Leicestershire Partnership NHS Trust

Prevention and Management of Slips, Trips and Falls Policy

This Policy describes the required practice to reduce falls in LPT care by assessing the risk of falls and delivering interventions to reduce or mitigate those risks. It also describes the clinical management of patients who have fallen and the importance of learning from the incidents, reviewing and updating care plans to reduce the risk of further falls

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Which Relevant CQC Fundamental Standards?	*CQC Fundamental standards 9,11,12,15,20*	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
9	2023	Evidence based reviewed and updated Inclusion of • Post Falls Huddles • Use of new flat lifting equipment • Reference to use of new Safe Bed Management Policy replacing the Safe Use of Bed Rail Policy and risk assessment. • Post Falls processes and checklist • Management of falls risk and falls when taking patient off ward. • Updated protocol for lying + standing BP
	14/11/23	Shared with Falls Steering group
	17/11/23	Shared with PSIG members and wider stakeholders
10	12/12/23	Updated with amendments and feedback from Stakeholder consultation

For further information contact:
Chair of LPT Falls Steering Group
CHS AHP Lead

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 considers 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.

Due Regard
LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy
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	A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard. (OHID, Feb 2022)
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
Fall Safety Huddle	Short multi-disciplinary briefings after a patient has a fall designed to give healthcare staff, clinical and non-clinical opportunities to discuss the circumstances of fall with the patient and team and anticipate future risks to improve patient safety.
RIDDOR	RIDDOR requires employers and others to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work'. Generally, this covers incidents where the work activities, equipment or environment (including how work is carried out, organised or supervised) contributed in some way to the circumstances of the accident. (HSE Reporting injuries, diseases and dangerous occurrences in health and social care Information Sheet V3) Staffnet – Home / Support Services / Health and Safety Compliance / RIDDOR or contact lpt.healthandsafety@nhs.net
Flat Lifting	A two-piece air assisted device designed to lift a patient from the floor in a supine position and transfer laterally on to a bed /trolley
Top to Toe screening	Post fall assessment to check for injury – will include vital signs, GCS, patient reported pain, looking for skin wounds, bruising, deformity, abnormal movement. Checks will cover head, face and neck, spine, shoulders, arms and hands, pelvis legs and feet.
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, Brigid
Community Falls Escalation options	**As of 12/12/23** **UCCH – Monday to Friday 9.00 – 17.00** **DHU falls response service** (County Residents including all care home and City just Care home residents): 7 days a week 08.00-18.00: 0300 323 0672 (professional use only) **ICRS** falls pathway (City Residents, not in care home): 7 days a week, 24hr: 0116 454 5370

1.0 Purpose of the Policy

1.1 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. The policy describes the arrangements in place to enable the risks associated with falls and the management of falls to be effectively assessed and addressed. It details a number of key areas, the training requirements, the risk assessment and prevention of falls, the processes for the management of persons who have fallen and the processes in place to monitor the effectiveness of existing arrangements.

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

- Health & Safety at Work Act 1974
- Safe system of work when working at height and use of kickstep/step
- The Management of Health and Safety at Work Regulations 1999
- Health & Safety Policy
- Reducing Risks Associated with Falls, Heights and Windows Policy
- Using Hoists to Move Patients Policy
- Manual Handling Policy
- Procedures for the Moving and Handling of Patients
- Incident Reporting and Management Policy
- Safe Bed Management Policy
- Cardiopulmonary Resuscitation Policy
- Record Keeping and Care Planning Policy
- Clinical Risk Assessment and Management Policy
- Plus Size Patient Pathway
- Medical Devices policy

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

2.0 Summary and Scope of Policy

2.1 Summary

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 organisation's settings. This Policy should be read in conjunction with local guidance and processes as outlined in section 1.1.

It describes the process to reduce falls by assessing the risk of falls and delivering appropriate interventions to reduce or mitigate those risks. It also describes the clinical management of patients who have fallen and the importance of learning from the incidents, reviewing and updating care plans to reduce the risk of further falls

Version 9 has been updated and key changes include,

- Post Falls Huddles
- Use of new flat lifting equipment
- Reference to use of new Safe Bed Management Policy replacing the Safe Use of Bed Rail Policy and risk assessment.
- Post Falls processes and checklist
- Management of falls risk and falls when taking patient off ward.

The scope of the policy covers all adult 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.

This policy aligns with NICE Guidance CG 161 Falls in older people: assessing risk and prevention (reviewed and updated 2019) which states it applies to

- People aged 65 or older who fall or are at risk of falling in the community, and their families and carers
- All hospital inpatients aged 65 or older.
- Hospital inpatients aged 50 to 64 who have been identified as being at higher risk of falling.

In LPT we also apply this guidance to all adults over 18 on our caseloads, whether they are inpatients or residing in the community, if they are identified as being at risk of falls through the Falls Risk Assessment Tool (FRAT)

2.2 Slips, Trips and Falls in Children

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

However, there are four 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.

d. Falls in children with non-deteriorating conditions such as eating disorders which may affect their blood pressure, or children with any condition, mental or physical, requiring medication which could affect mobility, balance or blood pressure and increase risk of falls.

The risks of falling and strategies for the management of the falls risks in children will be assessed on an individual basis, as part of weighing up benefits and risks of therapeutic interventions 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, however assessment of standard risk factors should be considered where appropriate as part of clinical assessment.

3.0 Introduction

3.1 A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level.

Slips, trips and falls have implications for both LPT and the individual. A single fall is not always a sign of a major underlying problem; it may simply be an isolated event but could have a major impact on all concerned. Therefore we must assess for the risk of falls and plan to reduce that risk as far as possible.

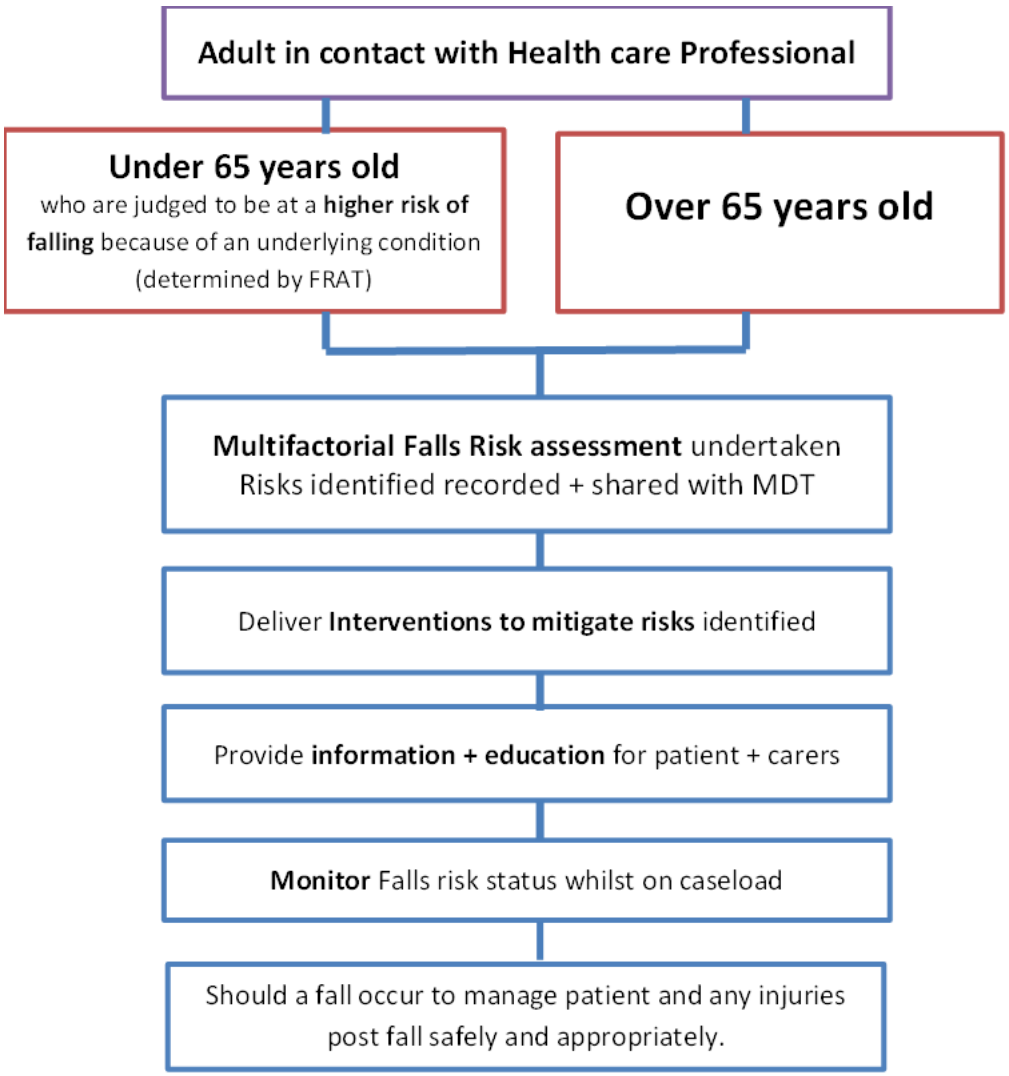
All witnessed falls, and unwitnessed falls in any inpatient setting, should be reported, investigated, learning identified, acted upon and shared so that the organisation habitually learns from insights to provide safer care through continuous improvement (NICE CG161 2013 updated 2019.)

