via Q&S Operational Group

8	**How the organisation raises awareness about preventing and reducing the number of slips trips and falls involving staff and others**	Risk Manager/ Service Managers Risk Manager	Incident reports Current initiatives	Quarterly Annually	The Risk Manager will issue quarterly reports to all areas. Service managers will raise with their staff the issues arising out of incidents Risk Manager will review mandatory training, which includes staff awareness, annually	Service Managers will initiate actions where necessary Using local and national information	Lessons will be shared via local arrangements e.g. team meetings Through staff training sessions

10 References

- National Service Framework for Older People 2001
- NICE Clinical Guideline 161 Falls: assessment and prevention of falls in older people 2013
- NICE Quality Standard 86 Falls in older people: assessment after a fall and preventing further falls 2015 updated 2017
- NICE clinical guideline 146 Osteoporosis: assessing the risk of fragility fracture 2012 (Updated 2017)
- NICE Guidelines for Primary and Secondary Prevention of Osteoporotic Fragility Fractures in post menopausal Women 2008
- NICE Guidelines (CG103) on Delirium, diagnosis, prevention and management (July 2010)
- NICE Guidelines (CG109) on Transient Loss of Consciousness ('Blackouts') management in adults and young people (August 2010) updated September 2014
- NICE guidelines [CG176] Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults 2014
- National Patient Safety Agency (2007), Slips, trips and falls in hospital. Patient Safety Observatory www.npsa.nhs.uk
- Rapid Response Report NPSA 2011- Essential care after an inpatient fall January 2011
- Patient Safety First - The "How to" Guide for Reducing Harm from Falls 2009 (Updated 2013)
- AGS/ BGS Clinical Practice Guideline: Prevention of Falls in Older Persons 2010
- DoH Falls and Fractures Effective interventions in health and Social Care 2009
- DoH Falls and Fractures Developing a local joint strategic needs assessment
- DoHFalls and Fractures Exercise Training to Prevent Falls
- RCP National Audit of the Organisation of services for Falls and Bone Health of Older People 2009
- MHRA Device Bulletin DB2006 (06) The safe use of bedrails. www.mhra.gov.uk
- MHRA Device Alert (207/009) Bed Rails and Grab Handles. www.mhra.gov.uk
- ProFaNE Prevention of Falls Network Europe
- RCP Fall Safe care Bundles and Resources to reduce inpatient falls
- National Osteoporosis society

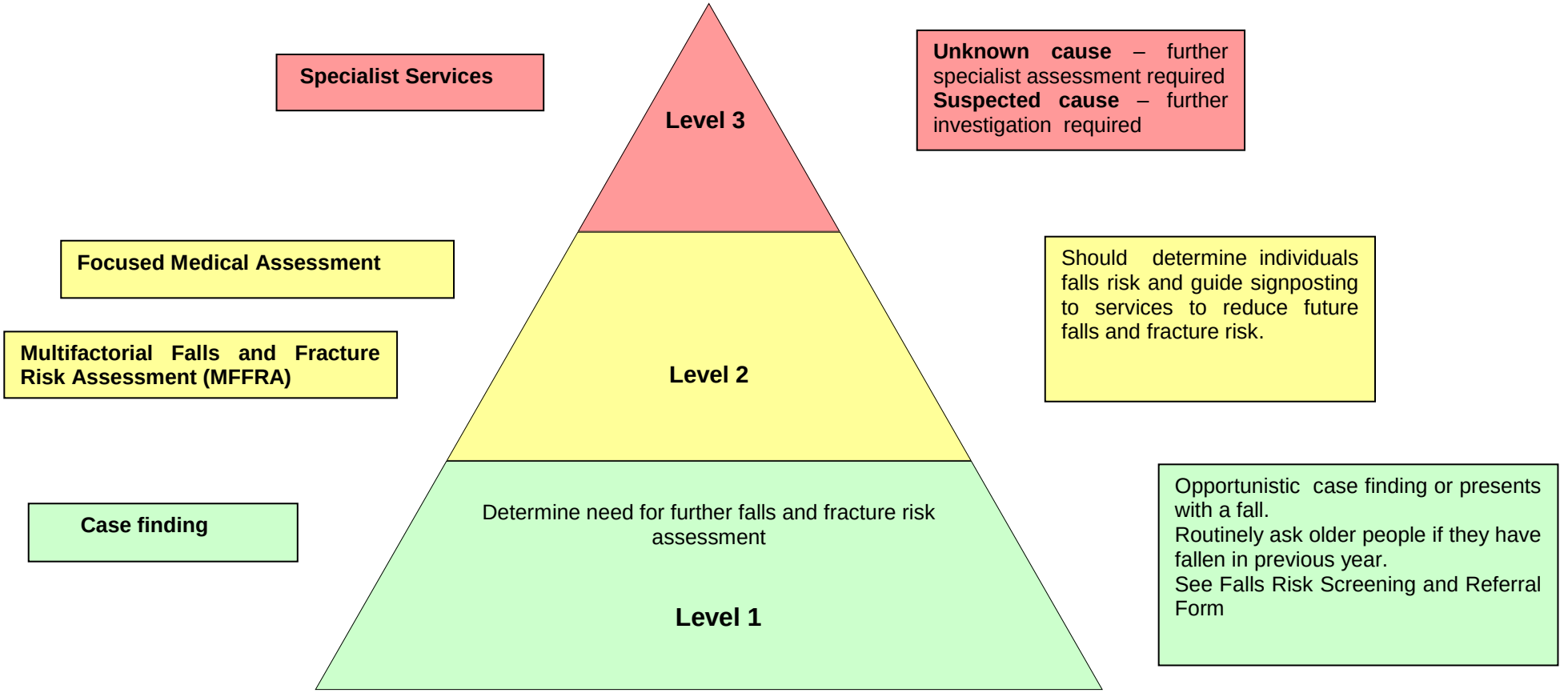
11 Associated Documents

The following documents contain information that relates to this policy:

