Leicestershire Partnership
NHS Trust

Prevention and Management of Slips, Trips & Falls Policy

This policy describes the process for reporting, investigating and managing slips, trips and falls by clinical staff in hospital and community settings.

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Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	Jan 2013	Harmonised Policy – former LCRCHS, Leicester City & LPT
2	Feb 2013	NHSLA
3	April 2014	NICE CG161
4	March 2016	Policy robustly reviewed and amended to include the Falls Risk Assessment tool and information on falls in children.
5	August 2018	Reviewed by Falls Steering Group – text reorganised to clarify guidance differences between Inpatient and Community guidance Updates from NICE QS86 (2017) reflected in policy
6	September 2018	Feedback from Lead nurses included
7	October2018	Additional flowchart for management of falls added
8	November 2018	Final amendments from stakeholders added

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Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

The Due regard assessment template is Appendix 4 of this document

Definitions that apply to this Policy

Slip	To slide accidentally causing the patient to lose their balance, this is either corrected or causes a patient to fall *(adapted from COED 2000)*
Trip	To stumble accidentally often over an obstacle causing the patient to lose their balance. This is either corrected or causes the patient to fall *(adapted from COED 2000)*
Fall	An event, which results in the patient or a body part of the patient coming to rest inadvertently on the ground or other surface lower than the patient, whether or not an injury is sustained *(Cohen & Guin 1991)*
FRAT	Falls Risk Assessment Tool
Multifactorial Falls Risk Assessment Tool	Following the identification of a person at risk using the FRAT tool, the Multifactorial Falls Risk Assessment Tool assesses the common factors associated with increased risk of falls and indicates likely interventions that will reduce the risk
RIDDOR	The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Certain incidents that arise out of or in connection with work have to be reported to the Health and Safety Executive (HSE). These may include falls resulting in fractures amongst other incidents. Further guidance on RIDDOR is available on the Trust Intranet: http://nww.leicestershire.nhs.uk/Larnet/webs/LPT/_Services-HealthandSafety-RIDDOR.aspx
ABCDE	Basic Life support Acronym **A**irway **B**reathing **C**irculation **D**isability **E**xposure
GCS	**G**lasgow **C**oma **S**core
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low
EPR	Electronic patient Record i.e. Systmone, RIO, Nerve Centre

1. Purpose of the Policy

The aim of this policy and related documents is to ensure that all clinical employees, (including medical staff who work for LPT, those on bank, agency or honorary contracts in in-patient settings, out-patient settings or community services) are clear of their responsibilities towards service users, staff and others in relation to the prevention and management of Falls and to provide a clear assurance framework for the LPT Trust board.

This policy confirms the LPT's commitment to the prevention and management of falls through appropriate risk assessment and includes potential falls from height. The policy describes the arrangements in place to enable the risks associated with falls and the management of falls to be effectively addressed. It details a number of key areas, the training requirement, the processes for the management of persons who have fallen and the processes in place to monitor the effectiveness of existing arrangements.

All documentation used by each Directorate within LPT for the assessment and management of falls can be found via the appropriate electronic recording system e.g. RIO, Nerve centre, SystmOne.

1.1 All employees, including medical staff who work for LPT and those staff on bank, agency or honorary contracts, whether in the in-patient settings, out- patient settings or community services will adhere to the following supporting policies and guidelines pertaining to falls prevention and management procedures:

- Health & Safety at Work Act
- Top Tips for Ladder and Step ladder Safety
- Health & Safety Management Regulations
- Health & Safety Policy
- Health and safety at Work Policy
- Preventing Falls from windows and Heights Policy
- Using Hoists to Move Patients Policy
- Manual Handling Policy
- Procedures for the Moving and Handling of Patients
- Incident Reporting Policy
- Safe Use of Bed rail Policy
- Resuscitation Policy
- Record Keeping and the Management of the Quality of Health Records Policy
- Clinical Risk Assessment Policy
- Heavy Patient Pathway
- Code of Practice for Using Electric Profiling Beds

All health professionals should ensure that they work within the scope of their Professional Code of Conduct.

2. Summary and Key Points

This document describes the process within Leicestershire Partnership NHS Trust (LPT) for managing the risks associated with slips, trips and falls involving patients, staff, visitors and volunteers in the organisations settings,. This Policy should be read in conjunction with local guidance and processes as outlined in 1.1.

3. Introduction

Slips, trips and falls have implications for both LPT and the individual. A single fall is not always a sign of a major problem, it may simply be an isolated event. However all witnessed falls, and unwitnessed falls in any inpatient setting, should be reported and investigated (NPSA, 2007). Due to the nature of the Leicestershire Partnership Trust's patients / clients it is necessary to balance the risk of falls with the process of rehabilitation. Informed consent for therapeutic rehabilitation should include a discussion of risk factors associated with the increased risk of a fall. Slips, trips and falls will never be totally eliminated. However, there is clear guidance that all health care settings must work towards reducing the number of falls which result in serious injury and ensure that there is effective treatment and rehabilitation for those who have fallen. (NICE QS86 Falls in Older People)

The effects of a fall can have major consequences on patients, leading to depression, anxiety, short and long term disability, reduced confidence and social isolation. It has been estimated that over a year 30% of patients who fell frequently, were either admitted to hospital, residential care or had died.

3.1 Slips, Trips and Falls in Children

Falling is part of normal childhood development when acquiring independent standing balance, stepping and walking.

However there are three broad categories of children where falling is outside the normal parameters:

a. Children who, pre-school, show delay with their mobility and may present with increased falling, tripping when developing independent mobility at a later age. This does not require therapeutic intervention and should be managed through adapting activities and environment.
b. Children with co-ordination difficulties, usually school age up to early teenage years, who may report increased falling, tripping etc. when participating in activities requiring more advanced levels of balance and co-ordination. This may require assessment of co-ordination difficulties to rule out any underlying long term pathologies and intervention, preferably in an MDT context.
c. Falls in children with deteriorating conditions (diagnosed or undiagnosed) due to regression in their mobility and functional skills. This requires timely diagnosis and therapeutic intervention.

The risk of falling and strategies for the management of the falls risks in children are assessed on an individual basis as part of weighing up benefits and risks of therapeutic intervention and discussed with the child and their parents/carers as part of gaining consent.

The FRAT and Multifactorial Assessment tools stated in this policy are not validated for use with children

4. Duties within the Organisation

4.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

4.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

4.3 Divisional Directors and Heads of Service are responsible for ensuring this policy is implemented.

4.4 Managers and Team leaders are responsible for:

4.4.1 Ensuring, by delegation, that all risk assessments pertaining to environment hazards that may contribute to slips, trips or falls are carried out and acted upon.
4.4.2 To manage and / or delegate the responsibility for ensuring staff are trained in the management of falls prevention.
4.4.3 To ensure that all serious and non-serious incidents reported are acted upon and Root Cause Analysis recommendations are implemented.
4.4.4 Managers and Team leaders will ensure that staff participate in related clinical audits and that actions are taken following the audit.

Responsibility of Staff

4.5 Inpatient Services:

4.5.1 Medical Staff

- To clinically assess and review patients post fall at the request of ward staff within the clinical setting and, only if required, organise ongoing treatment / intervention / referral.
- (Medical and pharmacy staff) To assess and identify a patient's medication that may exacerbate or increase the risk of falls.
- To clinically assess patients for any contributing factors for falls and document in multidisciplinary notes / electronic patient record.