Due to the nature of the clinical presentation of many of the patients in the care of Leicestershire Partnership Trust, 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 CG161)

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 people who fell frequently, were either admitted to hospital, residential care or had died.

4.0 Flowchart/process chart

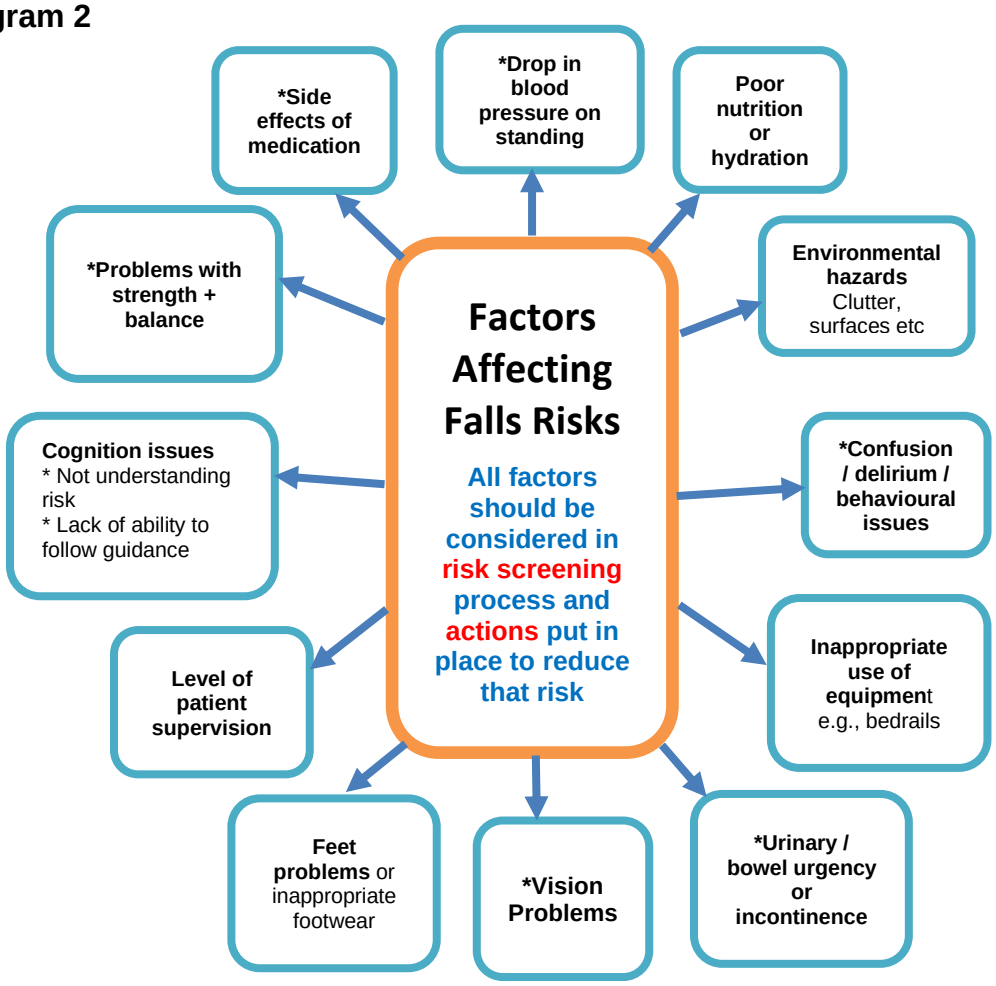
Diagram 1: Principles of Falls Risk Management (NICE CG161, 2013)



4.2 Factors contributing to Falls Risks

The risk factors outlined below should be considered when undertaking falls risk screening. Where a risk is identified, actions to reduce that risk should be implemented and recorded in the patients care plan. (For more detail see appendices 6-9.)

Diagram 2



(Based on NICE CG161)

5.0 Duties within the Organisation

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

5.2. The Trust Policy Committee is mandated on behalf of the Trust Board to adopt policies.

5.3. The Trusts Falls Steering Group is mandated by the LPT Patient Safety and Improvement Group to develop and update the Prevention and Management of Slips, Trips and Falls Policy.

5.4. Divisional Directors and Heads of Service are responsible for ensure this policy is implemented.

5.5 Team Leads / Ward Managers/ Matrons/ Service Team Managers / Line managers in Community Settings have responsibility:

- 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 complete Falls Awareness training compliance with training is monitored.
- To ensure that staff are clear in their roles and responsibility in managing and reducing the risk of falls as per the Policy and that all patient documentation is correctly completed and onward referral made as appropriate.
- To ensure the care plan post fall is reviewed to reduce risk of further falls and that any learning is shared across the team.
- To lead / contribute to incident investigations as identified.
- To ensure the staff participate in any audit related to falls prevention and ensure actions are identified and improvements are made following the audit.
- To work in line with the LPT's Incident Reporting Policy including the reporting of falls in line with RIDDOR.
- To assist in identifying physical and financial resources to assist in reducing and managing falls risks.

5.6 Responsibility of Staff & volunteers

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 and Management Policy.
- Adhere to policy and ensure that correct documentation is completed and any actions taken are noted.

5.7 Responsibility of all Clinical Staff

- All Clinical Staff will undertake 2 yearly role essential Falls Awareness training.
- Staff 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**.**

5.7.1 Clinical Staff working in inpatient setting

- As agreed locally for each in-patient setting, this multifactorial risk assessment should be carried out within 24 hours of admission along as part of the admission process with the use of supporting documentation as appropriate (Note: 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)
- The Falls Risk assessment should be repeated within 24 hours of any internal transfer of patients between LPT CHS inpatient sites.
- For transfer of patients between DMH wards, if the patient is identified as having falls risks on originating ward they should be reassessed using MFRAT on admission to new ward.
- Medical (including Advanced Clinical Practitioners) and pharmacy staff will support this process by reviewing and identifying any medication the patient is prescribed that may exacerbate or increase the risk of falls.

- Ensure that patients are re-assessed for falls risks following a fall or near miss or if it is perceived that the level of falls risks has changed, for example this could be due a change in the patients presentation or a change in medication
- Ensure that inpatients receive the necessary interventions and equipment to reduce risks and are nursed in the most appropriate area of the ward for monitoring.
- **If a patient leaves the ward temporarily for example on escorted walks in hospital grounds or while out in the community** (generally Mental Health wards). Prior to them leaving the ward a conversation should be had with the staff nurse/medic to ensure that the patient is medically fit to leave the ward and if any rescue medications are needed, their mobility status should be known and the patient should have the appropriate walking aids and footwear to reduce risk of falls, this assessment of the risks should be documented on SystmOne according to local policy and process. Ensure the patient has an appropriate and up to date care plan.
- Ensure the patient's leave paperwork is completed as per ward process (Mental Health wards).

5.7.2 Clinical staff working in Community/Domiciliary Setting

- All appropriate patient documentation is completed using the Falls Risk Screening tool (FRAT) and Falls Multifactorial Assessment (MFRAT) at the beginning of the episode of care and interventions, tailored to address the patient's individual risk factors for falling, are implemented, monitored and reviewed. (Appendix 6*)*. (Note: Any clinical reasoning for not using falls risk assessment tools on initial contacts must be documented in the patients record)
- Standard operating procedures within each service should set out expectations of timings for initial assessment and reviews as appropriate for their patient cohort.

5.7.3. Consent

- Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered and this consent documented in the patient record. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed and the person consenting must have the capacity to make the decision.
    - In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a **mental capacity assessment** is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following,
        - Understand information about the decision
        - Remember that information
        - Use the information to make the decision
        - Communicate the decision

6.0 Training

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 essential training.

6.2 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 role essential for Inpatient clinical staff and for Community clinical staff.

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

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

7.0 Management of Falls Risks

Falls risks are identified through use of the **Falls Risk Assessment tools** that are appropriate for the clinical area and align with NICE Guidance CG161

- The Falls Risks Assessment Tools (FRAT) – identify those patients who will need to be fully assessed using a Multifactorial Falls Risk Assessment Tool (MFRAT) (Appendix 6)
- In areas where it is considered that all patients require a Multifactorial Risk assessment due to the nature of the patient cohort (e.g., CHS wards, MHSOP, all adult LD wards), it is not necessary to complete the FRAT first and this should be made explicit in any local Service Standard Operating Procedures**.**

7.1 Interventions to mitigate falls risks

Following completion of the Falls risk assessment, appropriate interventions need to be put in place to mitigate those risks identified, as part of the care planning process

Care plans should be personalised to the individual and reviewed on a weekly basis alongside the review of the Falls Risk assessment.