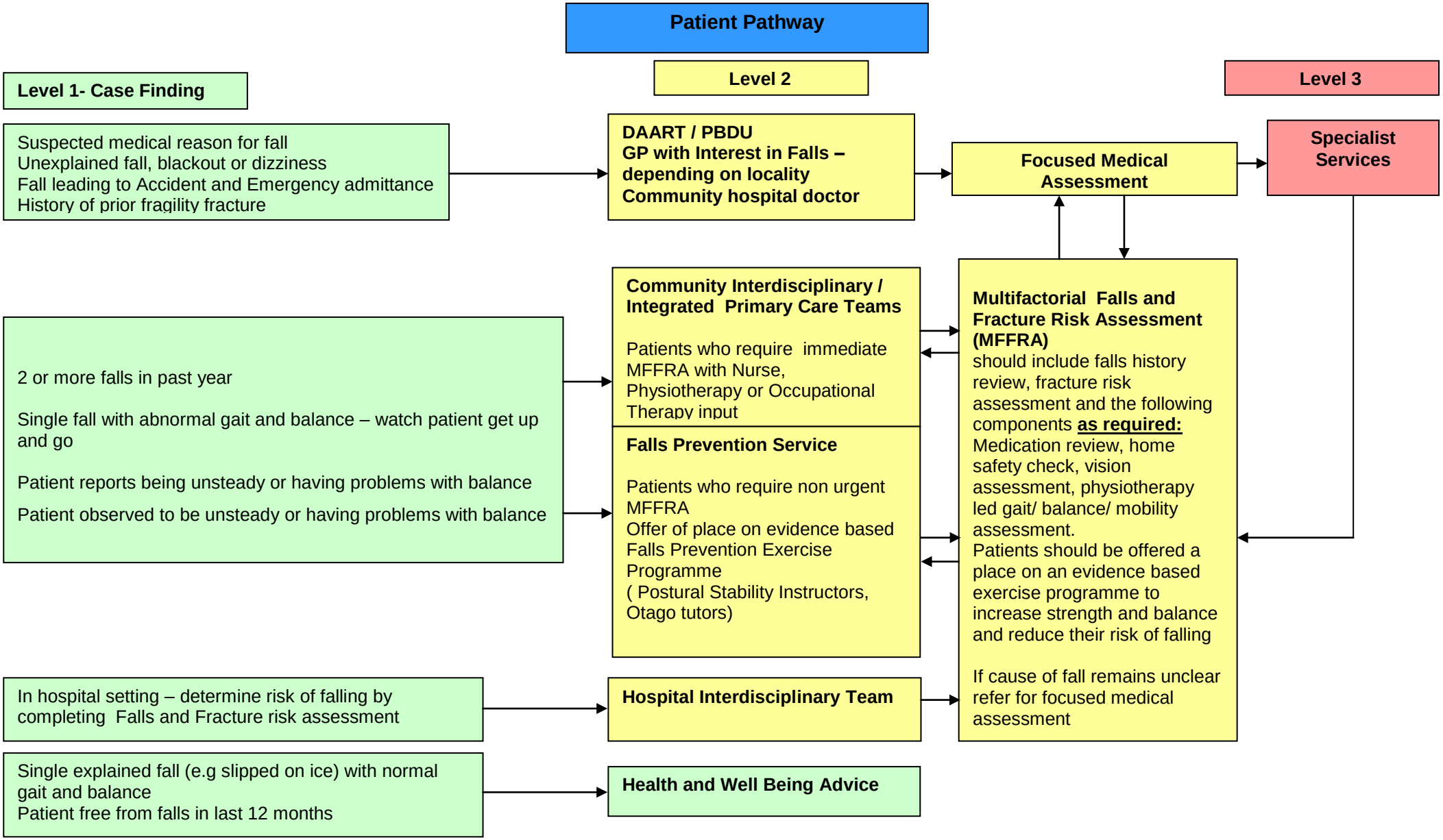
- SCHT Guidelines for the Integrated Management of Falls and Fracture Risk in Vulnerable People within Community Services Records Management Policy
- SCHT Bed Rails Policy
- SCHT Manual Handling Policy
- SCHT Clinical Record Keeping Policy
- SCHT Prevention of Slips, Trips and Falls Code of Practice
- SCHT Consent to Examination or Treatment Policy
- SCHT Chaperone Policy
- SCHT Mental Capacity Act Policy
- SCHT Safeguarding Adult Guidelines
- SCHT Risk Management Strategy and Policy
- SCHT Incident Reporting Code of Practice
- SCHT Deprivation of Liberty Safeguards (DoLS) – Multi Agency Guidance and Procedures
- SCHT Altered Behaviour Policy

Appendix 1: Guideline for the Integrated Management of Falls and Fracture Risk in Vulnerable People within Community Services

Consider all elements below and refer according to Pathway[1].



[1] Adapted from the Sheffield Do Once and share Falls Pathway


Patient Pathway
Level 1- Case Finding
Level 2
Level 3
Suspected medical reason for fall
Unexplained fall, blackout or dizziness
Fall leading to Accident and Emergency admittance
History of prior fragility fracture
DAART / PBDU
GP with Interest in Falls – depending on locality
Community hospital doctor
Focused Medical Assessment
Specialist Services
2 or more falls in past year
Single fall with abnormal gait and balance – watch patient get up and go
Patient reports being unsteady or having problems with balance
Patient observed to be unsteady or having problems with balance
Community Interdisciplinary / Integrated Primary Care Teams
Patients who require immediate MFFRA with Nurse, Physiotherapy or Occupational Therapy input
Falls Prevention Service
Patients who require non urgent MFFRA
Offer of place on evidence based Falls Prevention Exercise Programme
(Postural Stability Instructors, Otago tutors)
Multifactorial Falls and Fracture Risk Assessment (MFFRA)
should include falls history review, fracture risk assessment and the following components as required:
Medication review, home safety check, vision assessment, physiotherapy led gait/ balance/ mobility assessment.
Patients should be offered a place on an evidence based exercise programme to increase strength and balance and reduce their risk of falling
If cause of fall remains unclear refer for focused medical assessment
In hospital setting – determine risk of falling by completing Falls and Fracture risk assessment
Hospital Interdisciplinary Team
Single explained fall (e.g slipped on ice) with normal gait and balance
Patient free from falls in last 12 months
Health and Well Being Advice

Level 1

1. Presents with a Fall or Fracture following a Fall

Definition of a fall:

"An unexpected event in which the participant comes to rest on the ground, floor or lower level"
[Prevention of Falls Network Europe (ProFounD]

- Treat any injury due to a fall before an individual enters the falls pathway
- Treat any acute medical condition before an individual enters the falls pathway
- Consider engagement with carers

2. Opportunistic case finding - Routine Elderly Check or Contact. Enquire about Falls in the previous year and prior Fragility Fractures

Older people in contact with health and social care professionals should be asked routinely (at least once a year) whether they have fallen in the past year and asked about the frequency and characteristics of the fall/s (NICE Clinical practice guideline for the assessment and prevention of falls in older people, 2004)

- Enquire about falls every 6-12 months
- Advise medicines review
- Advise routine eyesight test
- Advise routine podiatry

See Falls Risk Screening and Referral Form

3. Health and Well Being

Give general advice about:

- Lifestyle (Physical and Mental Health)
- Alcohol awareness
- Smoking cessation
- Healthy Eating
- Home Safety / Housing
- Exercise
- Footwear
- Hearing and sight loss
- Avoiding risk
- Access to local sports / leisure facilities
- Information about local voluntary agencies

Guidance on Falls Prevention may be obtained from the following:–

- RoSPA www.rospa.org.uk
- National Osteoporosis Societywww.nos.org.uk
- Leaflets and fact sheets may be accessed from Age UK www.ageuk.org.uk
- Shropshire Community Health NHS Trust website : Falls Prevention Service

Further health and Well Being advice from:

- Help2Quit nurses for smoking cessation
- Age UK for activities, social visits and general advice
- Community Mental Health Nurses for any mental health concerns
- Community Council of Shropshire for list of Extend and Otago community exercise classes or visit www.healthyshropshire.co.uk www.energizestw.org.uk
- Red Cross for Home from Hospital service

4. Initial Falls and Fracture Risk Screen

Medical Problem / Unexplained Fall

Reports of:

- loss of consciousness
- suspected blackouts, unexplained falls, dizziness
- previous fragility fracture

Go straight to Focused Medical Assessment either in Primary or Secondary Care (the setting for this and the professionals contributing to it depend on local guidelines)
If indicated, the multifactorial assessment can proceed alongside this assessment.

Recurrent falls / Single fall with abnormal gait and balance/ patient report or staff observation of gait and balance problems

Individuals who report:

- Recurrent falls (eg 2 or more falls in past year)
- Single fall with abnormal gait and balance problems
- Patient reports being unsteady or having problems with balance
- Patient observed to be unsteady or having problems with balance

Should go straight to a multifactorial assessment performed by healthcare professionals with appropriate skills and experience. Patients declining assessment should be offered Health and Well being information and suggest medicines review if taking more than 4

Single Explained Fall

If presenting with a single explained fall (eg clear slip on ice) with normal gait and balance, give Health and Wellbeing advice and review in 6-12 months

Level 2

5. Focused Medical Assessment

For those who have suspected or confirmed blackouts, and those with unexplained falls, vertigo and dizziness (minimum requirement, other parts will be directed by clinical findings)

History from patient and witness

- Past Medical History including history of Stroke, Parkinsons disease, epilepsy, fracture, arthritis, ischaemic heart disease, heart failure, diseases associated with autonomic neuropathy
- History of falls and blackouts
  - Frequency, circumstances and situation, description from witness
  - Prodromal symptoms- light-headed, dizziness, palpitations, chest pain
  - Post- event weakness, disorientation
- Smoking and Alcohol History
- Medication History