4.5.2 Team Lead / Ward Sister/Charge Nurse / Hospital Matron

- To ensure that the falls policy is adhered to in the clinical setting and that there is a clear process for dissemination.
- To ensure that staff are released to meet training needs.
- To ensure that ward staff are clear in their roles and responsibility in managing and reducing the risk of falls as per the Policy.
- To assist in identifying physical and financial resources to assist in reducing and managing falls.
- To ensure actions post patient fall are completed and acted upon.
- To lead / contribute to Root Cause Analysis as identified.
- To ensure the wards participate in any inpatient falls audit and ensure actions are identified and improvements are made following the audit.

4.5.3 Registered Nurses and Therapists

- To ensure that patients are correctly risk assessed for falls as part of the admission process to services and after a fall.
- To ensure that inpatients are nursed in the most appropriate area of the ward for monitoring.
- To assess patients post falls using falls assessment checklist and request medical review if required
- To update risk assessment and care plan post fall

4.5.4 All Clinical Staff Working in In-Patient Settings

- Will undertake, and put into practice, 2 yearly mandatory falls awareness training.
- Will ensure all patients aged over 65 and those aged under 65 who are judged by a clinician to be at a higher risk of falling because of an underlying condition will have a multifactorial falls risk assessment. As agreed locally for each in-patient setting, this risk assessment should be carried out within 24 hours of admission along with the use of supporting documentation as appropriate. Any non-compliance should be recorded and the assessment completed at the first available opportunity.(In the Learning Disability Short Breaks service local policy requires, where appropriate, the multi factorial risk assessment to be completed within first week of admission)
- Where falls risks are identified staff will ensure a multifactorial intervention plan is completed, tailored to address the patient's individual risk factors for falling and implemented, monitored and reviewed.
- Where a fall is witnessed or discovered to manage the fall appropriately (sections 8, 9 and10)
- Will be aware of the risk of slips, trips and falls within the clinical setting and to be aware of the local inpatient falls pathway and need to review the risk assessment post fall.
- To participate in any inpatient falls audit and take action to improve practice where indicated.

4.6 Community Domiciliary Services

4.6.1 Service Team Manager / Line manager in Community Settings

- To ensure that the falls policy is adhered to in the clinical setting and that there is a clear process for dissemination.
- To ensure that the staff are clear in their roles and responsibilities in managing and reducing the risk of falls as per the Policy.
- To lead / contribute to Root Cause Analysis as identified.
- To ensure that patients in their own homes and care settings are correctly risk assessed for falls in agreement with local clinical guidelines and onward referral made as appropriate.
- That staff undertake training and records of attendance are kept.
- That all patient documentation is correctly completed.
- That witnessed patient falls are investigated and an action plan put in place to remove/ reduce the risk of further falls.
- To work in line with the LPT Incident Reporting Policy

4.6.2 All Clinical Staff working in Community Settings

- Will undertake 2 yearly role essential falls awareness training.
- All appropriate patient documentation is completed using the Falls Risk Screening tool (FRAT) and Falls Multifactorial Assessment and intervention planning correctly. (Section 6.1)
- Ensure that patients identified as at risk of falling are reviewed appropriately whilst on caseload. Any new risks are identified and interventions to reduce risks are implemented
- Ensure any witnessed patient falls are managed appropriately (section 8), investigated and an action plan put in place to remove / reduce the risk of further falls.
- To work in line with the LPT's Incident Reporting Policy including the reporting of falls in line with RIDDOR.
- To contribute to Root Cause Analysis as required.
- To ensure staff participate in any Community Falls audit and actions taken following the audit to improve Falls Risk identification as part of the patient holistic assessment.

5. Training Needs

5.1 There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as role development training.

5.2 All clinical staff will undertake training in awareness of the factors increasing risk of falls through the uLearn Module "Falls: Prevention and Management" and local training needs will be delivered through cascade training by local falls champions and education leads. This is mandatory for Inpatient clinical staff and role essential for Community clinical staff.

5.3 A record of the event will be recorded on the uLearn.

5.4 The Governance groups responsible for monitoring mandatory training are the Learning and Development and Workforce Groups.

5.5 Specific falls training for each Directorate has been developed along with the mechanism for delivery through the LPT Falls Group and with support of LPT training and education leads.

6. Management of Fall Risks

6.1 Principles of Managing Falls Risks **in the <u>Community Domiciliary Setting</u>**

6.1.1 All patients aged over 65, and those aged under 65 who are judged by a clinician to be at a higher risk of falling because of an underlying condition, will be screened for risk of falls using the questions on the **Falls Risk Assessment Tool** (FRAT) as part of the initial assessment.

- If the patient is identified as being at risk of falls then staff will ensure they undertake a **Multifactorial assessment** with the patient as appropriate with the use of supporting documentation or tools on the EPR. (see Appendix 7)
- Where appropriate staff will then ensure a multifactorial intervention plan is completed, tailored to address the patient's individual risk factors for falling and implemented, monitored and reviewed whilst the patient is on the caseload.
- If referred onto any other health of social care services the falls risks should be part of the referring information if relevant

6.1.2 If a patient reports a fall since the previous visit, it should be ascertained if any injuries were sustained and appropriate action taken. The patient should be reassessed using the multifactorial assessment and their multifactorial action plan reviewed.

6.1.3 If a fall is witnessed patients should be initially assessed for any injury as in section 8.1

6.2 Principles of Managing Falls Risks **in <u>Inpatient</u> Settings**

6.2.1 On admission or transfer all patients should have a multifactorial falls risk assessment as agreed locally for each in-patient setting carried out within 24 hours of admission along with the use of supporting documentation as appropriate. (In Learning Disability Short Breaks Service local policy requires, where appropriate, the multifactorial risk assessment to be completed within first week of admission)

6.2.2 Where risks are identified, a multifactorial intervention plan should be completed, tailored to address or modify the patient's individual risk factors for falling, implemented as soon as possible, monitored and reviewed if there are any changes in patient's condition (including having a fall).

6.2.3 All patients should be medically assessed for risks of falls against their pathology and medications

6.2.4 Patients identified as being at risk of falling must have the location of their bed on the ward considered as part of ensuring a safe environment.

6.2.5 The whole of the Multi-disciplinary team should be involved in reducing falls risks and ensure the following professions are involved as required:

- Nursing
- Advance nurse practitioners
- Doctors
- Physiotherapy
- Occupational therapy
- Pharmacist
- Psychologists
- Podiatry
- Dietician
- Optician

7. Bed Rails

7.1 The decision to use bed rails should be in line with standards set out in the **Safe Use of Bed Rails for Adults Policy**, There are clear guidance and a risk assessment tool that must be completed prior to the use of bed rails.