The following diagram shows suggestions of possible interventions in relation to risks identified

Diagram 3: Possible interventions to reduce someone's risk of having a fall (Further detail in appendices 6 – 11)

7.2 Management of the Risk of Falling out of Bed

7.2.1 Following the completion of the Falls Risk Assessment and Moving and Handling Risk assessment, the patient may be identified as being at risk of falling or slipping out of bed. The patient's clinical presentation regarding their physical and mental status should be considered to inform the clinical reasoning the best option for managing the risk

7.2.2 The clinical decision making should be in line with standards set out in the **Safe Bed Management for Adults Policy**, there is clear guidance and a risk assessment must be completed. Options include use of bed rails (not on Mental Health Wards or Adult LD wards), use of low bed with mats or mattresses or increasing levels of patient supervision.

7.2.3 Bed rails are NOT to be used to restrain the movements of patients and are associated with risks of entrapment and patients climbing over (MHRA Bed rails: management and safe use August 2023)

7.2.4 The use of low beds also holds risks for mobile patients trying to get up from low levels. Additionally the crash mat or mattress used in conjunction with the low bed can present a trip risk or balance issues for unsteady patients (NPSA The safe use of ultra-low beds Feb 2011)

7.2.5 Where use of bed rails or low beds present additional risk to a patient who is already at risk of falls then consideration should be given to providing increase levels of supervision.

- In **CHS** the need for increased supervision can be assessed by using the **Checklist for Enhanced Observations** (Appendix 10) this can support decision making and options range from intermittent observation, within eyesight or continuous observation dependent on the patient's circumstances.

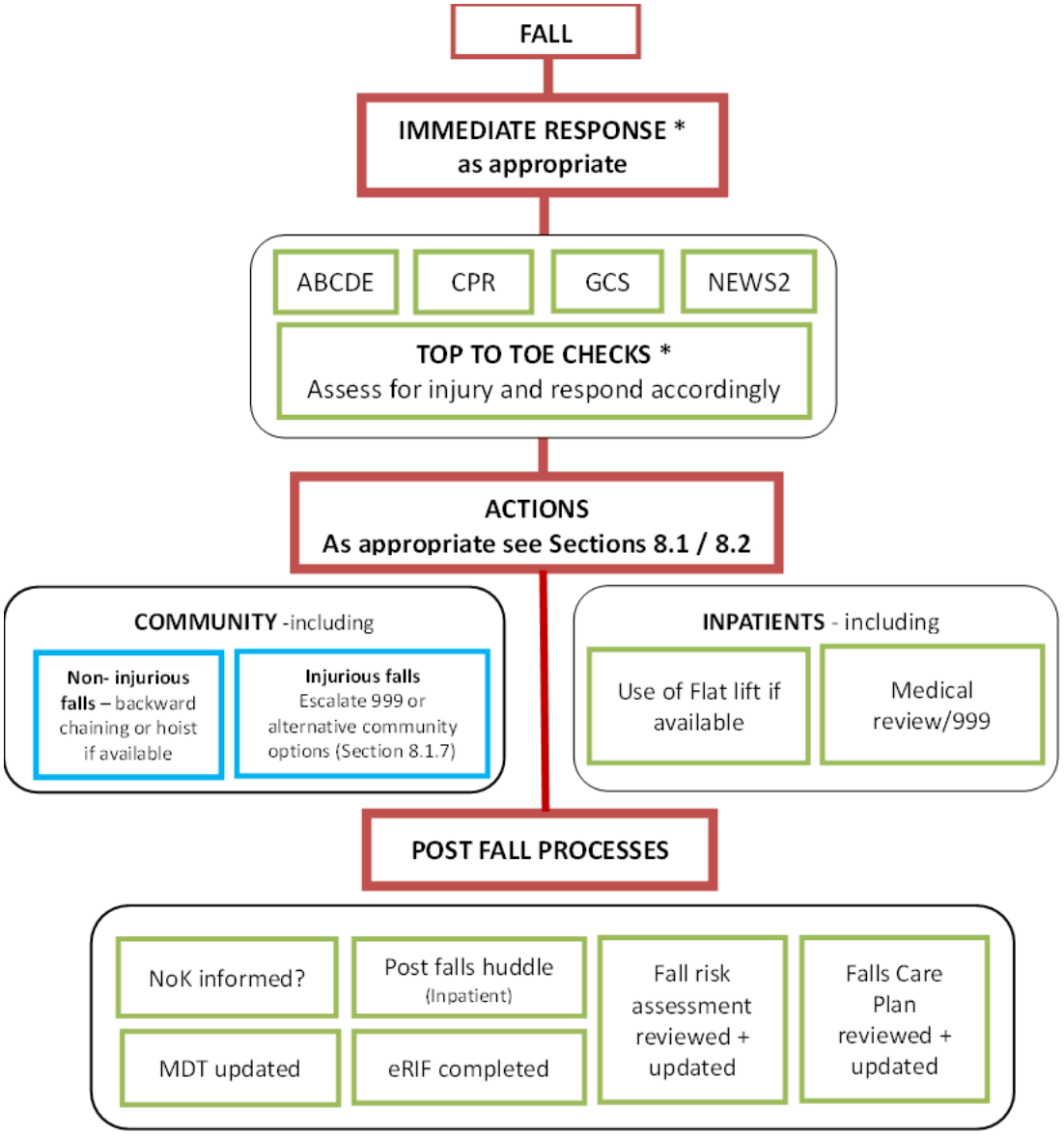
- In **Mental Health or MHSOP or LD wards** Therapeutic Observations can be used to manage someone's risk of falling. The level of supervision should be decided in line with the **Supportive Observation and Engagement of Inpatients Policy** (this can be found on the trust website).

- In the **community setting** this may need a review of the patient's level of care support in discussion with social care services

7.2.6 On some occasions bed rails (split bed rails) may be used as part of a therapeutic rehabilitation plan. This need will be assessed by a Registered Physiotherapist or Occupational Therapist and the clinical reasoning for this action will be documented in the clinical record

8. Management of witnessed or discovered falls

Principles of post falls management



8.1 Falls witnessed or discovered by a Health Professional in the <u>Community / Domiciliary / Clinic Setting</u>

8.1.2 Ensure the immediate environment is safe for staff and the patient.
Before patient is moved, assess patient using **ABCDE, NEWS assessment and GCS as appropriate (dependent on service and competency) and top to toe screen for obvious injuries** particularly for head injuries or suspected fractures to spine or femur (Appendix 12)

8.1.3 If there is suspected injury that requires specialist intervention (i.e. head or spinal injury, fracture or acute deterioration), medical or emergency assistance (999) should be called immediately and the patient left unmoved.

8.1.4 With a discovered, unwitnessed fall, even when there is no suspected injury, the clinician should 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, in the Community this may involve the use of a hoist or backward chaining.

8.1.7 If the patient is not safe to remain at home, and is not an emergency, liaise with the patient's GP for medical review or to consider hospital admission or suitable alternatives. Referral to Home First services or the Unscheduled Care Coordination Hub can also be considered. Also for non-injurious falls the DHU falls car in the county, DHU falls car for City care home patients and/or ICRS support in the City. (See Glossary for more details p5)

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 including falls as a causal incident.

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, review and update the multifactorial risk assessment and care plan as appropriate in the clinical record.

8.1.12 Inform GP of fall if not already involved and refer on to other agencies as necessary.

8.2. Fall witnessed or discovered by a Health Professional in the <u>Inpatient Hospital Setting</u> (See appendix 12 for Flowchart)

8.2.1 Ensure immediate environment is safe for patient and staff. Once established as not in immediate danger, undertake actions as described in Post Falls Flowchart, including Top to Toe assessment and Management of Falls checklist (Appendices 12 + 16) to identify any injury or trauma. This should be acted upon appropriately, including emergency medical assistance 999 if needed.

8.2.2. **Before the patient is moved, assess the patient using ABCDE, Top to Toe screen for obvious injury and GCS as appropriate**, particularly for any suspected head injuries or fractures to spine or femur
If injury is suspected to have occurred in the fall, seek immediate assistance (Medic / ANP / Paramedic / OOH) and follow clinical guidelines appropriate to the injury. For management of specific injuries see appendices for management of spine or hip fractures and suspected head injury (see **Appendices12,13,16**)

8.2.3 Most LPT adult wards have access to **Flat Lifting Equipment** and this can be used to raise someone off the floor even if an injury is suspected. It can be used to get patients off the floor safely with minimal risk of exacerbating any fracture site. (See Appendix 14 for specific advice)

8.2.4 If satisfied it is safe to do so, the patient can be moved onto their bed/chair, in line with LPT Procedures for the Moving and Handling of Patients, using flat lifting equipment or some wards also have access to the Raiser chair which is appropriate for use where there is a witnessed non injurious fall or where patient has been witnessed lowering themselves to the floor.

8.2.5 The patient's physical observations should be recorded post fall and acted upon accordingly.

8.2.6 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.

8.2.7 **Management of witnessed or discovered Falls of an inpatient whilst off the ward.** including escorted walks on hospital grounds or while out in the community.

8.2.7.1 If injury is suspected, seek immediate assistance (Medical / ANP / Paramedic (999), Ward doctor, Nurse in Charge, OOH) In all cases notify Nurse in Charge and follow clinical guidelines appropriate to the injury.

8.2.7.2 If no injury is suspected seek telephone advice and support from the ward, a medic, nurse or senior staff member, explain the circumstances of the fall and patient presentation, before moving the patient. If the fall occurred within the hospital grounds, support may be requested from inpatient staff for example a wheelchair could be provided to transport the patient back to the ward.