Examination

- Pulse rate and rhythm
- Lying and standing blood pressure*
- Auscultate for aortic stenosis
- Sensory and motor neurological assessment
- Assess gait
- Anxiety / Depression/ Cognition
- Visual acuity and fundoscopy
- Visual impairment or change in vision
- Hearing impairment
- Urinary incontinence or urgency

Basic Tests

U&E, FBC, B12, Calcium, LFT, RBG, TSH,
12 lead ECG, Urine dipstick and CXR as clinically indicated

* Measuring postural drop

- Lie patient flat for 5 minutes then take BP
- Stand patient and observe for postural sway and dizziness
- Record BP and any symptoms after 1 and 3 minutes of standing
- Record further if BP is falling after 3 minutes
- Observe for drop of Systolic BP by 20mmHg, diastolic by 10mmHg

(ESC guidelines, 2018)

Note : If cause of fall remains unexplained or blackouts suspected – refer to DAARTs / PBDU or Consultant falls clinic depending on locality

6. Multifactorial Assessment

This should be performed by a health care professional with appropriate skills and experience.
(NICE Clinical Guidelines 21, 2013) CG 161

The assessment may include the following:

- Medical Examination **-** see Box 5
- Identification of Falls History ***i***
- Assessment of gait, balance, joint range of movement, and muscle strength ***i***
- Footwear examination /check ***i***
- Assessment of osteoporosis risk ***i***
- Assessment of the person's perceived functional ability ***i***
- Fear of falling ***i***
- Assessment of visual impairment ***i***
- Assessment of hearing ***i***
- Assessment of cognitive impairment ***i***
- Assessment of continence ***i***
- Assessment of home hazards ***i***
- Medication review ***i***
- Review alcohol intake ***i***
- Nutrition / Dehydration ***i***
- Pain assessment ***i***

Key: *i* - information node - in following white boxes

Multifactorial Assessment

i Osteoporosis Risk

- History of fragility fractures (any fracture caused by a fall from standing height)
- Taking systemic corticosteroids for more than 3 months
- Parental hip fracture
- Body mass index less than 19kg/m^2
- Early menopause(less than 45 years of age)
- Hypogonadal conditions
- Medical conditions independently associated with bone loss, such as rheumatoid arthritis, coeliac, inflammatory bowel disease, etc

Recommendation

- Over 75's with prior fragility fracture should be referred to GP for consideration of commencing Bisphosphanate without need for DEXA.
- Complete FRAX (Fracture Risk Assessment Tool) and give Lifestyle Advice, or refer to GP for DEXA (Dual Energy X-Ray Absorptiometry or Treatment as indicated.
- See NICE and Local guidelines for Osteoporosis

i Falls History

- Activity at the time of Fall
- When and where
- Frequency of falls
- Ability to get up from the floor unassisted (unassisted, not requiring help from another person)
- How many falls in the past twelve months
- Changes to lifestyle as a result of falling, e.g. not going out alone, now uses walking aid, not getting to the bath etc
- What footwear was worn at time of fall (Provide information regarding suitable shoes. Refer podiatrist/ orthotist for shoe raises/ foot splints/ specialized footwear)

i Fear of Falling

Ask

- Are you frightened of falling?
- What frightens you? (eg lying there all night, fractures)

Assess

- Ability to summon help
- Ability to prepare for a long lie

Use appropriate assessment tool e.g.

- Tinetti Fear of falling – falls efficacy scale (FES)
- FES-I (Yardley)

Recommendation

- Teach strategies to get up from floor
- Provide info re summoning help
- Teach coping strategies to prepare for long lie Consider:
- Referral for stress and anxiety management
- Referral to mental health services
- Referral to Falls Prevention Service

i Assessment of gait, balance, joint range of movement and muscle strength

Assess gait, balance, joint range of movement and muscle strength. Assessment tools may include:

- Timed 'get up and go' test(TUAG)
- Timed Unsupported Steady Stand (TUSS)
- 30 second Sit-Stand test
- 180 Turn
- Functional Assessment Grid

Recommendation

- Check use of and / or provide appropriate mobility aid
- Refer to Falls Prevention Service for evidence based strength and balance exercise programme

See (Guidelines for collaborative management of elderly people who have fallen: CSP and Royal College of Occupational Therapists[R.C.O.Ts], 2000)

i Functional ability

- Subjective questioning of ability to manage personal and domestic activities of daily living.

Choose appropriate treatment

Recommendation

- Refer to Community Physiotherapists and Occupational Therapists for new / worsening mobility problems, provision of appropriate mobility aids and/ or home environment assessment or low level equipment
- Refer to Social Services for home care
- Refer to Social Service O.Ts for major adaptations
- Recommend visit Independent Living Centre (ILC)or ILC Outreach Clinics for advice on equipment / mobility aids

Multifactorial Assessment

i Assessment of Hearing

- Check for ear wax
- Check hearing aid working / batteries fitted and working
- Ensure correct use of hearing aid
- Advise about having hearing tested and corrected

Recommendation

- Refer to GP for new hearing loss for referral to Audiology if appropriate

- Advise to attend Audiology clinic if problems with hearing aids or Community Council Shropshire (CCS) Sensory Impairment Resource for volunteer peer support

i Urinary and Faecal Continence Assessment

- Is there urgency of micturition?
- Is person taking diuretics?
- Does s/he have problems at night?
- Does s/he have access to commode at night?
- Is s/he wearing appropriate aids?

Recommendation

- If continence problems persist refer for specialist continence assessment.

i Assessment of Visual Impairment

- Has there been any change in vision?
- Has the individual visited Optician during the last 12 months?
- Is the individual wearing their glasses and are they clean?

Recommendation

- Visit the Optometrist annually if there is a history of
- Diabetes
- Glaucoma or immediate family member with Glaucoma
- Early cataracts that need monitoring
- Over 70 years of age
- Visit Optometrist every 2 years if no problems
- Advise of Outside Clinic for housebound (Housebound is anyone unable to get to opticians without assistance)

i Pain Assessment

- Assess pain using appropriate assessment tool.

Recommendation

- Review analgesia using WHO guidelines

i Assessment of Home Hazards

- Poor lighting, particularly on stairs
- Stairs
- Loose carpets or rugs
- Trailing bed clothes
- Slippery floors
- Need for safety equipment such as grab rails
- Poor heating
- Trailing wires
- Cluttered rooms
- Pets

Recommendation

- Identify need and refer for equipment, aids and adaptations and minor repairs
- Low Level Equipment : refer to IDT, Home Improvement Agency(Telford), Independent Living Centre(ILC), Mears Shropshire Handyperson Service
- Major Adaptations : refer to Social Service O.Ts

i Assessment of Cognitive Impairment

- Abbreviated mini mental test
- Validated Cognitive Assessment tool
- HADS - Hospital Anxiety and Depression Scale
- GP Depression Scale

Recommendation

- Refer to medical clinician

i Nutrition / Dehydration

Nutrition

Nutritional Screening to identify if at risk of malnutrition/ or nutritional support required.