7.2 Bed rails are NOT to be used to restrain the movements of patients.

8. Management of a witnessed or discovered fall:

8.1 Trip, slip or fall witnessed or discovered by a Health Professional **in the Community Domiciliary/Clinic Setting**

8.1.1 **Before patient is moved, assess patient using ABCDE and GCS as appropriate and screen head to toe for obvious injuries particularly for head injuries or suspected fractures to spine or femur**

8.1.2 Ensure the immediate environment is safe for staff and the patient.

8.1.3 **If there is suspected injury that requires specialist intervention, medical or emergency assistance should be called immediately and the patient left unmoved.**

8.1.4 With discovered unwitnessed fall, even when there is no suspected injury, consider the effects of a 'long lie' on the patient, (e.g. pressure ulcers, rhabdomyolysis, pneumonia, hypothermia, and dehydration) Medical assistance should be sought if any concerns (contact GP or 111 or 999 as appropriate).
(*Definition of a 'long lie' will vary depending on the situation and medical status of the patient; a very frail patient may be exposed to greater risk in a shorter time)*

8.1.5 Seek telephone advice and support from a senior staff member when appropriate to do so.

8.1.6 Once satisfied that there is no obvious fracture that requires specialist moving and handling, ensure patient moved onto their bed/chair in line with LPT Procedures for the Moving and Handling of patients.

8.1.7 If the patient is not safe to remain at home and is not an emergency, liaise with the patient's GP to consider hospital admission or suitable alternative.

8.1.8 If the patient has the capacity to be able to do so**,** they should be asked to describe how they slipped, tripped or fell. This should be clearly documented for future reference in their therapy/nursing clinical records.

8.1.9 An incident form should be completed on Ulysses in line with the Incident Reporting Policy.

8.1.10 With patient consent, if they have capacity, inform the next of kin, if known, of the incident and give appropriate reassurance / information.

8.1.11 Address any factors noted that contributed to the slip, trip or fall.

8.1.12 Inform GP of fall and refer on to other agencies as necessary

8.2 Trip, slip or fall witnessed or discovered by a Health Professional **in the Inpatient Hospital Setting** (Based upon NPSA / 2011 / RRR001)

(SEE FLOWCHART APPENDIX 5)

8.2.1 Ensure immediate environment is safe for patient and staff

8.2.2. Before the patient is moved, assess the patient using ABCDE, GCS and top to toe screen for obvious injury particularly for any suspected head injuries or fractures to spine or femur

8.2.3 If no suspected head injury or fractures

8.2.3.1 Once satisfied that there is no obvious fracture that requires specialist moving and handling, ensure the patient is moved onto their bed/chair in line with LPT Procedures for the Moving and Handling of Patients

8.2.3.2 The patient's physical observations should be recorded post fall and acted upon accordingly. Any inability to comply should be recorded in the patient record.

8.2.3.3 If the patient has the capacity to be able to do so, they should be asked to describe how they slipped, tripped or fell. This should be clearly documented for future reference in their record.

8.2.3.4 The Management of Falls Checklist (Appendix 9) should be used to review all appropriate actions outlined in checklist

8.2.3.5 An incident form on Ulysses should be completed in line with the LPT Incident Reporting Policy

8.2.3.6 The next of kin should be informed of the incident and appropriate reassurance / information given. If the patient does not consent to this information being discussed, this should be recorded in the patient record.

8.2.3.7 Review/reassess the patient's multifactorial assessment and multifactorial intervention plan, action identified changes accordingly and update patients care plan.

8.2.3.8 Address any factors noted that contributed to the slip, trip or fall.

8.2.4 **If suspect head injury, spinal or femoral fracture (Serious Injury) following slip, trip or fall** (Based upon NPSA / 201 / RRR001)

8.2.4.1 Once established as not in immediate danger, undertake actions outlined in Management of Falls checklist (Appendix 8) to identify any injury or trauma. This should be acted upon appropriately, including emergency medical assistance 999 if needed.

8.2.5 **Management of Specific Injuries**

Suspected Spine or Hip Fracture

8.2.5.1 If the patient has a suspected spine or hip fracture they should be nursed on the floor, and should only be moved and handled if there is a need to provide a safe environment. The clinical reasoning for the patient remaining on the floor until the arrival of emergency services should be fully documented in the patient record.

8.2.5.2 If fracture is suspected an urgent review by any medical staff / ANP on site should be sought.

8.2.5.3 If there is a suspected neck/head/spinal/limb fracture injury requiring specialist intervention dial 999 to request emergency transfer for secondary care for assessment of injury.

8.2.5.4 Patients with communication difficulties may not be able to express pain verbally. If there is evidence of pain in the hip or pelvis on mobilising, or mobility is reduced following a fall, consider an x-ray to look for evidence of a fracture.

8.2.5.5 If the patient is at more harm by not being moved, advice should be sought from onsite medical staff or emergency services and the conversation and decision documented in the patient record. The patient should not be placed in a sitting position.
Conventional hoisting is contraindicated as this can lead to fracture displacement. Ensure immobilisation of suspected injury throughout

8.2.5.6 Ensure the patient has a regular reassessment of vital signs whilst waiting for interventions. Observe and monitor for evidence of deterioration, administer analgesia if required. The patient should be made as comfortable as possible.

8.2.5.7 Consider the effects of a 'long lie' on the patient, (e.g. pressure ulcers, rhabdomyolysis, pneumonia, hypothermia, and dehydration) Medical assistance should be sought if any concerns (contact GP or 111 or 999 as appropriate).

(*Definition of a 'long lie' will vary depending on the situation and medical status of the patient; a very frail patient may be exposed to greater risk in a shorter time)*

8.2.6 Suspected Head Injury (inpatients)

See Appendix 6 – Clinical Support Information for Neurological Assessment in Adults

8.2.6.1 Patients who we suspect have sustained a head injury and have 1 or more of the following factors should be assessed by the Advanced Nurse Practitioner/ANP (or other medical clinician) for the possibility of a serious head injury:

- Glasgow Coma Score (GCS) less than 15 (or a change in baseline for patients with a baseline of less than 15)
- Loss of consciousness
- Focal deficit
- Suspected skull fracture
- Amnesia of events before or after
- Persistent head ache / vomiting
- Seizure
- Previous neurological surgery
- History of bleeding / clotting disorder
- Current anticoagulation therapy but not prophylactic Dalteparin should be sent for review and CT scan within 8 hours [NICE CG176 2017]
- Patients who have fallen from a height of 1 metre or more, or more than 5 stairs

8.2.6.2 These factors should prompt the assessing clinician to consider if more specialist advice is required. This can be from the supervising consultant, the duty consultant geriatrician or in the out of hours period, discussion with the OOH doctor. Transfer to the emergency department will be required if advised by the ANP / OOH doctor/ consultant following assessment

8.2.6.3 All patients incurring a head injury should have their vital signs monitored as below on a neurological chart for a minimum of 24 hours and should continue as advised by supervising ANP/ medical practitioner.