8.2.7.3 The patient's physical observations should be completed on return to the ward, recorded and the normal post falls processed commence.

8.2.8 **Post Falls Safety Huddle**

A post falls huddle should be undertaken with staff on the shift at the time (or as soon as possible) to discuss possible reasons for the fall and patients view should be included. An example of questions discussed in a post falls safety huddle are in Appendix 15.

The purpose of the huddle is to identify contributory factors, patient centred learning and key actions to prevent that individual having a repeat fall. the risk assessment and care plan should be updated accordingly.

8.2.9 An **incident form on Ulysses** should be completed in line with the LPT Incident Reporting and Management Policy.

8.2.10 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.

8.2.11 Following a fall the patient's multifactorial assessment and multifactorial intervention plan should be reviewed. Any additional interventions to reduce falls risks as identified from the Falls Huddle should be implemented. A review of the patient's **bed position in the ward**

should be carried out and, if necessary, moved to facilitate monitoring and ensure the patients care plan is updated

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

8.2.13 A Post Falls checklist (example in Appendix 16) 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

8.2.14 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. Investigations will use the After Action review template and the learning will inform improvement plans on the wards.

9. Management of a fall by a member of staff or other

9.1 It is a requirement under the Management of Health and Safety at Work Regulations 1999 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.

9.2 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 and Management Policy and Incident Reporting and Management Policy should also be followed. Consideration should be made to decide if the incident should be reported through RIDDOR (see appendix 17) (Contact Health and Safety team lpt.healthandsafety@nhs.net)

10.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
6.0 p12	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 Sharing learning post investigation	Role essential Training Register monthly	LPT Falls Steering Group Training, Education + Development Group / Workforce groups	Monthly

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
5.7 p11	How the organisation assesses the risk of slips, trips and falls involving patients	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 risks 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 DMH directorates This includes completion of care plans and actions to reduce or modify risks. Record Keeping Audits	LPT Falls Steering Group Trust Patient Safety Improvement Group	Screening and multifactorial assessment included in standard operating procedures. Monthly review Formal audit frequency in response to service review and previous actions At least annual
8.0 p 16	How the organisation manages the risk of slips, trips and falls involving patients and those that have fallen	Falls Care planning related to risk assessment findings Falls Huddles post falls	Directorate Falls Audits Record Keeping and Care planning Audit Falls Huddles post fall through monthly reporting	Falls Steering Group	Annual Monthly
8.2.9 + 8.2.14 p18/ 19	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	Monthly

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
9.0 p19	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 and Safety Team.	Directorate Health, Safety and Security Action Groups LPT Health and Safety Committee	Bi-monthly Annually

11.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
NICE CG 161 – Falls in Older People; Assessing risk and prevention (2013) **NICE QS 86** – Falls in Older People (updated 2017)	Delivering Multifactorial Falls Risk assessments and interventions to reduce risk Post falls protocol Records audit
CQC Regulation 9 Person-centred care The care and treatment of service users must be appropriate, meet their needs and reflect their preferences.	Individualised care Planning Audit of Post Falls Huddles
Regulation 11 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person.	Ensuring Patients are aware of their risk of falls and contribute to care planning Records audit
Regulation 12 Safe care and treatment Care and treatment must be provided in a safe way for service users.	Falls Risk assessment and care planning to mitigate risks. Safe Bed Management tool supports clinical reasoning for bed rails, low beds and levels of supervision Post falls protocol re management of falls Equipment is cleaned and LOLER tested where applicable. SOP for flat lifting equipment. Completion of hoist/flat lift checklist.
Regulation 15 Premises and Equipment Premises are clean, suitable and maintained.	Equipment used to deliver care is clean, suitable, maintained, stored securely and used properly for intended purpose
Regulation 20 Duty of Candour Providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment	With patient consent relatives are informed if their relative has fallen Patients and relatives are kept informed of any Falls incident investigations

12.0 References and Bibliography

The policy was drafted with reference to the following:

NICE QS86 Falls in Older People 2015. Updated 2017 https://www.nice.org.uk/guidance/qs86)

NICE CG161 Falls in older people: assessing risk and prevention. Published: 12 June 2013 (updated 2019) https://www.nice.org.uk/guidance/cg161

MHRA Bed rails: management and safe use: Guidance on managing and using bed rails safely. Published 30 August 2023
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1181044/Bed_rails_guidance.pdf

National Patient Safety Agency, The safe use of ultra-low beds. Signal
Ref no1309, Issue date14 February 2011 https://www.rcplondon.ac.uk/file/932/download

The NHS Patient Safety Strategy: Safer culture, safer systems, safer Patients July 2019
https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

Office for Health Improvement and Disparities (OHID) Falls: applying All Our Health Updated 25 February 2022
https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health
The 2023 National Audit of Inpatient Falls (NAIF) report: Inpatient falls and fractures – one chance to get it right. Report on 2022 clinical data

National Falls Prevention Coordination Group Medicines and Falls NFPCG July 2023

NICE NG232 Head injury: assessment and early management. Published: 18 May 2023
https://www.nice.org.uk/guidance/ng232/chapter/Recommendations#pre-hospital-assessment-advice-and-referral-to-hospital

Appendix 1

Training Requirements

Training Needs Analysis

Training topic:	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ✓Role specific ☐ Personal development
Directorate (s) to which the training is applicable:	✓Adult Mental Health & Learning Disability Services ✓Community Health Services ☐ Enabling Services ✓Families Young People Children ☐ Hosted Services
Staff groups who require the training:	All staff and volunteers involved in patient facing teams will require Falls Awareness Training All clinical staff will require area specific training related to applying principles of this policy in their local area
Regularity of Update requirement:	2 years
Who is responsible for delivery of this training?	Basic Awareness training will be delivered through e-learning via ULearn Directorate Falls Leads and Falls champions will oversee deliver of local bespoke training
Have resources been identified?	Yes
Has a training plan been agreed?	Yes
Where will completion of this training be recorded?	✓ULearn ☐ Other (please specify)
How is this training going to be monitored?	Falls Awareness training will be reported through ULearn Each directorate will monitor staff compliance via training reports delivered to Workforce groups. LPT Falls Group will monitor trust compliance

Appendix 2

The NHS Constitution

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

Appendix 3

Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Stephanie O'Connell	AHP Lead CHS
Amy Kent	Therapy Team Lead MHSOP
Susanne Ziegler	Lead Physiotherapist FYPC
Mandy Steele	Matron CHS
Rachel Draper	Therapy Lead CHS
Ruth Tandy	CHS Nurse Consultant Advance Practice
Elizabeth Ortu	Physiotherapist Adult Learning Disabilities
Lisa Brighty	Lead Physiotherapist AMH / LD
Christian Knott	Health and Safety
Mark Dearden	Moving And Handling
Nirmala Pillai	MHSOP RMN
Amanda Jones	Physical Health Nurse DMH
Sue Arnold	Lead Nurse Corporate Patient Safety
Shifa Jussab	Physiotherapist DMH
Shelley Crossland	Clinical Lead Occupational Therapist CMHT

Circulated to the following individuals for comment

Name	Designation
Members of Patient Safety Improvement Group	Level 2 Committee
Trust Policy expert Group	
Tracy Ward	Head of Patient Safety
Joanne Charles	Lead Pharmacist
Sarah Latham	CHS Head of nursing
Saskia Falope	DMH Head of Nursing
Zayad Saumtally	Head of Nursing FYPC/LD
Heather Darlow	Clinical Governance & Quality Lead
Emma Wallis	Deputy Director of Nursing and Quality
Samantha Roost	Head of Health, Safety & Risk
Haseeb Ahmed	Head of EDI
Sam Branston	Physiotherapy Professional Lead CHS
Louise Moran	Deputy Head of Nursing CHS inpatients
JonPaul Viviers	Deputy Head of Nursing – Adult Inpatient Mental Health - AFPICU/ Rehab
Jackie Moore	Team manager MHSOP
Bernie Light	Deputy Head of Nursing FYPC/LD
Rebecca College	AHP Lead DMH
Victoria Apparacio	AHP Lead FYPC/LD
Claire Turvey	CHS OT Professional Lead
Mathew Buxton	Medical Devices Asset manager
Debbie Leafe	CHS Clinical Education lead
Cathy Booth	CHS Inpatient Therapy Team Leader OT
Fern Barrell	Risk Manager, LPT

Tom Allison	Falls Prevention Team Lead
Ruth Tandy	CHS Advanced Nurse Practitioner
Debbie Parmar	Clinical Services Manager CINNS
Michaela Ireland	Community Hospitals Ops and Transformation Lead
Tracy Yole	DHoN CHS Community
Donna Frazer	CHS Community Matron
Nima Makanji	Clinical Lead Community Therapy
Rebecca Hall	Medical lead Physical Heath DMH
Simon Guild	DHoN MHSOP
Rachael Shaw	Matron Bennion Centre

Appendix 4

Due Regard Screening Template

Section 1	
Name of activity/proposal	The Prevention and Management of Slips, Trips & Falls Policy
Date Screening commenced	November 2023
Directorate / Service carrying out the assessment	LPT CHS
Name and role of person undertaking this Due Regard (Equality Analysis)	Stephanie O'Connell CHS AHP Lead
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. It also covers the management of the fall should it occur.	
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	There is no impact
Gender reassignment	There is no impact
Marriage & Civil Partnership	There is no impact
Pregnancy & Maternity	There is no impact
Race	There is no impact
Religion and Belief	There is no impact
Sex	There is no impact
Sexual Orientation	There is no impact
Other equality groups?	There is no impact

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 <u>tick</u> 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:			
Risk assessment to prevent falls is personalised to the patient and management pathway if a fall were to occur applies equally to all regardless of protected characteristics			
Signed by reviewer/assessor	Steph O'Connell	**Date**	14/11/23
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Tracy Ward, Head of Patient Safety	**Date**	16/12/2023

Appendix 5

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) 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 following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	**The Prevention and Management of Slips, Trips & Falls Policy**	
Completed by:	**Steph O'Connell**	
Job title	**AHP Lead, CHS**	**Date 14 November 2023**

Screening Questions	**Yes / No**	**Explanatory Note**
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 them? 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 Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk

In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	**Hannah Plowright**
Date of approval	**27/11/2023**

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust

Appendix 6

OVERVIEW OF MULTIFACTORIAL FALLS RISK FACTORS

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.