Ask if

- Difficulties with eating e.g. badly fitting dentures
- Difficulties with handling meals/drinks e.g. arthritic condition, visually impaired
- Problems with digestion/absorption e.g. constipation
- Reduced appetite/intake
- Special dietary needs
- Unintentional weight loss (3kg/12months)

Nutritional Screening tools may be used: either a local one or Malnutrition Universal Screening Tool (MUST) devised by BAPEN

Recommendation

If no dietary problem/s identified:

No dietary intervention required but explain importance of

- A well balanced diet for good health and well being
- Calcium, vitamin D, sunlight for bone health

If problems identified:

Refer as appropriate to

- Dietetic Services for full nutritional assessment, intervention, monitoring
- Therapy /Dental services for physical problems handling food
- Speech & Language Therapy for problems with dysphagia
- Social Services: for help with meal provision where there is limited support for cooking and feeding, and the ability to do this is impaired; delivery services; lunch clubs for social situation. Medical/Pharmacy to adjust prescribed medication if reduces appetite
- CPN/Psychological service for mental health/psychological problems

Dehydration

- Signs of thirst, sunken eyes, loss of strength
- Dry skin (loss of turgor)
- Dry mouth / clarity of speech (which may be affected)
- Dizziness on sitting or standing
- Decrease in urine output, confusion, constipation
- UTI
- Vomiting / diarrhoea
- Fever
- Recent changes / additions of diuretics

Recommendation

A minimum of 8 glasses of 250mls daily will improve these symptoms and postural hypotension:

Multifactorial Assessment

i Review Alcohol Intake

Determine units of alcohol consumed per week

Recommendation

- Advise about risks of taking alcohol with medications
- Give sensible drinking advice
- Advise about immediate and long term risks of falling due to dulling of neurological capacity from alcohol

i Foot wear examination /check

- Toes able to wiggle freely within shoe/depth of toe box
- Width and depth of shoe should be adequate for the individual
- Sole does not interfere with normal foot function
- Shoe Upper and lining should be made of soft material
- Shoe construction should be of reasonable quality
- Whether fits snugly around heel
- Heel height low or moderate
- Shoe should not have sharp protrusions or edges internally
- Shoe covering over instep
- Shoe must not noticeably slip on the foot – through the presence of a strap, lace or buckle
- The level of sole grip must be safe for the individual

Recommendation

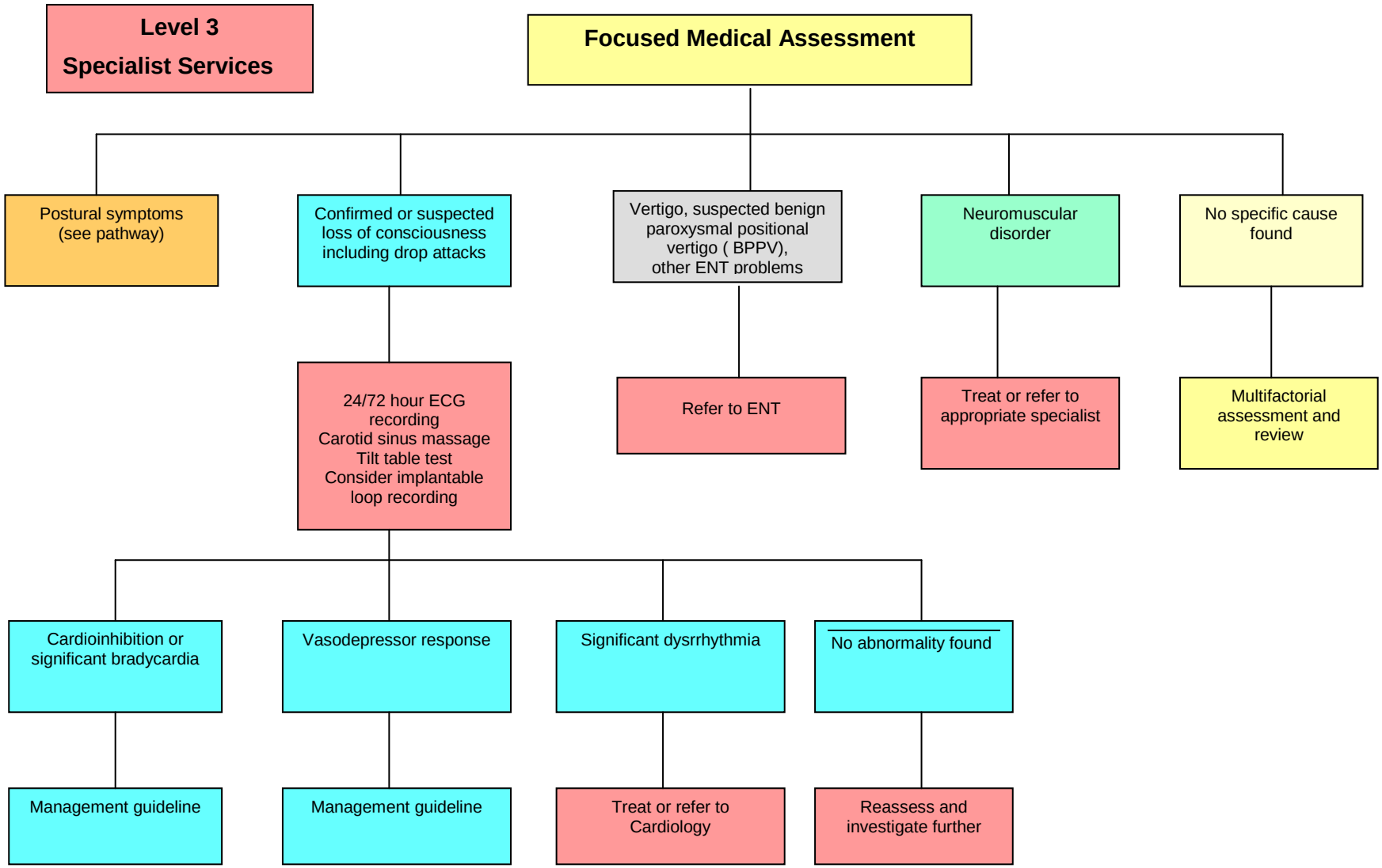
- Provide information regarding suitable shoes
- Refer if appropriate to orthotist