If GCS is less than 15 or less than pre-fall baseline status

- Undertake ½ hourly observations until GCS is 15 or baseline status achieved

If GCS is 15 or at pre fall baseline status continue neuro observations as below

- For first 2 hours every 30 minutes
- For next 4 hours every hour

- Every 2 hours thereafter
- After 8 hours consult with supervising ANP / medical practitioner to confirm if post fall observations need to continue or should be continued as advised

8.2.6.4. If the patient shows signs of deterioration in observations medical advice should be sought and observations should revert to every 30 minutes *(NICE Guidance 2017)*

8.2.6.5 Staff must use the 15 point version of the Glasgow Coma Scale (GCS) for recording neurological observations so that changes in the GCS will support staff to trigger an urgent medical review. Staff who have concerns that the patient has a suspected or known head injury must seek immediate medical advice. (Appendix 6: Clinical Support Information for Neurological Assessment in Adults)

8.2.6.6 Incident Reporting Policy should be adhered to and the incident reported on Ulysses. Further investigation completed to a level as advised by Patient Safety team

9. Procedures Post Fall in Inpatient settings (Witnessed or unwitnessed)

9.1 All patients who experience a slip trip or fall should have an incident form completed on Ulysses. This should contain the following information:

- Location of fall
- Equipment involved in fall
- Height of fall to be estimated
- Witnesses account
- Patients own account of fall (or carer/school/parent when appropriate)
- Any predisposing factors

9.2 A post Falls checklist (Appendix 10) or its local equivalent should be completed and any actions identified, implemented immediately. A copy of this assessment should be kept in the patient's record.

9.3 A clear account of the fall and actions taken should be recorded in the patient's documentation.

9.4 Review multifactorial assessment and intervention plan. Implement any additional interventions to reduce falls risks including a review of the patient's bed position in the ward should be carried out and, if necessary, moved to facilitate monitoring.

9.5 Any lessons learnt following the investigation of a fall should be shared with all in-patient staff at team meetings and through the LPT Inpatient Falls network.

10. Management of Patients Who Frequently Fall

10.1 As previously identified, all patients are at risk from falling. However, there are some patients, who, due to their condition will fall frequently, and as a result may need monitoring 24 hours per day.

10.2 Inpatient units will consider use of protective measures e.g., helmets, assistive technology, sensor mats and increased monitoring where clinically appropriate. (Appendix 8: Assessment to support the prescribing of specialling care for patients)

11. Duties, Responsibility and Accountability for All Staff & Volunteers

11.1 All staff & volunteers working within any setting have a responsibility for safety, and are accountable for their practice in achieving this. All will:

- Be aware of the risk of slips, trips and falls within their settings such as environmental factors e.g. trailing wires and clutter etc. and take appropriate action to reduce/eliminate such risk in line with Clinical Risk Assessment Policy.
- Adhere to policy and ensure that correct documentation is completed and any actions taken are noted.

12. Management of a Fall by a Member of Staff or Other

12.1 It is a requirement under the Management of (Health and Safety) at Work Regulations that appropriate risk assessments (including potential falls from height) are undertaken for all significant risks including slips, trips and falls to patients, staff and others.

12.2 If a member of staff, a visitor or other has a slip, trip or fall the actions outlined in section 8 should be followed. Appropriate actions in line with Clinical Risk Assessment Policy and Serious Incident/Incident Reporting Policy should also be followed.

13. Monitoring Compliance and Effectiveness - complete the template below

13.1 Overall monitoring responsibility of this policy will sit with the LPT Patient Safety Group as the responsible committee. Monitoring will take place via the following mechanisms:

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
4.3 (b)	b) how the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height)	Risk assessments are undertaken to reduce or remove risks identified. Risks are regularly monitored and reviewed through Ulysses system and governance processes.	Health & safety risk assessment process Audits undertaken by Health, Safety and Security Team.	Divisional Health, Safety and Security Action Groups LPT Health and Safety Committee	Bi-monthly Annually
4.3 (d)	d) how the organisation raises awareness about preventing and reducing the number of slips, trips and falls involving staff and others	- Mandatory training policy -E-learning -Cascade training -Local Falls champions - bimonthly 5 key messages circulated	Mandatory Training Register monthly	LPT Falls Steering Group Learning and Organisational Devt Group / Workforce groups	Bi-monthly
4.4 (b)	b) how the organisation assesses the risk of slips, trips and falls involving patients (including falls from height)	All patients aged over 65 and those aged under 65 who are judged by a clinician to be at a higher risk of falling because of an underlying condition are screened for falls risk and will have a multifactorial assessment as agreed locally for each in-patient/ community setting.	Audits of falls risk screening and multifactorial assessment in CHS, LD and AMH directorates This includes completion of care plans and actions to reduce or modify risks	Trust Patient Safety Group	Screening and multifactorial assessment included in standard operating procedures Audit frequency in response to service review and previous actions

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
4.4 (d)	d) how the organisation raises awareness about preventing and reducing the number of slips, trips and falls involving patients	Falls are recorded through incident reporting on Ulysses in line with the LPT Incident Reporting Policy. Analysis of incidents happens at Falls Steering group and networks and the learning shared across directorates	Reported via the Quarterly Quality and Patient Safety Reports in Directorate and Corporately to Patient Safety Group. Falls Steering group review bimonthly	Divisional Patient Safety Groups and actioned locally in terms of investigation and action plans Falls Steering group report into Patent Safety group	Quarterly

14. Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Appropriate relevant standards set within the National Health Service Litigation Authority (NHSLA) standards, Safe Environment, Standard 3 – Criterions 3 and 4: Slips, Trips and Falls (Staff & Others) and Slips, Trips and Falls (Patients) apply.	Incident reports Serious incident reports Lessons learnt from incidents Audit results
Care Quality Commission (CQC) Fundamental Standard Safety. You must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care and make sure staff have the qualifications, competence, skills and experience to keep you safe.	Falls Risk screening assessments Multifactorial risk assessments Training reports CQC reports Health and safety inspections

15. Approval of This Document

15.1 This Policy has been written by the CHS Directorate Lead Therapist in conjunction with other LPT representatives. It has been circulated for comments to the Trust Health and Safety Committee and the Trust Patient Safety Group. It will be approved and ratified at the Trust Quality Assurance Committee.

16. Process for Review of This Document

16.1 The Patient Safety Group (PSG) in consultation with other stakeholders will review the policy every 2 years or sooner where a change to legislation, national policy or guidance occurs.

17. Dissemination and Implementation

17.1 This policy will be disseminated immediately throughout the LPT following adoption by the Quality Assurance Committee.

The dissemination and implementation process is:

- Line Managers will convey the contents of this policy to their staff
- Staff will be made aware of this policy using existing staff newsletters and team briefings
- The policy will be disseminated as part of the Mandatory training
- The policy will be disseminated via the Trust Patient Safety Group and the Directorate Patient Safety Groups.
- E-Source – the Policy will be published on the Intranet via e-Source, all documentation in relation to the assessment, monitoring and care planning of falls is available on the Slips, Trips & Falls web pages on e- Source.

18. References and Bibliography

Policy was drafted with reference to the following:

- Cohen and Guin P (1991) Implementation of Patient Fall Prevention Programme. Journal of Neuroscience Nursing 23 (5); pgs. 315-319

- Essence of Care – Patient – focused benchmarking for health practitioners. DOH (February 2001)

- Department of Health; The National Service Framework for Older People: Standard 6: Falls March 2001)

- National Institute for Health and Care Excellence: Clinical Guideline 176: Head Injury-Assessment and Early Management January 2014 (updated June 2017)

- National Institute for Health and Care Excellence: Quality Standard QS86 Falls in Older People March 2015 (updated January 2017)

- National Patient Safety Agency (2007) *Slips, trips and Falls In Hospitals*

- www.npsa.nhs.uk

- National Patient Safety Agency (2011) *Rapid Response Report – Essential Care after an In-Patient fall*

- Management of Health and Safety at Work. Management of Health and Safety at Work Regulations 1999. Approved Code of Practice HSE Books 1999.