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 (See appendix 7)

- Taking four or more individual medications per day OR any of below
- Anti-hypertensives
- Diuretics
- Neuroleptics (Antipsychotics)
- Anti-depressants
- Sleeping tablets
- Tranquilizers

Postural Hypotension (See Appendix 8)
Defined as a drop in BP (usually >20/10mmHg) within 3 mins of standing and can present high risk of falling/collapse.
Can be caused by certain medications (appendix 7), fluid imbalance, prolonged bed rest or certain medical conditions. Also, sometimes after eating.

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.

Vision impairment is associated with increased risk of falls and hip fractures. Certain common conditions in older people present increased risks. (See example of Vision assessment Appendix 9)

- **Cataracts** - Patient may have blurred and/or double vision, be affected by glare and find it difficult to see in dim or very bright lights.
- **Glaucoma** - Due to loss of peripheral vision the patient may be unable to see objects around them and bump into things. They may not be able to see steps or thresholds, leading to trips and falls.
- **Diabetic Retinopathy** - Patchy vision, blurry vision or 'floaters,' the patient may have a particular difficulty in avoiding obstacles or navigating stairs and steps.
- **Hemianopia** - Loss of one side of the field of vision in both eyes often caused by stroke – the patient may bump into things or miss things on the side without vision.

- **Age-related macular degeneration** - Loss of central vision. Makes it difficult to read and recognise people.
- **Dementia** – distorted vision, visual confusion, and poor depth perception.
- **Spectacles** – even use of bifocals or varifocals or an old, out-of-date or recently changed prescription can increase falls.

Continence status
If a patient needs to access the toilet frequently or urgently this can increase their risk of falling. Consider their risk of falls if they suffer from urgency, frequency or incontinence and develop appropriate continence management plan.

Nutrition and Hydration
- Dehydration and malnutrition can negatively impact on a person's risk of falling.
- Check moistness of mucus membrane and skin turgor
- Use of MUST tool in inpatient setting

Agitation/confusion: short-term memory, comprehension difficulties or confusion (sudden onset/acute), which may affect ability to follow advice, awareness of environment and understanding risk factors.
Consider delirium pathway and assessment of cognition and or capacity related to specific decision making (Mental Capacity Assessment / MCA)

Environmental Risk Factors
Consider the 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 the 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.

Mental Status:
A patient's level of mental capacity can impact/influence their ability to understand risk and follow instructions. Similarly, patients who are experiencing confusion or delirium or live with dementia or demonstrate behavioural issues may also not be able to engage in their falls care plan. Consider assessment of cognition and or capacity related to specific decision making (MCA)
Consideration should be given to the level of observation required in relation to the level of their falls risk (See Enhanced Observations (CHS Appendix 10) or Supportive Observation and Engagement of Inpatients Policy (DMH))

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 the patient falls or has a change in clinical presentation.

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 Community Falls Prevention Service via SPA
Medication issues	GP / Consultant / Psychiatrist / ANP Community Nurse / Pharmacist
Sensory problems	Optician / GP / Audiology / Occupational Therapy / SALT / Physio
Medical condition incl Postural Hypotension	GP / Consultant / ANP / ACP
Environmental risk factors	Occupational Therapy / Physiotherapy / Social Services
Continence Problems	GP / Nurse / Continence team
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
Mental Capacity	MCA - ward team/assessing clinician

Appendix 7

Medicines and Falls

A number of medicines can cause or contribute to falls and these are sometimes referred to as falls risk increasing drugs (FRIDs)
Guidance below is from National Falls Prevention Coordination Group
https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Pharmacy%20guide%20docs/Medicines%20and%20falls%209%2023%20(RPSendorsed).pdf?ver=kHy696ZEbkwR7eopGgbkFw%3d%3d

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
ALFUZOSIN	Alpha blockers	Severe orthostatic hypotension, sedation	AEC score 0. Review indication if OH present. Stopping it may precipitate urinary retention in men.
ALIMEMAZINE	Antihistamines – phenothiazine derivative	Central sedative effect	AEC score 3 – consider review or switch to safer alternative. Rate of excretion decreases in old age.
AMIODARONE	Anti-arrhythmic	Bradycardia, other arrythmias	AEC score 1
AMISULPIRIDE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score not available
AMITRIPTYLINE	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision	AEC score 3 – consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
AMLODIPINE	Calcium channel blocker	Hypotension and paroxysmal hypotension	AEC score 0
ARIPRIPAZOLE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 1
ATENOLOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome	AEC score 0. May accumulate in older patients due to renal excretion
BACLOFEN	Muscle relaxant	Sedation, reduced muscle tone	AEC score not available. Drug used in conditions which predispose to falls

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
BENDROFLUMETHIAZIDE	Thiazide Diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion	AEC score 0
BETAHISTINE	Antihistamine	Sedation, no evidence of benefit for long term use	AEC score 0
BISOPROLOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, hypotension, vasovagal syndrome	AEC score not available
BUMETANIDE	Loop Diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion, nocturia	AEC score not available
BUPRENORPHINE	Opioid analgesic	Sedation, slow reactions, impaired balance, delirium risk	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
CANDESARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score 0
CAPTOPRIL	ACE inhibitor	Orthostatic hypotension; renally eliminated and can accumulate in dehydration or renal failure	AEC score not available
CARBAMAZEPINE	Antiepileptic	Sedation, slow reactions, excess levels can cause ataxia and unsteadiness	AEC score 1
CARVEDILOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, hypotension, vasovagal syndrome	AEC score not available

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
CHLORDIAZEPOXIDE	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
CHLORPHENAMINE	Anithistamine	Sedation, no evidence for prolonged use	AEC score 2
CHLORPROMAZINE	Antipsychotic	Orthostatic hypotension, sedation, slow reflexes, impaired balance	AEC score 3
CHLORTHALIDONE	Thiazide Diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion, nocturia	AEC score not available
CINNARIZINE	Antihistamine	Sedating, no evidence for long term use	AEC score not available
CITALOPRAM	Antidepressant (SSRI)	Orthostatic hypotension, may impair sleep quality	AEC score 1. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
CLOMIPRAMINE	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
CLONAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
CLONIDINE	Centrally acting AH	Orthostatic hypotension, sedating	AEC score not known.
CLOZAPINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 3
CODEINE	Opioid analgesic	Sedation, slow reaction times, impaired balance, cause delirium	AEC score not known. Variable metabolic pathways
DANTROLENE	Muscle relaxant	Sedation, reduced tone, used in conditions associated with falls	AEC score not known
DIAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score 1. Active metabolite accumulates in renal impairment. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
DIGOXIN	Cardiac glycoside	Bradycardia	AEC score not known
DIHYDROCODEINE	Opioid analgesic	Sedation, slow reactions, impaired balance, cause delirium	AEC score not known
DIPHENHYDRAMINE	Antihistamine	Sedation, no evidence for prolonged use	AEC score 2
DILTIAZEM	Calcium channel block	Hypotension, paroxysmal hypotension, bradycardia, fatigue	AEC score 0
DONEPEZIL	Acetylcholinesterase inhibitor	Symptomatic bradycardia and syncope	AEC score 0
DOSULEPIN	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
DOXAZOSIN	Alpha blocker	Severe orthostatic hypotension, sedation	AEC score 0
DOXEPIN	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision.Rate of falls doubled	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
DULOXETINE	Antidepressant (SNRI)	Orthostatic hypotension, impaired sleep quality	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
ESCITALOPRAM	Antidepressant (SSRI)	Orthostatic hypotension, may impair sleep quality	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
ENALAPRIL	ACE inhibitor	Orthostatic hypotension; renally eliminated and can accumulate in dehydration or renal failure	AEC score 0
EPROSARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
FELODIPINE	Calcium channel blocker	Hypotension and paroxysmal hypotension	AEC score 0
FENTANYL	Opioid analgesic	Sedation, slow reaction times, impaired balance, cause delirium	AEC score 1.
FLECAINIDE	Antiarrythmic	Bradycardia, other arrythmias	AEC score 0