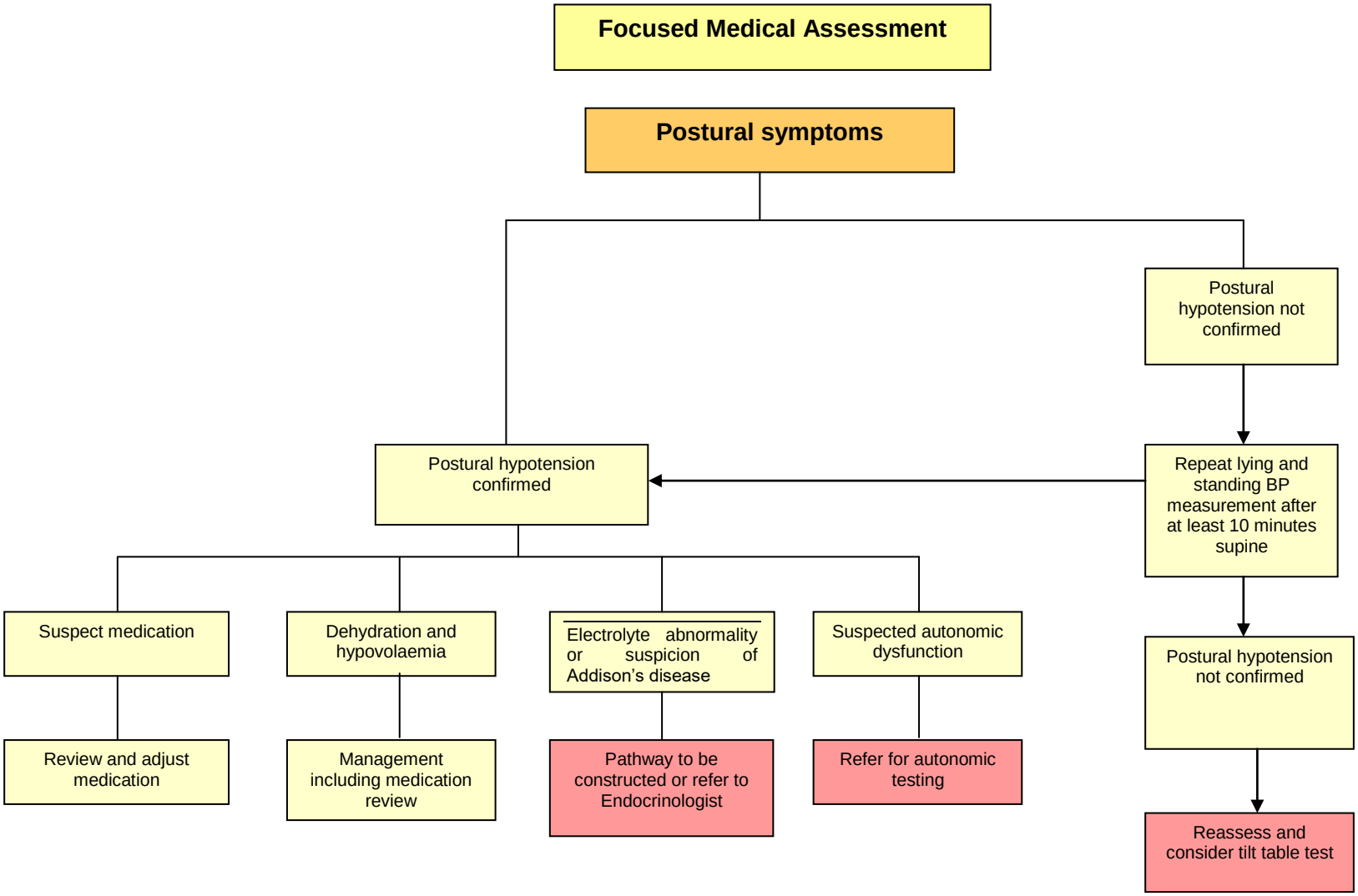
i Medication Review

- 4 or more drugs including medicines bought ‘over the counter’ and herbal remedies
- Recent change in medication
- Compliance / ability to take medication
- Taking drugs that may increase the risk of falls:
  Benzodiazepines &sleeping tablets
  Psychiatric drugs
  Antidepressants
  Sedating Antihistamines
  Anticholinergic drugs
  Drugs for dizziness & nausea
  Analgesics / Opiates
  Drugs for Parkinson’s disease
  Anticonvulsants
  Hypertension drugs
  Cardiac / Angina medication
  (this list is not exhaustive)

Recommendation

Refer to Hospital or Practice Based Pharmacist /GP
Any changes to medication must be followed up


Level 3
Specialist Services
Focused Medical Assessment
Postural symptoms (see pathway)
Confirmed or suspected loss of consciousness including drop attacks
Vertigo, suspected benign paroxysmal positional vertigo (BPPV), other ENT problems
Neuromuscular disorder
No specific cause found
24/72 hour ECG recording
Carotid sinus massage
Tilt table test
Consider implantable loop recording
Refer to ENT
Treat or refer to appropriate specialist
Multifactorial assessment and review
Cardioinhibition or significant bradycardia
Vasodepressor response
Significant dysrrhythmia
No abnormality found
Management guideline
Management guideline
Treat or refer to Cardiology
Reassess and investigate further


Focused Medical Assessment
Postural symptoms
Postural hypotension not confirmed
Repeat lying and standing BP measurement after at least 10 minutes supine
Postural hypotension not confirmed
Reassess and consider tilt table test
Postural hypotension confirmed
Suspect medication
Review and adjust medication
Dehydration and hypovolaemia
Management including medication review
Electrolyte abnormality or suspicion of Addison's disease
Pathway to be constructed or refer to Endocrinologist
Suspected autonomic dysfunction
Refer for autonomic testing

Appendix 2 : Falls Risk screening and Referral Form

Falls Referral Form

EXCLUSION CRITERIA: (If yes to any on list below please seek medical review from GP or DAART) Recent injurious fall without investigation. Uncontrolled angina/unstable or acute heart failure. Resting BP >180/100MMhg. Tachycardia >100BPM. Acute systemic illness. Pain/visual. Un-investigated vestibular problems. Cognitive impairments (can patient follow instructions in group setting?). Unable to maintain seated upright posture due to neurological deficits. Places themselves and other at risk (drug/alcohol problems). Hip or knee surgery within past 4 months. Unable to sit-stand independently from dining room chair. Not registered with Shropshire GP. **Lives in nursing or residential home.**

First Name: ……	NHS Number: ……
Last Name: ……...	GP & Practice: ……..……..……..
Address: ……	……..……
……	Form completed by: ……..……
Telephone: ……..……..	Contact Number: ……..……..….
Date of Birth: ……..……	Date completing form: ……
Sex: □ Male □ Female	Ethnicity: ……..……

Falls History
Has the patient had a fall in the last 12 months? Yes □ No □
Give number of falls and details. (e.g. indoor/outdoor injuries, hospital admissions)
What happened? (e.g. - legs gave way)

Medical History – referral will be returned if not completed	
If you are an employee of SCHT please ensure you have completed an assessment form for your service in the last 6 months on RiO.	**Date assessment completed:**
Other healthcare professional: Please attach a medical summary or EMIS.	**Name of assessment completed:**
Any episodes of dizziness, blackouts or unexplained falls – please refer to DAART – shropscom.daart@nhs.net	

Additional Information	
To avoid duplication please discuss the **Keep Up Right and Keep Active Leaflet** (KUKA) with patient.	**Date completed:**
Please provide **Chair Based Exercise Leaflet** and initiated prior to referral. Please indicate if patient has already progressed onto Otago leg strength exercises.	**Date completed:** **Date started:**
Please complete FRAX before sending referral Bone Heath/Fracture Risk Assessment: www.shef.ac.uk/FRAX	**Date completed:** **Action Taken:**

Name:	Signature:
Designation:	Date:

Email: shropcom.fallstherapy@nhs.net

Address: Shropshire Falls Therapy Service, Louise House, Roman Road, Shrewsbury, SY3 9JN

Telephone: 01743 730035

Appendix 3: Community Hospital Falls and Injury Risk Screening and Management
Plan

Patient Addressogram

Shropshire Community Health NHS Trust

Falls and Injury Risk Screening and Management Plan

Both sections below to be completed on all patients aged 65 or older and patients aged 50 to 64 who are judged by a clinician to be at higher risk of falling because of an underlying condition (NICE Guideline 161).

Falls Risk Screening Tool

Note: to be completed on admission

History of falls before or on admission?	Yes* ☐ / No ☐	Patient unsteady/ unsafe with / without walking aid/s and/or tries to walk alone	Yes ☐ / No ☐
Falls since admission?	Yes* ☐ / No ☐	Patient or relatives anxious about patient at risk of falling?	Yes ☐ / No ☐
*Give brief details where applicable:			
Name:		Signature:	
Designation:		Date:	Time:

Falls Management Plan

Note: to be completed within 24 hours of admission and thereafter weekly or following change in patients condition

	Action Suggested	Prevention Interventions	Initials of Healthcare Professional Note: Record full details on last page		
	A plan of care will be required for all **actions identified and implemented below.**	Document relevant actions in this section. Refer to Care Plans initiated.	Initial Assessment Date: Time:	Review Date: Time:	Review Date: Time:
1	**Was the patient admitted after a fall / have they fallen since admission?** Yes ☐ / No ☐				
a.	Monitor and record lying and standing BP for first 3 days of admission. If systolic BP drops by more than 20mmHg or BP is high / low Inform Doctor.				
b.	Refer to doctor to consider examination of the patient's cardiovascular, and neurological systems to look for causes of falls				
c.	Perform an ECG and ensure ECG has been reviewed by a doctor, and recorded in medical notes. All patients must have ECG.	ECG Print out filed in Medical notes: Yes ☐ / No ☐ GP Reviewed date: __/__/__			
d.	Complete FRAX in line with relevant NICE Guideline CG 146. File in medical notes and liaise with doctors to consider osteoporosis risk. Consider prescribing a bisphosphonate, in line with NICE Guideline TA 161				
e.	Offer the patient and their family or carers, a copy of the SCHT Falls prevention leaflet	Leaflet issued: __/__/__			