- Equality Act 2010

- National Institute for Health and Care Excellence, Quality Standard 86 – Falls in older people: assessment after a fall and preventing further falls.(update January 2017)

- National Health Service Improvement: The incidence and costs of inpatient falls in hospitals, July 2017

Appendix 1

Training Needs Analysis

Training Required	YES
Training topic:	Prevention and Management of Slips, Trips and Falls
Type of training: (see study leave policy)	X☐ Mandatory (must be on mandatory training register) X☐ Role specific ☐ Personal development
Division(s) to which the training is applicable:	X☐ Adult Mental Health & Learning Disability Services X☐ Community Health Services ☐ Enabling Services X☐ Families Young People Children X☐ Hosted Services
Staff groups who require the training:	*Basic awareness training will be mandatory for all staff and volunteers, provided through Core Mandatory training and Induction* *All clinical staff will require Division specific Prevention and Management of Slips, Trips and Falls training*
Regularity of Update requirement:	2 yearly for both awareness training and Division specific training
Who is responsible for delivery of this training?	Awareness training through online training (ULearn) Division specific training – each Division
Have resources been identified?	No
Has a training plan been agreed?	In progress via LPT Falls Steering Group
Where will completion of this training be recorded?	☒ULearn ☐ Other (please specify)
How is this training going to be monitored?	LPT Falls Group Each Division will monitor staff compliance via training reports delivered to Workforce groups.

NHS Constitution Checklist

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	X
Respond to different needs of different sectors of the population	X
Work continuously to improve quality services and to minimise errors	X
Support and value its staff	X
Work together with others to ensure a seamless service for patients	X
Help keep people healthy and work to reduce health inequalities	X
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	X

Stakeholders and Consultation **Appendix 3**

Key individuals involved in developing the document

Name	Designation
Stephanie O'Connell	Lead Therapist CHS
Amy Kent	Therapy Team Lead MHSOP
Susanne Ziegler	Lead Physiotherapist FYPC
Sarah Jane Walker	Physiotherapy Lead CHS community
Sarah Clements	Matron CHS
Jenny Dolphin	Clinical Governance Manager AMH/LD
Caroline Barclay	CHS Nurse Consultant Advance Practice
Jane Martin	Ward Matron AMH/LD
Lisa Brighty	Physiotherapist LD
Shelly Crossland	Occupational therapist MHSOP community

Circulated to the following individuals for comment

Name	Designation
Jo Nicholls	Trust Lead for Quality, Risk and Patient Safety
Joanne Charles	Lead Pharmacist
Jude Smith	CHS Head of nursing
Michelle Churchard-Smith	AMH/LD Head of Nursing
Heather Darlow	Clinical Governance & Quality Lead
Emma Wallis	Associate Director of Nursing
Bernadette Keavney	Health, Safety & Security Manager
Leona Knott	Equality and Human Rights Co-ordinator
Suraiya Hassan	Physiotherapy Professional Lead CHS
Sarah Latham	Lead Nurse CHS inpatients
Laura Belshaw	Lead Nurse MHSOP
Clare Armitage	Lead Nurse Adult Mental Health
Sue Wyburn	Occupational Therapy Professional Lead
Kerry Palmer	Medical Devices Asset manager
Debbie Leafe	Clinical Education lead
Sue Deakin	Moving and Handling Advisor
Cathy Booth	CHS Inpatient Therapy Team Leader OT
Fern Barrell	Risk Manager, LPT
Tom Allison	Falls Team Lead
Laura McNulty	CHS Inpatient Therapy Team Leader Physiotherapy
Ruth Tandy	Advanced Nurse Practitioner
Debbie Blaze	Clinical Services Manager CINNS
Susannah Ashton	Community Services Matron ICS
Tracy Yole	Lead Nurse CHS Community
Sonia Sunner	Community Matron East Central Hub

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	The Prevention and Management of Slips, Trips & Falls Policy
Date Screening commenced	
Directorate / Service carrying out the Assessment	LPT CHS
Name and role of person undertaking this Due Regard (Equality Analysis)	Stephanie O'Connell CHS Lead Therapist
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This document describes the process within Leicestershire Partnership NHS Trust (LPT) for managing the risks associated with slips, trips and falls involving patients in the organisation's settings, staff, visitors and volunteers.	
OBJECTIVES: To provide a clear assurance framework for the LPT Trust board in relation to the prevention and management of Falls.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	There is no impact.
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No✓
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
All aspects of this Policy are equally applicable to all patients, staff volunteers and visitors regardless of protected characteristics being present of not.			
Signed by reviewer/assessor	S R O'Connell	**Date**	**18/2/19**
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 5

PRIVACY IMPACT ASSESSMENT SCREENING

Privacy impact assessment (PIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet individual's expectations of privacy. The first step in the PIA process is identifying the need for an assessment.

The following screening questions will help decide whether a PIA is necessary. Answering 'yes' to any of these questions is an indication that a PIA would be a useful exercise and requires senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**Prevention and Management of Slips, Trips and Falls in Adults Policy**		
Completed by:	**Stephanie O'Connell**		
Job title	**Lead Therapist CHS**	**Date**	**23/1/19**

	Yes / No
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	**No**
2. Will the process described in the document compel individuals to provide information about themselves? This is information in excess of what is required to carry out the process described within the document.	**No**
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	**No**
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	**No**
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	**No**
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	**No**
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	**No**
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**

If the answer to any of these questions is 'Yes' please contact the Head of Data Privacy Tel: 0116 2950997 Mobile: 07825 947786
Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, adoption n of a procedural document will not take place until approved by the Head of Data Privacy.

IG Manager approval name:	
Date of approval	

Acknowledgement: Princess Alexandra Hospital NHS Trust

Appendix 6

Managing Falls in Inpatient settings

See Section 8.2

Patient assessment ABCDE, quick screen for injury before patient is moved. If injury is detected administer analgesia before attempting move

Transfer patient to bed using safe manual handling methods. Consider suitable hoisting method from floor with appropriate equipment and technique Immobilise/support suspected injured part

Complete set of observations

If suspect injury - Request medical review

Inform NOK with patient consent Following Duty of Candour for level 3 harm and above

Investigate cause of fall and complete incident form on Ulysses

Review/reassess the patient's multifactorial assessment and multifactorial intervention plan and action identified changes accordingly

Update patient record

Potential fracture to head, spine or femur?

Conventional hoisting is contraindicated as this may lead to fracture displacement. Ensure immobilisation of suspected injury throughout

Suspected or actual head injury?

Neurological Observations MUST be completed

Initial Neurological Observations

Glasgow Coma Scale (GCS)

GCS = 15 or baseline

Y

½ hourly for 2 hours THEN Hourly for 4 hours THEN 2 hourly thereafter

N

½ hourly obs until GCS is 15 or baseline

After 8 hours Dr/ANP to review frequency and continued need for neuro obs

(Section 8.2.6)

Appendix 7

Clinical Support Information for Neurological Assessment in Adults

Acknowledgement
This clinical support information has been adapted from the UHL Guideline for the Escalation of Deteriorating Glasgow Coma Scale (GCS) 2012 and we thank our UHL colleagues for their assistance.