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
FLUOXETINE	Antidepressant (SSRI)	Orthostatic hypotension, may impair sleep quality	AEC score 1. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
FLUPHENAZINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 1
FLURAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
FOSINOPRIL	ACE Inhbitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
FUROSEMIDE	Loop diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion, nocturia	AEC score 0
GABAPENTIN	Antiepileptic	Sedation	AEC score 0
GALANTAMINE	Acetylcholinesterase inhibitor and nicotinic agonist	Symptomatic bradycardia and syncope	AEC score 0
GLYCERYL TRINITRATE	Nitrate	Hypotension, paroxysmal hypotension	AEC score not known
HALOPERIDOL	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 0
HYDROXYZINE	Antihistamine	Sedation, no evidence for prolonged use	AEC score 1

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
HYOSCINE BUTYLBROMIDE	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 1
HYOSCINE HYDROBROMIDE	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 3
IMPIRAMINE	Tricyclic Antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
INDAPAMIDE	Thiazide diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion	AEC score 0
INDORAMIN	Alpha blocker	Severe orthostatic hypotension, sedation	AEC score not available
IRBESARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not available
ISOCARBOXAZID	Monoamine Oxidase inhibitor (MAOI)	Severe orthostatic hypotension	AEC score 1
ISOSORBIDE MONONITRATE	Nitrate	Hypotension, paroxysmal hypotension	AEC score 0
LACIDIPINE	Calcium channel blocker	Hypotension and paroxysmal hypotension	AEC score not known
LAMOTRIGINE	Antiepileptic	Some data on falls association	AEC score 0
LERCANIDIPINE	Calcium channel blocker	Hypotension and paroxysmal hypotension	AEC score 0
LEVETIRACETAM	Antiepileptic	Some data on falls association	AEC score not known

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
LISINOPRIL	ACE inhibitor	Orthostatic hypotension; renally eliminated and can accumulate in dehydration or renal failure	AEC score 0
LOFEPRAMINE	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision Rate of falls doubled	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
LORAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score 0. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
LORMETAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score not known. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
LOSARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score 0
METOLAZONE	Thiazide diuretic	Dehydration causes hypotension, low potassium can cause fainting and general weakness, low sodium can cause confusion	AEC score not known
METOPROLOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, hypotension, vasovagal syndrome	AEC score 0

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
MIANSERIN	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity), dizziness, blurred vision. Rate of falls doubled	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
MIRTAZAPINE	Antidepressant (SNRI)	Sedation, Orthostatic hypotension, impaired sleep quality	AEC score 1. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
MORPHINE	Opioid analgesic	Sedation, slow reactions, impaired balance, delirium risk	AEC score 0. Accumulates in renal impairment. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
MOXONIDINE	Centrally acting anihypertensive	Sedation, orthostatic hypotension	AEC score not known
NICORANDIL	Potassium channel activator	Hypotension, paroxysmal hypotension	AEC score not known
NIFEDIPINE	Calcium channel blocker	Hypotension and paroxysmal hypotension	AEC score 0
NIRTAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score not known
NORTRIPTYLINE	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity),	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
OLANZAPINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 2
OLEMSARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
ORPHENADRINE	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score not known
OXAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
OXYBUTYNIN	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 3. Consider review or switch to safer alternative.
OXYCODONE	Opioid analgesic	Sedation, slow reactions, impaired balance, delirium risk	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
PAROXETINE	Antidepressant SSRI	Orthostatic hypotension, may impair sleep quality	AEC score 2. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
PERINDOPRIL	ACE inhibitor	Orthostatic hypotension; renally eliminated and can accumulate in dehydration or renal failure	AEC score 0
PHENELZINE	Monoamine Oxidase Inhibitor (MAOI)	Severe orthostatic hypotension	AEC score 1
PHENOBARBITAL	Antiepileptic	Sedation, slow reactions. Excess blood levels cause unsteadiness and ataxia	AEC score not known

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
PHENYTOIN	Antiepileptic	May cause permanent cerebellar damage and unsteadiness in long term use. High levels cause unsteadiness and ataxia	AEC score not known
PRAZOSIN	Alpha blocker	Severe orthostatic hypotension, sedation	AEC score 0
PREGABALIN	Antiepileptic	Sedation	AEC score not known
PROCHLORPERAZINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 2
PROMAZINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 2
PROMETHAZINE	Antihistamine	Sedation, no evidence for prolonged use	AEC score 3
PROPRANOLOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, hypotension, vasovagal syndrome	AEC score 0
QUETIAPINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 2
QUINAPRIL	ACE inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
RAMIPRIL	ACE inhibitor	Orthostatic hypotension; renally eliminated and can accumulate in dehydration or renal failure	AEC score not known
RISPERIDONE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 0
RIVASTIGMINE	Acetylcholinesterase inhibitor	Symptomatic bradycardia and syncope	AEC score 0

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
SERTRALINE	Antidepressant (SSRI)	Orthostatic hypotension, may impair sleep quality	AEC score 1. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
SODIUM VALPROATE	Antiepileptic	Some data on falls association	AEC score 0
SOLIFENACIN	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 1
SOTALOL	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome	AEC score 0. May accumulate in older patients due to renal excretion
SULPIRIDE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 0
TAMSULOSIN	Alpha blocker	Severe orthostatic hypotension, sedation	AEC score 0
TELMISARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
TEMAZEPAM	Benzodiazepine	Drowsiness, slow reactions, impaired balance, tolerance with prolonged use	AEC score 1. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
TERAZOSIN	Alpha blocker	Severe orthostatic hypotension, sedation	AEC score not known
TIMOLOL EYEDROPS	Beta blocker	Bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome	AEC score not known
TOLTERODINE	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 2
TOPIRAMATE	Antiepileptic	Some data on falls association, sedation	AEC score not known

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
TRAMADOL	Opioid analgesic	Sedation, slow reactions, impaired balance, delirium risk	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
TRANDOLAPRIL	ACE inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
TRANYLCYPROMINE	Monoamine oxidase inhibitor (MAOI)	Severe orthostatic hypotension	AEC score not known
TRAZODONE	Antidepressant (TCA related)	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity)	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
TRIFLUPERAZINE	Antipsychotic	Sedation, slow reaction times, impaired balance, orthostatic hypotension	AEC score 2
TRIHEXPHENIDYL	Antimuscarinic	Sedation, dizziness, blurred vision, dry eyes	AEC score 3
TRIMEPRAZINE	Antihistamine	Sedation, no evidence for long term use	AEC score 3
TRIMIPRAMINE	Tricyclic antidepressant	Sedation (antihistamine effect), slow reaction times, impaired balance, orthostatic hypotension (alpha blocking activity)	AEC score 3. Consider review or switch to safer alternative. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
VALSARTAN	Angiotensin 2 inhibitor	Orthostatic hypotension; excreted by liver and kidney	AEC score not known
VENLAFAXINE	Antidepressant (SNRI)	Orthostatic hypotension, may impair sleep quality	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen

Name of medication	Drug class	Effect on Falls risk	Considerations and Anticholinergic score (AEC)
VERAPAMIL	Calcium channel blocker	Hypotension, paroxysmal hypotension, bradycardia, fatigue	AEC score not known
ZOLPIDEM	Hypnotic	Sedation, slow reactions, impaired balance, hangover effect next morning, tolerance with prolonged use	AEC score 0. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen
ZOPICLONE	Hypnotic	Sedation, slow reactions, impaired balance, hangover effect next morning, tolerance with prolonged use	AEC score not known. You may wish to consider gradual withdrawal if prolonged exposure – see www.medstopper.com for suggested regimen

Appendix 8

Postural Hypotension or Orthostatic hypotension (OH)

Definition

- Defined as a drop in BP (usually >20/10mmHg) within 3 mins of standing.
- Affects up to 30% of over 65's .In Parkinson's up to 60% of patients
- Common Symptoms: dizziness, light headedness, blurred vision, weakness, fainting = **HIGH RISK of falls**

Main Causes:

- Medications including anti-depressants, levodopa, phenothiazine antipsychotics
- Hypovolaemia e.g. blood/fluid loss, diuretic or vasodilation drugs (dehydration),
- Prolonged bed rest
- Conditions producing OH include cardiac arrhythmias, MI, advanced heart failure, pernicious anaemia, diabetes, Parkinson's

Post Prandial OH (after eating)

- More common than simple OH. Mainly occurs in elderly and associated with high carbohydrate-containing meals.
- Cause unclear, defined as fall in BP (20mmHg) within 2hrs of a meal can be sooner
- Common cause of fainting and falls

How to take lying and standing BP

- **Patient to lie down for 5 mins.**
- **Take BP while lying down.**
- **Stand upright and take BP after 1 minute.**
- **Take BP again after 3 mins of standing.**
- **When in standing position the patient's arm needs to be supported at the elbow to maintain it at the correct level and ensure accuracy:**

References:

NICE NG136 March 2022

NICE 2023 surveillance of hypertension in adults: diagnosis and management (NICE guideline NG136) and transient loss of consciousness ('blackouts') in over 16s (NICE guidelineCG109) Feb 2023

RCP 2023, How to measure lying and standing blood pressure (BP) as part of a falls assessment.