	Action Suggested	Prevention Interventions	Initials of Healthcare Professional Note: Record full details on last page		
A plan of care will be required for all **actions identified and implemented below.**		Document relevant actions in **this section. Refer to Care Plans initiated.**	Initial Assessment Date: Time:	Review Date: Time:	Review Date: Time:
f.	Consider Physiotherapy and/or Occupational Therapist (OT) Referral	Referred to: Physio ☐ __/__/__ OT ☐ __/__/__			
g.	Confirm Intentional Rounding is being carried out. Note agreed frequency of rounding.	Yes ☐ / No ☐ Frequency:			
2	**Does the patient seem to be confused or agitated at any time?** Yes ☐ / No ☐				
a.	Complete Dementia Diagnostic Assessment (CH038)	Date: __/__/__			
b.	Seek advice from psychiatric services if appropriate.				
c.	Consider causes of confusion/delirium – undertake infection screening if appropriate				
d.	Establish the appropriate level of interaction (Observation) required. Is the patient in the right bed, in the right bay? Consider cohorting patients if enhanced interaction (observation) required.				
e.	Assess the need for bed rails, if not suitable, document on this form (Refer to the Bed Rail Guidelines)				
f.	Where no bed rails used consider use of a low-profile bed if available. If not keep the bed at its lowest level.				
g.	Refer to occupational therapy if further cognitive assessment required				
3	**Does the patient have poor eyesight?** Yes ☐ / No ☐				
a.	If the patient wears spectacles, ensure they are clean and worn or within reach at all times				
b.	If eyesight is poor despite spectacles, advise patient to arrange to see an optician after discharge				
c.	Ensure lighting is adequate where possible				
d.	Explain use of overhead light				
e.	Can patient recognise 2 objects e.g. Pen / Keys from end of bed to screen for severe eyesight problem				

	Action Suggested	Prevention Interventions	Date/ time/ Initials of Healthcare Professional Note: Record full details on last page		
A plan of care will be required for all actions identified and implemented below.		Document relevant actions in this section. Refer to Care Plans initiated.	Initial Assessment Date: Time:	Review Date: Time:	Review Date: Time:
4	**Does the patient need to go the toilet frequently?** Yes ☐ / No ☐				
a.	Assess continence. Does the patient take diuretics?	Implement relevant Continence Care Plans.			
b.	Complete and document urinalysis. Ensure results are acted upon.				
c.	Assess for constipation. Does the patient take aperients?				
d.	Consider proximity to the toilet on ward.				
e.	Encourage good fluid intake. Consider use of fluid balance chart if appropriate.				
f.	Ensure call bell is within reach and patient instructed in use.				
g.	Offer a routine of frequent toilet visits as part of the intentional rounding and tailor to patients needs				
5	**Is the patient on 4 or more medications? All patients require avoidance of new night sedation.** Yes ☐ / No ☐				
a.	Communicate to pharmacist that patient is at risk of falls.				
b.	Pharmacist will identify patient on escript system				
c.	The ward Pharmacist will complete Medication use review and liaise with medical team				
d.	If CVD Drugs changed commence BP monitor & record as section 1 for one week				
e.	Ensure Parkinson's patients issued medication on time. Use appropriate aid.				
f.	Ensure any change of medication explained to patient				
g.	Changes communicated to patients GP on discharge via discharge summary				
6	**Does the patient have any mobility/transfer problems with or without walking aids?** Yes ☐ / No ☐				
a.	Perform and implement Moving and Handling Assessment	Completed on admission ☐			
b.	Consider use of Sara steady transfer aid				

	Action Suggested	Prevention Interventions	Initials of Healthcare Professional Note: Record full details on last page		
A plan of care will be required for all actions identified and implemented below.		Document relevant actions in this section. Refer to Care Plans initiated.	Initial Assessment Date: Time:	Review Date: Time:	Review Date: Time:
c.	Refer to physiotherapist via ward handover and record date of referral.	Date referred: __/__/__			
d.	Ensure walking aids (specify .....) are within easy reach				
e.	Ensure patient wears own shoes or sturdy slippers that fit. Discuss footwear provision with family if required				
f.	Patients who do not have appropriate footwear, supply a pair from ward stock if required and available				
g.	Discuss at MDT which services are required on discharge. Consider referral to falls prevention service				
7	**Are there any environmental hazards that contribute to a fall?** Yes ☐ / No ☐				
a.	Minimise bedside clutter and trip/slip hazards such as wet floors, trailing flexes, leads, drips and catheters. Ensure patient can reach his/her possessions (e.g. water and tissues) safely.				
b.	Ensure use of call bell is explained and it is within reach				
c.	Ensure the bed and chairs are of a height and size that allow safe transfers. Liaise with occupational therapist / Physio				
d.	Consider length of time that is appropriate for patient to be sitting in chair.				
e.	Consider one way glide sheet				

Healthcare Professional Details	
Name (print):	Designation:
Signature:	Initials:

Name (print):	Designation:
Signature:	Initials:

Name (print):	Designation:
Signature:	Initials:

Name (print):	Designation:
Signature:	Initials:

Note: this form replaces the previous Falls Risk Assessment (CH005) and Falls Care Plan (CP 014)

Appendix 4: Community Hospital Post Fall Incident Form and Post Fall Flow Chart For Health Professionals

Patient Addressograph

Shropshire Community Health NHS
NHS Trust

Post Fall Incident Form

(See relevant guidance notes and flowchart overleaf)

Post Fall Assessment

Key:	**	*Consider sections for reporting in Section 19 ref. SBAR*

1. **	Patient fell on:	Location:	Date:	Time:
2.	Family informed:	Yes* ☐ No ☐	Date:	Time:
	* Name of person informed:		Informed by:	
3. **	Tick if any of the following happened: Blackout ☐ Faint ☐ Dizziness ☐ Slip or Trip ☐ Loss of Balance ☐			
4. **	If able, Patient's description of fall:			
5. **	If applicable, Witness description of fall:			
6. **	Current Ward / Bay:	Can the patient be moved for closer observation Yes ☐ No* ☐ *If No state why:		
7.	Call Bell within reach? Yes ☐ No* ☐ * If No record details:			
8.	Are the following Documents in Place? Falls Risk Screening Tool and Management Plan: Yes ☐ No* ☐ Bed Rails Patient Risk Assessment: Yes ☐ No* ☐ Moving and Handling Risk Assessment: Yes ☐ No* ☐ Have the above assessments/ care plans been reviewed following this incident: Yes ☐ No* ☐ Dementia Diagnostic Assessment (if applicable) N/A ☐ Yes ☐ No* ☐			
	* If No give details as required:			

9. **	Temperature:	Pulse:	Blood Pressure:	Respirations:	O^2 Sats:	Blood Glucose	Urine:

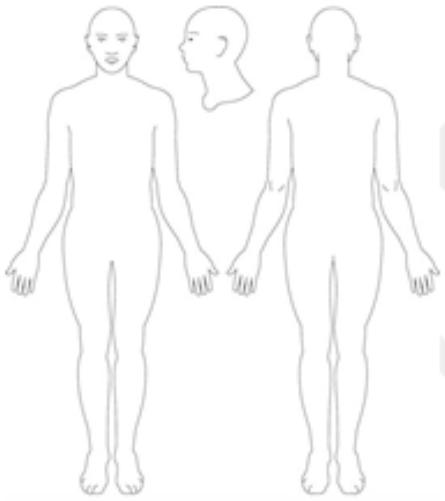
10. **	Twelve Lead Electrocardiograph (ECG) completed Yes** ☐ No* ☐	** time recorded:
11. **	Neurological Observations recorded if suspected /known head injury/ unwitnessed fall: Yes ☐ No* ☐ (in line with guidance notes overleaf)	
12. **	Has the patient been observed to have recent change/altered behaviour? Yes* ☐ No ☐	
13. **	Does the patient have a diagnosis of Dementia or memory issues? Yes* ☐ No ☐	
14.	* Record relevant details from questions 10 to 14 above:	
15.	Does patient require 1:1 observation: Yes* ☐ No ☐ *If yes: record time that request for 1:1 observation made :	

Patient Addressogram

Shropshire Community Health NHS Trust

Post Fall Incident Form

(See relevant guidance notes and flowchart overleaf)