1 Introduction

1.1 This document provides clinical support information on how to identify when neurological assessment should be used and what to do with any deterioration in a patient's conscious level.

1.2 The Glasgow Coma Score (GCS) is used to assess a patients' level of consciousness in a variety of clinical settings (NICE 2017).

1.3 The "Alert Voice Pain Unresponsive" tool (AVPU) is the monitoring of responsiveness that is included within the Trust's electronic and paper National Early Warning Score (NEWS) systems. If GCS scoring is required this should not be done instead of the AVPU monitoring tool, both should be carried out simultaneously.

2 Scope

2.1 This clinical support information applies to all Healthcare Professionals (HCP) employed by LPT who are required to assess and record Neurological Observations in adults and act on the observations taken. It assumes that the HCP has sufficient knowledge and experience to carry out these observations competently.

3 Who Needs GCS?

3.1 Patients who have suffered a traumatic head injury including a fall, or blow to the head (where a wound to the head has been sustained or is suspected), or those known or suspected to have suffered a stroke or an intracranial bleed should be monitored using the GCS tool.

3.2 In line with LPT Prevention and Management of Slips, Trips & Falls Policy (2018), patients who have sustained **more than 1** of the following factors should be assessed by the Advanced Nurse Practitioner (ANP) or other clinician, for the possibility of a serious head injury. These factors should prompt the assessing clinician to consider if more specialist advice is required or if referral to an emergency department is needed:

a) Glasgow Coma Score (GCS) less than 15 (or a change in baseline for patients with a baseline of less than 15). In some patients (for example, patients with dementia, underlying chronic neurological disorders or learning disabilities) the pre-injury baseline GCS may be less than 15. Establish this where possible, and take it into account during assessment.(NICE 2017)

b) Loss of consciousness

c) Focal deficit

d) Suspected skull fracture

e) Amnesia of events before or after
f) Persistent head ache / vomiting
g) Seizure
h) Previous neurological surgery
i) History of bleeding / clotting disorder
j) Current anticoagulation therapy
k) 65 years +
l) Concern re: diagnosis. Patients who have fallen from a height of 1 metre or more, or more than 5 stairs

3.3 In addition, a clinician should consider referral to an emergency department if the following factors are present, depending on judgement and severity:

a) There are any safeguarding concerns (for example, possible non accidental injury or a vulnerable person is affected)
b) Continuing concern by the professional, injured person or their family or carer about the diagnosis
c) No one is able to observe the injured person at home (NICE 2017)

3.4 Other patients who may require GCS monitoring include the following:

a) Any patient scoring less than A on the AVPU score
b) Any patient with new limb weakness
c) Any patient with new confusion/agitation/aggression
d) Overdose; deliberate or accidental
e) Meningitis or other suspected infection of the brain
f) Liver failure that is affecting AVPU
g) Brain tumour
h) Spinal Injury (as mechanism of injury may also result in head injury)

This is not an exhaustive list and there may be other occasions where the nursing or medical team may consider GCS scoring to be appropriate.

4 How to carry out GCS assessment

GCS assesses responsiveness and awareness and is divided into 3 areas;

a) Eye Opening
b) Verbal Response
c) Motor Response

Before commencing a GCS assessment it is important to explain to the patient/ carers what you are going to do even if their consciousness appears altered. All assessments must be recorded on the GCS Chart (appendix 1)

4.1 Eye opening

4 = Eyes open spontaneously – this must be confirmed as purposeful not just that the eyelids are not fully closed

3 = Eyes open to speech – it is important to speak to the patient but not to specifically ask them to open their eyes e.g. “Hello Mrs Jones, can you hear me” not “Mrs Jones, open your eyes for me” the latter is testing motor response.

2 = Eyes open to pain only – this should be in the form of a trapezius squeeze (firm pressure with thumb and forefinger on the flesh part between the neck and collar bone – See fig 1 below).

1 = No eye opening to voice or painful stimuli

4.2 Verbal Response

5 = Orientated – can tell you their name, date of birth and where they are
4 = Confused – may not know where they are or what’s wrong with them
3 = Inappropriate words – speaking but not making sense
2 = Incomprehensible sounds – groaning, screaming, whimpering, no words
1 = No sound – no response despite verbal and painful stimuli. If patient has a tracheostomy then marks (T) and score 1.

4.3 Motor Response

Step1

6 = Obeys commands – these should be specific e.g. “stick your tongue out” or “squeeze my fingers and let go” it is important if using the latter that you ensure the patient squeezes and lets go as you ask to ensure this is not a spinal reflex. *If appropriate response is seen the patient’s motor score is 6. If not move on to step 2*

Step 2

5 = Localises to painful stimuli – *A painful stimuli can be given by squeezing the trapezius muscle, or by applying supra-orbital pressure (at the supra-orbital notch). (Resuscitation Council UK 2016)*. The latter is contraindicated in patients with facial injuries, those who have had maxillofacial surgery and those with glaucoma, *and should only be used if the clinician is trained and competent to apply this pressure technique (Resuscitation Council (UK) The ABCDE Approach)*

The arm should come up above the line of the clavicle to attempt to move away painful stimuli. Sternal rub is not advised as this leaves bruising. *If appropriate response is seen the patient’s motor score is 5. If not, move onto step 3*

Step 3

Apply firm pressure to the fingernail bed (e.g. by using a pen) *(Resuscitation Council UK 2016)*

4 = Withdraws from pain – patient purposefully reaches towards or moves away from general area of pain but fails to specifically locate it.

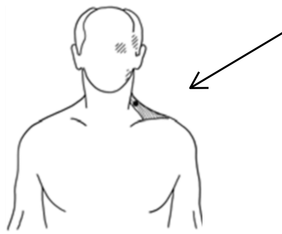
3 = Flexion to pain – patient bends the arms and there is internal rotation i.e. the knuckles of each hand rotate to face inwards.

2 = Extension to pain – patient stretches arms downwards; sometimes this is mirrored in the leg movement. This can also involve inward rotation of the arms and/or legs i.e. the arms stretch and the knuckles of each hand rotate to face inwards.

1 = No motor response – no movement of limbs despite painful stimuli

Following assessment of the 3 above areas, record on the appropriate GCS observation chart and calculate the total GCS score out of 15.

Fig. 1 Trapezius Squeeze



Pressure should be applied at shaded area. (Davies, 2011)

5 Pupil Response

It is vital that an assessment of pupil size and reaction/response to light is carried out alongside GCS monitoring.

When checking pupil size it is important to explain to the patient what you intend to do.

4 Ensure lights are dimmed or the environment is darkened when carrying out pupil response assessment.

5 If the patient is able ask them to open both eyes and keep them open, if they cannot do this then use one hand to hold open both eyelids.

6 Quickly shine a pen torch (use a medical pen torch only, no other light source to be used) into the left eye, look for the size and reaction of the left pupil.