Appendix 9: EXAMPLE from National Audit for Inpatient Falls (NAIF)

Bedside vision check for falls prevention

Assessments 1, 2 and 3 should be attempted for all patients at risk of falls.
Assessments 4 and 5 should be attempted for all patients at risk of falls whenever possible

https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool

1. Questions to ask patient	**Actions**
When did you last have a sight test? (Should be every year) Date of last sight test:	**Document answers in the falls care plan.** *Note: If the patient does not have their glasses, ask their carer to bring them in. If this is not possible, mark on the care plan that the patient usually wears glasses but does not have them in hospital (and that their eyesight will be affected while they are in hospital).* *Poor vision or inability to read the written words may have other implications for patient care other than falls prevention.*
Do you wear glasses? Yes/No	
Are your glasses up to date? Yes /No Date of last pair:	
What do you wear your glasses for? Circle one: reading/distance/everything[bifocals/varifocals]	
Have you got your glasses with you? Yes / No	
Do you have any eye conditions? If so, are you using any prescribed treatment? (eg eyedrops for glaucoma)	*Make a note of the name of the eye condition.* *If medications are used, check these are on the drug chart, or ask doctor to prescribe*
Eye condition:	
Prescribed treatment names:	
See answer sheet in links https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool	
2. Check distance vision	
Can you see the television clearly at home? Yes/No	**Document answers in the falls care plan**
Can you read this? or Tell me what the picture is? Yes/No See answer sheet in links https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool	*Ask the patient to wear distance glasses if they have them. Do without glasses if they do not wear them for distance.* *Show patient **Image 1** from a bed length (2 metres) away – stand at the foot of the bed if they are sat up in it, or in a chair near the head of the bed.* Note if the patient can read/identify the picture
3. Check near vision	
Can you usually see to read newspaper print, shopping lists or medicine labels? Yes/No	**Document answers in the falls care plan**
Can you read this or tell me what the picture is? Yes No Cat and fish assessment_0_0_0.pdf	*Ask the patient to wear their reading glasses if they have them. Do without if they do not wear them.* *Show the patient **Image 2** .* *Ask them to hold this card in a comfortable reading position (bent arm's length away).* Note if patient can read/identify.
4. Check side vision	

➢ **Ask the patient to keep looking at your face** throughout the test. ➢ Raise your right hand to the 2 o'clock position (towards the edge of your field of vision, i.e. a good bent arm's length, and halfway between you and the patient) and wiggle your fingers. ➢ Ask the patient: '**Can you see my fingers moving?'** (they must remain looking at your face and you look at their face). ➢ If you can see your fingers moving so should they See answer sheet in links https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool	*There is no need for the patient to wear their glasses. The object of this check is to compare the patient's peripheral/side vision with yours. The patient's vision should be roughly the same as yours. Ideally you should sit face to face with the patient, knees nearly touching, but you can also do this if they are in bed, as long as they can look directly at you* ***Note:** If it's clear they cannot understand this instruction, stop and document this. If the patient is able to continue then:* ➢ *Repeat the above steps while holding your hand at the 4 o'clock position.* ➢ *Then change to using your left hand and repeat at the 8 o'clock and 10 o'clock positions.*
5. Check Eye Movements	
Ask: '**Do you ever get double vision/see two of things?'** ➢ Look at the patient. Are their eyes not pointing straight or do their eyes jiggle about and not keep still? ➢ While still sitting, hold your pen in front of you midway between you and them. Ask the patient to: '**Watch my pen moving around'** then move it up and down and left and right smoothly and steadily. See answer sheet in links https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool	*There is no need for the patient to wear their glasses. The object of this check is to see if the patient has double vision or difficulty looking to the side. Again, ideally you should sit face to face with the patient, knees nearly touching, but you can do this if they are in bed as long as they can look directly at you.* *Note If their eyes are moving together and following your pen all the way across and up and down.* *Note if the patient complains of double vision at any point*

Signature: **Print name:** **Designation:**

The results of this check will give an indication only of any visual problems, known or unknown, that the patient may have. This should not replace a definitive expert assessment if indicated.

Any concerns about patient vision should be discussed with the medical team for formal evaluation.

Appendix 10

Safe Bed Management

When a patient is at risk of falling or rolling out of bed then clinical reasoning, based on the patients mental and physical status, must be applied to identify interventions to manage the risk. **Refer to Safe Bed management Policy**

Patient is confused +/or disorientated Doesn't understand risk	Bedrail* or low bed indicated	Appropriate monitored bed at normal height with increased observation	Appropriate monitored bed at normal height with increased observation
Patient is drowsy but not confused	Bedrail* or low bed indicated in discussion with patient	Appropriate monitored bed at normal height with increased observation	Appropriate monitored bed at normal height with increased observation
Patient is alert + orientated + understands risk	Bedrail* or low bed indicated in discussion with patient	Bedrail* or low bed indicated in discussion with patient	Bedrail* or low bed indicated in discussion with patient
Patient is unconscious	Bedrail* or low bed indicated	Bedrail* or low bed indicated	Bedrail* or low bed indicated
*¾ length bedrails only NOT split bed rails	Patient is very Immobile e.g. bedbound / unable to sit up in bed	Patient is neither independent nor immobile	Patient can mobilise without help from staff

Bed Rails Risks

Bed rails are NOT to be used to restrain the movements of patients and are associated with risks of entrapment and patients climbing over and falling (MHRA Safe use of bed rails V4 Jan 2021) Bed rails are not used on DMH wards due to ligature risks.

Low bed risks

The use of low beds also holds risks for mobile patients trying to get up from low levels and the crash mat or mattress used in conjunction with the low bed can present a trip risk or balance issues for unsteady patients (NPSA The safe use of ultra-low beds Feb 2011)

Levels of Supervision

CHS reference "Checklist for Enhanced Observations" (appendix 11)

- 1:1 supervision
- Cohort supervision

DMH reference "Supportive Observation and Engagement of Inpatients Policy" this can be found on the Trust website.

Appendix 11

CHS Community Hospitals
Checklist for Enhanced Observation

Leicestershire Partnership NHS Trust

Patient No: Surname: Forename: DOB: Gender: M/F	Hospital Site: Ward:

1.This tool should be used to support decision making for patients that are a falls risk, displaying self-harming behaviours, wandering and may need increased workforce to facilitate enhanced care.
2.This checklist should have an MDT review every 24 hours.

Checklist of Factors to be considered.	**Yes**	**No**	**Brief details of identified Factor**
Is the patient currently detained in hospital under the Mental Health Act (MHA) or the Deprivation of Liberty Safeguards (DoLs)?			
If the patient is attempting to leave the area – are there reasonable doubts (i.e., impaired memory/cognition) about their mental capacity to make an informed decision about leaving?			
Is there a history of the patient absconding? (Either recent or previous to admission)			
Is the patient currently at risk from others? e.g., exploitation, abuse/neglect?			
Is the patient currently a risk to self? (e.g., suicide, self-harm, fire hazard)			
Is the patient currently a risk to staff/patients/others? (e.g., verbal aggression/physical violence)			
Is the patient currently under the influence of alcohol/illicit substances or are they suspected/known to have a history of alcohol/substance abuse?			
Are there any possible physical causes of agitated/challenging behaviour(s)? (e.g., delirium, brain injury, sepsis, CVA, medication, dementia)			
Does the patient have a Learning Disability?			

Has the patient targeted their challenging behaviours towards a specific group of people? (e.g., based on sex/gender/race)			
Does the patient have a history of falls/ increased risk of falls/ demonstrating behaviour that increases risk of falls.			
Can the patient use a call bell?			
What is the bed location of the patient – would a move support enhanced care?			Location:
Have you considered alternative resources to support the patient e.g., family, friends, MAC?			
Based on the checklist does the patient require enhanced care			
Assessing Nurse's name:	Date: Time:		Signature.