16. **	Record location and type of injury on diagram below: *Some injuries may not be apparent at time of fall – ensure patient checked regularly*	
		
17.	Record in Patient's Medical / Nursing notes (*insert this form into medical notes*)	Yes ☐
18.	Incident report (Datix): Yes ☐	Datix Reference Number:
19.	Inform GP / Shropdoc of fall and assessments undertaken using **S**ubject **B**ackground **A**ssessment **R**ecommendations (SBAR) for GP to decide what action is required	Yes ☐
20. **	Specialist advice required: Yes* ☐ No ☐	* Specialist advice given by:
	* If Yes Give details of advice given:	
21.	Was the patient wearing appropriate footwear:	Yes ☐ No ☐ N/A ☐
22.	Was the patient using appropriate walking aid:	Yes ☐ No ☐ N/A ☐
23.	Vision: Good ☐ Poor ☐	Glasses: Yes ☐ No ☐ N/A ☐ Available: Yes ☐ No ☐ N/A ☐
24.	Incontinence: Yes ☐ No ☐	Frequency:
25.	Review frequency of SSKIN Intentional Rounding:	Yes ☐
26.	Document need for Lying / Standing BP on three consecutive days using National Early Warning Score Observation Sheet and report findings to GP using SBAR if required:	Yes ☐
27.	Referred for medication review:	Date: or N/A ☐
28.	Referred to Physio: Date: or N/A ☐	Referred to OT: Date: or N/A ☐

Name (printed):	Designation:
Signature:	Date and Time:

Post Fall Incident Form Guidance Notes

Neurological Observations

The NICE guidance on the triage, assessment, investigation and early management of head injury / unwitnessed fall includes the following frequency advice of neurological observations:

If Glasgow Coma scale (GCS) < 15, Dial 9 – 999

If Glasgow Coma scale 15/15:

1. Record neurological observations every 30 minutes for two hours
2. Then every hour for four hours
3. Then every two hours for six hours (a total of 12 hours post incident)
4. In the event of deterioration i.e. GCS< 15 dial 9- 999 and prepare patient for transfer

Neurological observations should be continued until GP has documented they may be discontinued

Specialist Advice

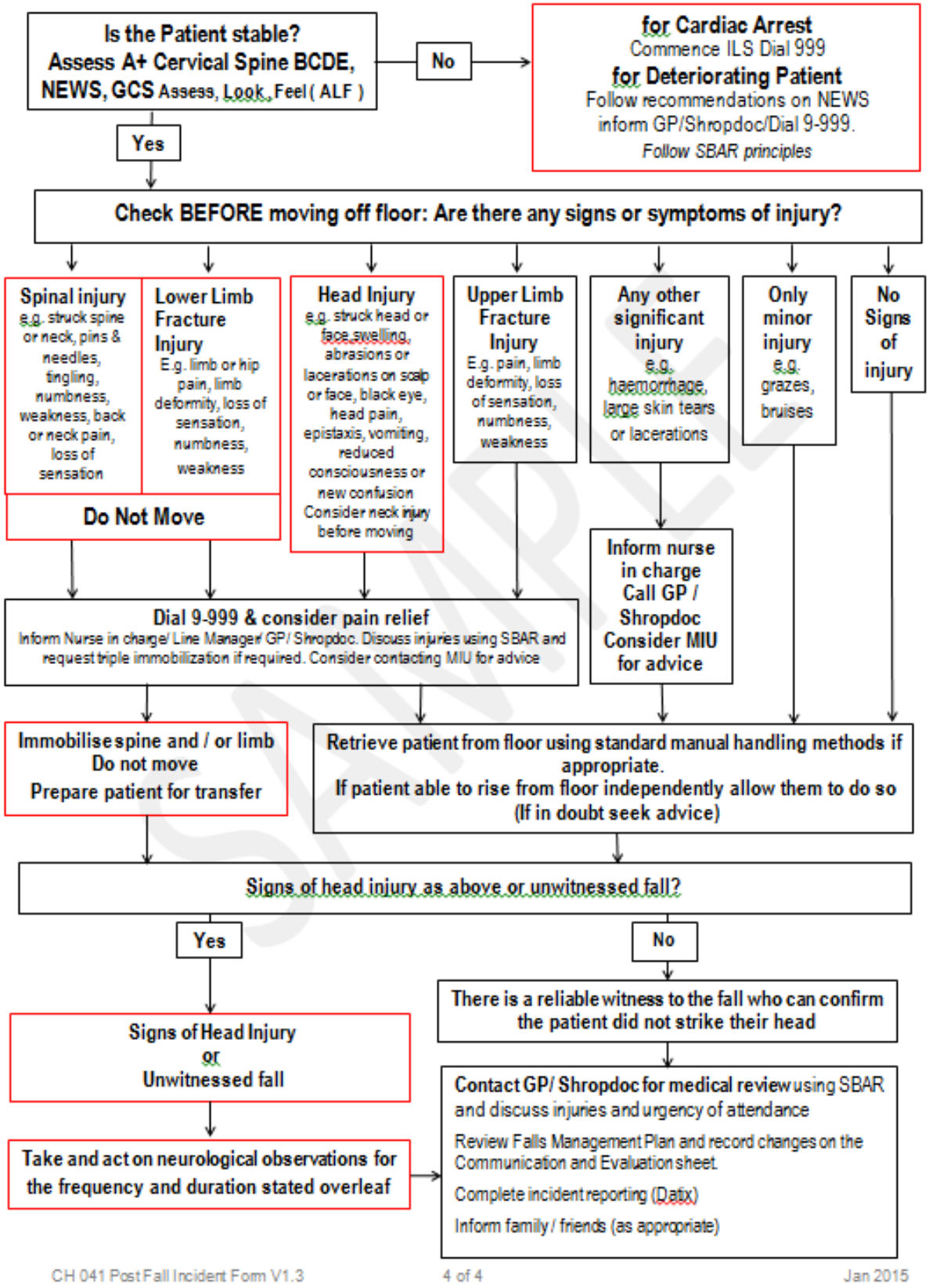
Contact Minor Injuries Unit for advice during working hours or Shropdoc if out of hours

Medical Checks

- Review need for sedative, tranquillizer, anti- coagulant, strong analgesic medications
- Review the need for antihypertensive or diuretic medication
- Identify the likely cause of the fall, outcome of review, outcome of follow-up investigations and record in patient's medical notes

Post-Fall Flow Chart for Health Professionals Actions

This is a brief memory aid – if in doubt seek GP / Shropdoc / MIU advice.



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Appendix 5: Extracts from NICE Head Injury Guidelines

5.3.6.1 Community health services and NHS minor injury clinics

1.1.4 Community health services (GPs, ambulance crews, NHS walk-in centres, dental practitioners) and NHS minor injury clinics should refer patients who have sustained a head injury to a hospital emergency department, using the ambulance service if deemed necessary, if any of the following are present:

- Glasgow coma scale (GCS) score of less than 15 on initial assessment.
- Any loss of consciousness as a result of the injury.
- Any focal neurological deficit since the injury (examples include problems understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking).
- Any suspicion of a skull fracture or penetrating head injury since the injury (for example, clear fluid running from the ears or nose, black eye with no associated damage around the eyes, bleeding from one or both ears, new deafness in one or both ears, bruising behind one or both ears, penetrating injury signs, visible trauma to the scalp or skull of concern to the professional).
- Amnesia for events before or after the injury[4].
- Persistent headache since the injury.
- Any vomiting episodes since the injury (clinical judgement should be used regarding the cause of vomiting in those aged 12 years or younger and the need for referral).

- Any seizure since the injury.
- Any previous brain surgery.

- A high-energy head injury (for example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 m or more than five stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorized recreational vehicles, bicycle collision, or any other potentially high-energy mechanism).