7 Repeat this with the right eye.

8 A pupil size guide should be available on the GCS observation chart

9 Ensure the size of both pupils is documented with a "+" sign if they are reactive a "-"if un- reactive and if you are unable to open the eyes due to swelling record "c".

6 What to do next (NICE 2017)

- Minimum acceptable observations for patients requiring GCS monitoring are full N EWS observations along with pupil size and response and limb strength and movement.
- Observations should be performed and recorded every 30 minutes until a GCS of 15 has been achieved (unless a known previous deficit exists)
- Once a GCS of 15 has been reached then monitoring should continue every 30 minutes for 2 hours
- Then 1 hourly for 4 hours
- Then 2 hourly thereafter
- After 8 hours observations should be continued as advised by supervising ANP / medical practitioner

Should the GCS deteriorate from 15 or the patients baseline status at any point then the monitoring should revert to the start of the above schedule.

7 If any of the following occur an immediate medical review or consideration for referral to a hospital emergency department is required (NICE 2014)

a) Development of agitation or abnormal behaviour

b) A sustained (for 30 minutes or more) drop of 1 point in GCS; greater concern should be raised for a drop of 1 point in motor response

c) A drop of 3 points or more in eye or verbal response or a drop of 2 in motor response

d) Development of severe or increasing headache and/or persistent nausea/vomiting

e) Pupils becoming unequal or any change in their reactivity

f) Any new limb weakness or facial asymmetry

8 The following requires immediate medical attention

a) A GCS of 8 or less

b) One or both pupils size 6 or above with accompanying reduction in GCS

If a patient is found with a GCS of 5 or less or pupils are un-reactive a medical emergency (9)999 call should be put out immediately.

9 Legal Liability Statement

Clinical support information issued and approved by the Trust is considered to represent best practice. Staff may only exceptionally depart from any relevant clinical support information and always only providing that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible healthcare professional' it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes

10 Supporting Documents and Key References

Davies, Clair (2011) The Trigger Point Therapy Workbook. Second Edition. New Harbinger Publications.

LPT (2018) Prevention and Management of Slips, Trips & Falls Policy, Leicestershire Partnership NHS Trust

NICE (2017) Head Injury: Triage, Assessment, Investigation and Early Management of Head Injury in Infants, Children and Adults. https://www.nice.org.uk/guidance/cg176/

Resuscitation Council (UK) The ABCDE Approach https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/ last accessed 18/09/2018

Resuscitation Council (January 2016) Immediate Life Support, 4th Edition, Resuscitation Council UK, London UK

UHL (2012) Guideline for Escalation of Deteriorating Glasgow Coma Score (GCS)

Appendix 8

MULTIFACTORIAL FALLS RISK ASSESSMENT

The Multi Factorial Risk Assessment should consider the following risk area to identify any falls prevention interventions that could reduce the risk of the patient falling.

Templates are available on RIO and SystmOne.

FACTORS AFFECTING FALLS RISKS

Relevant medical history

For example stroke, Parkinson's disease, epilepsy, osteoporosis, osteopenia (this is not an exhaustive list).

Medication: The following can increase the risk of falls and should be considered when assessing

- Taking 4 or more individual medications per day OR any of below
- Anti-hypertensives
- Diuretics
- Neuroleptics (Anti–Psychotics)
- Anti-depressants
- Sleeping tablets
- Tranquillisers

Alcohol/substance misuse can increase the risk of falls

Sensory abilities:

Having a visual impairment, altered spatial awareness or auditory impairment can increase the risk of falls.

Continence status

If a patient needs to access the toilet frequently or urgently this can increase their risk of falls. Consider risk if they suffer from urgency, frequency or incontinence

Nutrition and Hydration

Dehydration and malnutrition can negatively impact on a person's risk of falling
Check moistness of mucus membrane and skin turgor

Agitation/confusion: short-term memory, comprehension difficulties or confusion (sudden onset/acute), which may affect ability to follow advice, awareness of environment and risk factors?

Environmental Risk Factors
Consider following factors which may impact on the risk of a patient falling

- Trip hazards
- Poor lighting
- Living alone
- Need to do stairs
- Use of Assistive technology?
- Appropriate staffing in an inpatient or in a care setting?
- Bed rails – has bed rail assessment been done?

Mobility
Consider following factors which may impact on the risk of a patient falling

- Struggles to stand from sitting
- Unsteady gait/shuffles, takes uneven steps
- Poor balance
- Uses walking aids
- Uses moving and handling equipment
- Holds on to furniture
- Stops walking to talk
- Non ambulant patient-at risk of falls from bed/chair
- Fear of falling

Foot care/footwear:
Difficulty with foot care or inappropriate footwear care may affect mobility and increase falls risk

If Falls Risks are identified then they should be acted upon either by the assessor or signposted/ referred to someone who can address and modify the risk.

The actions and interventions needed should be reflected in the Falls Care Plan, which should be reviewed if needs change

Action and Referral Pathways

Risk Factors What you feel the risk is due to	Consider Contact with / Refer to / Signpost to
Difficulty with balance / transfers / walking / fear of falling	Physiotherapy Occupational Therapist Social Services OT Consider referral to Falls Service via SPA
Medication issues	GP / Consultant / Psychiatrist Community Nurse / Pharmacist
Sensory problems	Optician / GP / Audiology / Occupational Therapy / SALT
Medical condition	GP / Consultant / ANP
Environmental risk factors	Occupational Therapy Social Services
Continence Problems	GP / District Nurse
Alcohol / Substance misuse	GP / Specialist Services Psychologist / psychiatrist
Agitation / confusion	GP / Consultant Psychiatrist Psychologist / Outreach OT
Nutrition and /or hydration problems	Community Nurse / Dietitian / SALT / GP
Feet or footwear problems	GP / Podiatry / Physiotherapy

Appendix 9

Assessment to support the prescribing of Specialling care for patients

Specialling refers to increased level of observation and care such as one to one care. A decision to special is needed when a patient's clinical or behavioural risk exceeds the normal observation requirements of the allocated nurse and staffing levels of the ward. When a patient's condition changes and there is a demand for increased level of observation and care, the following assessment and decision aid tool can be used in line with the professional judgement to support the decision to increase the level of support.