- Any history of bleeding or clotting disorders. Current anticoagulant therapy such as warfarin.
- Current drug or alcohol intoxication.
- There are any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected).
- Continuing concern by the professional about the diagnosis. **[2003, amended 2007 and 2014]**

1.1.5 In the absence of any risk factors in recommendation 1.1.4, consider referral to an emergency department if any of the following factors are present, depending on judgement of severity:

- Irritability or altered behaviour, particularly in infants and children aged under 5 years.
- Visible trauma to the head not covered in recommendation 1.1.4 but still of concern to the professional.
- No one is able to observe the injured person at home.

- Continuing concern by the injured person or their family or carer about the diagnosis. **[2003, amended 2014]**

5.3.6.2 Transport to hospital from community health services and NHS minor injury clinics

1.1.6 Patients referred from community health services and NHS minor injury clinics should be accompanied by a competent adult during transport to the emergency department. **[2003]**

1.1.7 The referring professional should determine if an ambulance is required, based on the patient's clinical condition. If an ambulance is deemed not required, public transport and car are appropriate means of transport providing the patient is accompanied. **[2003]**

1.1.8 The referring professional should inform the destination hospital (by phone) of the impending transfer and in non-emergencies a letter summarising signs and symptoms should be sent with the patient. **[2003]**

Appendix 6: Emergency Walking Aid Provision

Background

- Physiotherapy services are not available at the weekend, evenings or Bank Holidays. Patients admitted to Community Services or Community Hospital during these times requiring emergency walking aids need provision of aids by nursing staff.

Potential benefits

- Earlier mobilisation of patients
- Improved manual handling for staff
- Reduced cross infection related to sharing of frames
- Reduction of falls

Potential Issues

- There is a need to ensure that all relevant health care professionals have the skills necessary to assess patients for walking aid provision. Staff will have completed the essential skills competency in walking aid provision.

Guidance

Walking Sticks

- These will not be available until assessed by a health professional accredited with this specific training e.g. physiotherapist

Zimmer Frames

- Staff who have shown competency in walking aid provision can provide Zimmer frames for patients if they normally use a Zimmer frame at home and there are no current issues with their mobility, or there is a decline in function and a Zimmer frame would assist with transfers.
- Staff should always apply appropriate handling of patient following manual handling training guidelines.
- Each ward/ service should ascertain from their physiotherapy staff where the Zimmer frames for that ward/ service are kept and how they can be accessed.
- A ‘booking out’ form will need to be filled in stating:
    - Date of provision
    - Patient’s name and ward or address if living in community
    - Name of person providing the frame
- Document provision in patient notes.
- In ward setting, label the frame stating the patient’s name.

Important points

- If a frame has been provided outside physiotherapy working hours, inform the physiotherapist on her return to duty.
- The health care professional who provides the frame should carry out an appropriate risk assessment

Link to Appendix 7, environmental risk assessment

Appendix 7: Community Hospital Environmental Risk Assessment
REDUCING PATIENT FALLS

Reducing Patient Falls – Environmental Risk Assessment Tool

Ward: .....

No of Beds: .....

Layout of Ward: ..... (*Cubicles/Side rooms)*

Client Group:.....

Age Range:.....

Staffing Levels:

Shift	Average	Trust Guidelines
Early		
Late		
Night		

Guidelines:

There is evidence to suggest that environmental factors contribute significantly to the number of patient falls within the ward area. The following environmental categories therefore require assessing within the ward area, toilet, bathroom and day room:

- Flooring
- Temperature
- Lighting
- Space
- Accessibility
- Alarm
- Equipment

An environmental assessment should be completed on an annual basis, or more regularly if there is significant change in the ward environment. The assessment should be completed by the Ward Manager and the Safety Representative. Any serious risks must be reported to Line Manager and if appropriate recorded in the organisation's Risk Register. Risk assessment should be entered into the Hospital Risk Assessment folder.

Assessment of Flooring

ENVIRONMENT	TYPE OF FLOORING	EVEN/ UNEVEN	IN GOOD REPAIR Y/N
Corridor			
Nurses Station			

Bed Space			
Bathroom			
Toilet			
Day room			

Category	Yes	No	Comments
Temperature			
Is heating system appropriate			
Does heating system work			
Are windows easily opened			
Lighting			
Are corridors clearly lit			
Do beds lights work			
Are night lights working			
Obstructions			
Is there appropriate storage on the ward			
Are visitors' chairs stored appropriately			
Are hoists stored appropriately			
Are wheelchairs stored appropriately			
Is patients' mobility equipment stored appropriately			
Space			
Is there adequate ward space considering number of beds			
Is there adequate space to store equipment appropriately			
Accessibility			
Is the ward wheelchair friendly			
Is there sufficient space for hoist access where appropriate			
Is there sufficient space for patients to mobilise with mobility equipment			
Door Entry Systems			
What type of system is in place			
Do they work			
Are they regularly maintained			
Date of last check:			

Signposts			
Are there signposts to toilet facilities			
Do signposts indicate how to use open/close doors			
Alarms			
Are the alarms easily accessible to patients in: a) Toilet b) Bathroom c) Bed d) Chair e) Day room			
Are the alarms audible to staff not at nurses station			
Do all alarms work			
Are the alarms visible to staff not at nurses station			
Do the emergency pull cords work			
Date of last check:			
Are there other alarms used in the ward			
Are they regularly maintained			
Windows			
Are all windows fitted with restrictors, and are they working			
Is there any aids to access windows (e.g furniture) Can these realistically be removed			
Stairs			
Are there stairs which present a hazard to patients, is so how are these risks being controlled			
BATHROOM			
Toilet			
Are there adequate patient toilet facilities on ward			
Are there adequate raised toilet seats			
Are the raised toilet seats fitted appropriately			
Are the raised toilet seats in good working order			
Are rails fitted in appropriate position			
Is the toilet roll accessible to patients			

Are there locks on toilet door			
Can access be gained in an emergency			
Sinks			
Are sinks in good working order			
Are taps appropriate for client group			
Are there “HOT WATER” warning signs			
Do taps have indicated hot/cold			
Are there plugs available			
If so are they on chains			
Are sinks at appropriate height for patient group			
Are the sinks appropriately positioned			
Is there a seat available near the sink			
Are there appropriate places for clothing/towels/toiletries			
Bath			
Is there appropriate manual handling equipment			
Is there appropriate bath board/seat available			
Are they fitted appropriately			
Does the bath have non-slip base			
Is there temperature control on the taps			
Showers			
Is there a shower seat			
Is the shower seat safe			
Is there a non-slip floor			
Is there suitable access for shower assistants			
Are the rails positioned appropriately			
EQUIPMENT			
Bed Space			
Does the bed raise/lower appropriately			
Do the brakes work			
Is there an adequate supply of bed rails			

Are the bed rails in working order			
Are the bed backrests easily raised/lowered			
Are the backrests safe when in use			
Are the monkey poles safe when in situ			
Are the monkey poles removed when not appropriate for individual patients			
Chair			
Are the chairs appropriate for the client group			
Does the ward have a supply of chair raises			
Do ward staff know how to fit chair raises			
Are the chair raises appropriate for the chairs on ward			
Are the chairs in good condition			
Bed Tables			
Do they raise/lower appropriately			
Do they wheel easily			
Do the tables have brakes			
Do the brakes work			
Locker			
Are the lockers mobile			
Are they appropriately positioned			
Drip Stands			
Are the drip stands in good working order			
Do they wheel evenly			
Are they positioned appropriately to allow access in/out of bed if appropriate			
Commodes			
Is there an appropriate amount for client group			
Are they in good working order			
Do they have removable arms			
Do the brakes work			

Does it manoeuvre easily			
Can it be accommodated within the bed space safely			
Wheelchairs			
Are there enough wheelchairs for the patient group			
Do they have a maintenance contract			
Do the brakes work			
Are the tyres pumped fully			
Are they stored appropriately			
Hoists			
Are the appropriate slings provided			
Is the hoist stored appropriately			
Do the brakes work			
Do they have a maintenance contract			

Are there any other pieces of equipment/factors that need assessing with regard to patient safety?

Equipment	**Comments**