Risk of Falls	Risk of absconding	An episode of increasing confusion/delirium/dementia	Score	Level of observation	Menu of Interventions ***Some or all of these may be appropriate to reduce the identified risk***
Patient identified as being at risk of falls. No history of actual falls either during admission or pre-admission	Limited risk to patients Health/safety if they were to abscond	Mild to moderate confusion. Requires regular reassurance and re-orientation to the ward environment. Can be occasionally agitated and restless	**GREEN LEVEL 1 SOME RISK**	**Intermittent observation**	• Additional family support e.g. relaxed visiting times • Consider relocation of patient in area of high visibility • Use available equipment to minimise risk. • Regular 60 minute confirmation of patient safety • Review medications with pharmacist and doctor • Communicate and escalate at board round and handover • Life History - Getting to Know You completed
1	1	1	<4		
Patient identified as being at risk of falls with one or more of the following: • An actual fall has occurred • Patient is impulsive and/or non-compliant in using nurse call bell. • GREEN level interventions have not made the patient safe	Patient is wandering. Patient with dementia- walking with a purpose. **Consider DOLS Application & document decision outcome**	Moderate confusion. Frequently agitated and restless or requires regular reassurance and re-orientation to the ward environment. • At risk of pulling out an indwelling device • Expressive dysphagia	**AMBER Level 2 Moderate risk**	**Within eyesight**	• Additional family support e.g. relaxed visiting times. • Life History - Getting to Know You completed • Relocation of patient in area of high visibility • Cohorting of at risk patients – 1 staff member per bay using current staffing levels. • Confirmation of patient's safety at regular 30 minute intervals. • Communicate & escalate at board round and handover. • Use available equipment to minimise risk. • Review medication with pharmacist & doctor. • Delirium assessment • Completion of a behaviour chart to establish triggers. • Consider DOLs Application or MH assessment – discuss with Nurse in Charge or Matron • Consider referral to MHSOP in-reach team for advice and support Tel: 0116 2953150/0116 2953152
3	3	3	3-12		
Patient is identified as being at significant risk of falls with serious harm with one or more of the following is present: • All amber actions have been attempted but risk remains • An actual fall with harm has occurred	Serious risk to patient's health/safety if they were to abscond. Consider DOLs Application & document decision outcome	Severe confusion with regular episodes of agitation, violent behaviour and/or aggression towards staff or other patient's Psychosis	**RED Level 3 High Risk**	**Continuous observation**	• 1-1 care-consider if this can be managed with current staff in the first instance. Where it cannot, escalate for additional staff to Matron/site manager. • Consider DOL's Application or MH assessment-seek advice from safeguarding lead, or MHSOP Liaison Team. • Communicate & escalate at board round and handover • Assess capacity to self- discharge. • Inform Ward Sister/Charge Nurse (NIC) to inform Matron.
12	12	12	12-36		

Specialling Assessment Record			
NHS Number: ……………………………………………………….. **Date of Completion: ………………………………………………..** **Signature of person completing form: …………………………**			
Risk reason - Please tick appropriate risk and risk score			
Risk/Reason		**Tick ✓**	**Score**
1. To reduce the risk of further falls by enhanced observation			
2. Confused and wandering presenting risks to self and or others			
3. Behaviour that is challenging to staff presenting risks to self and others			
Section 3: Specialling Prescription **This should be completed and discussed with the Ward Sister/Deputy Ward Sister/Charge Nurse and with the Matron in hours.**			
Specialling recommendation	**Tick ✓**	**Signature**	
1: 1 RGN			
1:1 HCA			
Bay/cohort specialling – please state number of patients and level of staff			
1:1 RMN (To assess plan, deliver and evaluate mental health care, dependant on patient need)			
Please document agreed recommendation, plan of care and outcome of discussion with Ward Sister/Matron **Please reflect specialling care needs in the patient care plan** **Ensure that specialling care plan is discussed with the patient as appropriate and agreed with the family/carers**		**Signature, Date and time**	

Continued Assessment Record					
Reassess risk reasons daily or if patient condition or presentation changes **Matron/ Ward Sister/Deputy Ward Sister/Charge Nurse to review decision**					
Date	**Time**	**Risk Assessment Score**	**Can the patient's care now be safely maintained within usual staffing levels?** Circle appropriately	**If no indicate risk reason (1-3)**	**Signature**
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		
			Yes / No		

Appendix 10

MANAGEMENT OF FALLS CHECKLIST

Management of Fall Checklist (V2) G6d

Patient's Name:		NHS No:
Date of Fall:	Time of Fall:	Safeguard No:

- Choose severity of fall and outcome
- Tick Y/N column as appropriate
- Record reason for variance from protocol in the patient's care plan and noy
* Policy for Managing, Reporting and Investigating Incidents and Serious Untoward Incidents

Uncomplicated Fall Yes / No		
ACTION	**Y**	**N**
Visual assessment for fracture		
Fracture suspected		
Hoisted to bed		
Assisted transfer to bed without hoist		
Vital signs recorded Track and Trigger score calculated		
Patient account of fall recorded		
Discussed with witnesses		
Safeguard Incident form completed		
Post Falls assessment completed		
Falls Risk reassessed		
Falls Prevention Care Plan raised/reviewed		
Safety monitoring commenced or increased		
Sensor Mat in use		
Patient's bed/seating position reviewed to improve visibility		
Referred to Dr/ANP for clinical assessment		
Next of Kin Informed Comments:		
Checklist completed by:		

Serious Injury /Head Injury Yes / No		
ACTION	**Y**	**N**
Visual assessment for trauma/injury		
Contact ANP/geriatrician for review. Or duty geriatrician . Out of Hours contact OOH service. Consider 9-999 if patient's condition deteriorates		
Suspected fracture		
Patient safe and not moved		
Made comfortable		
Vital signs recorded Track and Trigger score calculated		
Head Injury		
Head Injury instructions followed		
Incident Policy* followed		
Line Manager/Locality Service Manager or on-call manager informed if required		
Safeguard form completed and statements obtained		
Falls risk reassessed		
Next of Kin informed Comments:		
Riddor reportable Date reported: By whom:		
Signature:		

Head Injury Guidelines		
ACTION	**Y**	**N**
Contact ANP/geriatrician for review. Or duty geriatrician. Out of Hours contact OOH service. If **two or more** of the following are present additional investigations may be required eg: CT head. Consider 9-999 if patient's condition deteriorates - GCS <15 (or change for patients with baseline of <15 - Loss of consciousness - Focal deficit - Suspected skull fracture - Amnesia of events before or after - Persistent headache/vomiting - Seizure - Previous neurological - Glasgow Coma Scale (GCS) less than 15 - Loss of consciousness - Suspected skull fracture - Amnesia - Persistent headache - Vomiting - Seizure - Previous neurological surgery - History of bleeding/clotting disorder - Current anticoagulant therapy - 65yrs+ - Concerns re: diagnosis - Patients who have fallen from a height of 1 metre or more or more than 5 stairs		
Vital Signs Monitoring - every 30mins until GCS 15 or GCS baseline achieved - Every hour for next 4 hours - Every 2 hours for the first 24 hours post fall - QDS for further 3 days		
Date: Time:		

File original in patient record

Appendix 11

POST FALLS CHECK LIST AND ACTION PLAN

(To be completed following a patient slip, trip or fall)

Patient Name: ……………………………….... Unit No:……………………………… Date of Admission:………………… Date of Fall:…………..…… Time:………..

TRIGGERS	ASSESSMENT OF FALL	ACTIONS TO BE TAKEN	DATE COMPLETE	SIG
How did the fall occur?				
Describe fall in patients own words				
What were the patients injuries (if any)				
Was the fall from bed – if so were bed rails in situ	**Risk Assessment in place? Y / N**			
Where was nurse call buzzer – is patient able to use this?				
Does patient use a walking aid – what?				
Was this involved in the fall? How?				
What is patient's diagnosis?	Number of medicines taken:			

What is patient's mental health? (acute / chronic)				
What was patients risk assessment score?				
What frequency of monitoring is in place	When they were last checked?			
What was patients' foot wear? ?correctly fitting				
Has patient complained of dizziness on standing				
Was floor area safe				
Was area well lit?				

To be completed and kept with patients nursing notes. Copy to be attached to completed Incident form on Ulysses