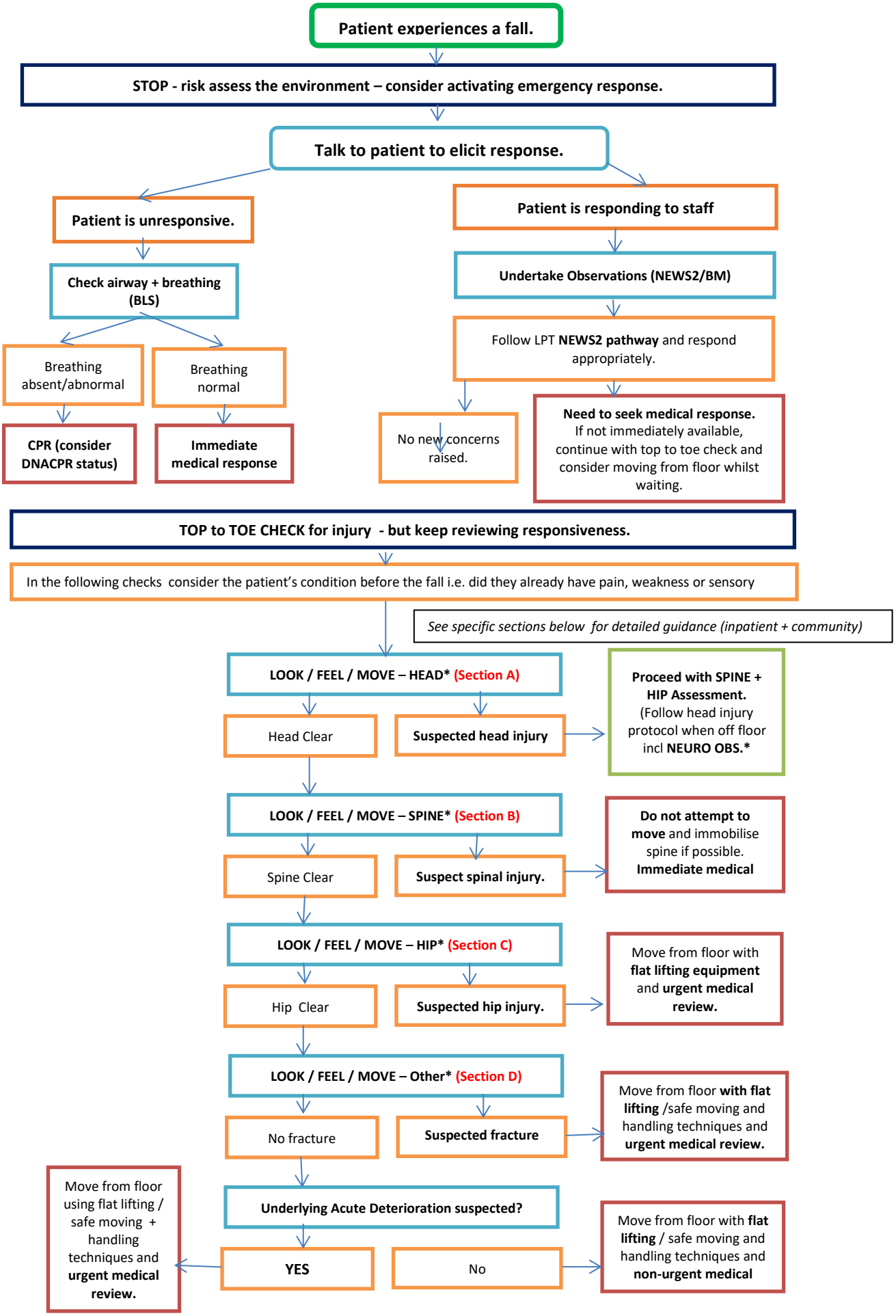
If the decision is made that extra staff above the ward establishment is required to support a patient (e.g., 1.1 support), it must be discussed with Matron/ Operational Lead/ On Call Manager first. Then, please ensure that the extra shift is created on Healthroster, put out to bank/agency and consider opening up to mental health. If enhanced care requires staff in addition to planned staffing, then a Dynamic Risk Assessment (DRA) will need to be completed.

<u>If patient is to receive Enhanced care:</u>
Preferred Name:
What level of enhanced care does the patient require: 1;1 or cohort (delete as appropriate)
Level of interaction with patient: I.e., none, conversation only, puzzle/games, support to leave ward for short periods, and mobility issues i.e., NWB?
Proximity to Patient: i.e., inside/outside room/bay, next to patient, within watching distance.
Any known triggers which exacerbate Patient's behaviours: i.e., noise, medical investigations, time of day, specific individuals, uniforms, medications
Specific Risks to Staff Member (as identified from checklist overleaf)
Yellow lanyard Provided:
Assessing Nurse's name: Date/ Time of Initial Assessment:

Name of Matron/ Ops Lead/ On Call Manager Approving:

MDT Reviews of Checklist – every 24 hours:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:
Date/ Time completed: Assessing Nurse's name: Based on a review of the factors identified above, are there any changes to the checklist and recommendations for enhanced care? YES/NO If YES please detail below:

APPENDIX 12: POST FALLS FLOW CHART including TOP TO TOE CHECK



SECTION A

Look – Feel – Move - HEAD

LOOK

- Did the patient hit their head when they fell?*
- Do they have obvious facial or head injuries (bruises or lacerations), or was the fall unwitnessed?
- Does the patient have new asymmetry of pupils?
- Is the patient on anticoagulant or anti-platelet medication, do they have a blood clotting disorder, or have they had recent brain surgery?
- Has the patient had any new reduction in level of alertness, loss of consciousness or seizures since the fall?

FEEL

- Is the patient complaining of new headache, memory loss, dizziness, double vision or vomiting after the fall?
- If the patient is confused or unable to give accurate answers, look for non-verbal signs of pain.

Response if head injury is suspected

Continue with the post-fall assessment flow chart, paying particular attention to assessing the neck before moving.

When the patient is off the floor, conduct:

- regular neurological observations in line with NICE head injury guidelines (Appendix 13)
- urgent medical review within 30 minutes.

If in a community setting without medical cover:

- call for an emergency ambulance on 999 and report a suspected head injury.
- while waiting for support, continue with regular ABC, NEWS2 observations, neurological observations, reassure the patient and keep them warm.

SECTION B

Look – Feel – Move - SPINE

Look

- Was the fall from higher than standing height (i.e. down the stairs or over the rails of a raised bed)?
- Is there obvious new neck or spinal deformity?
- Have you already identified external evidence of head or facial injuries?
- Does the patient have a history of spinal fracture, or do they have osteoporosis or another condition that affects bone composition (such as cancer with metastases)?

Feel

- Is the patient complaining of **new pain in the neck or spine**?
- Is the patient complaining of **new weakness or sensory changes (eg pins and needles or loss of sensation) in the arms or legs?**
- If the patient is confused or unable to give accurate answers, look for non-verbal signs of pain/weakness.
- If you suspect a spinal injury after 'looking and feeling', do not continue to the 'move' section – proceed to spinal immobilisation / call 999.
- If you do not suspect a spinal injury after completing the 'look' and 'feel' assessment, proceed to 'move and then assess the hip'.

Move

- Can the patient rotate their neck 45 degrees to the right and left?
- Is the patient able to move both arms and legs?

Always consider the patient's condition prior to the fall (i.e. – did they already have pain, weakness or sensory loss)

Response if spinal injury is suspected

- Aim to keep the patient **as still as possible**.
- Organise an immediate medical review prior to the use of any equipment.
- **If suspected spinal fracture (i.e. Is the patient complaining new pain in the neck or spine / new weakness or sensory changes / pins and needles / loss of sensation in the arms or legs?) maintain in an aligned position and wait for emergency services**.
- Following review if no signs/symptoms of spinal fracture transfer patient on to bed using flat lifting equipment using techniques to keep patient aligned and **not rolling** patient

In a community setting

- call for an emergency ambulance on 999 and report a suspected spinal injury.
- while waiting for support, continue with regular ABC, NEWS2 observations, reassure the patient and keep them warm. Do not use a sling hoist to transfer the patient

SECTION C

Look – Feel – Move - HIP

Look

- Is either leg shortened or rotated?
- Is there any new deformity (is the leg misshapen)?

Feel

- Is the patient complaining of new pain in the hip?

Move

- Can the patient raise each leg, keeping the knee straight and lifting the heel from the ground without significant pain (one at a time)?
- Always consider the patient's condition prior to the fall (i.e. – did they already have pain, shortening, deformity or weakness).
- If the patient is confused or unable to give accurate answers, look for non-verbal signs of pain.

Response if hip fracture is suspected

In an hospital setting

transfer the patient to the bed **using flat lifting equipment. Ensure techniques keep patient aligned and not rolling patient.**

- **do not** use a sling hoist
- conduct urgent medical assessment (within 30 minutes of the fall).
- give analgesia within 30 minutes of the fall.

In a Community setting (without access to flat lifting equipment or medical cover):

- call for an emergency ambulance on 999 and report a suspected hip fracture.
- consider keeping the patient comfortable on the floor if ambulance transfer likely to be rapid to avoid unnecessary transfers.
- consider giving analgesia if ambulance support is likely to take longer than 30 minutes.
- if a prolonged wait for ambulance support is anticipated, consider the risks of moving the patient (increased pain) against the risks of a prolonged period on the floor (pressure ulceration, hypothermia, rhabdomyolysis) and if indicated, arrange to use an alternative safe moving and handling technique to move the patient into bed. In such an event, it may be necessary to use a sling hoist or other lifting device

SECTION D

Look – Feel – Move – Other injuries

Look

- Did the patient fall onto an outstretched arm?
- Is there any obvious new deformity/ asymmetry/laceration/significant bruising in the chest, arms or legs?

Feel

- Is the patient complaining of new pain in the ribs/chest when moving/coughing/ taking a breath in?
- Is the patient complaining of new pain anywhere?

Move

- Ask the patient to lift and move both arms and legs (one at a time).
- Ask the patient to take a deep breath. If the patient is confused or unable to give accurate answers, look for non-verbal signs of pain.

If other fracture suspected

In an Hospital setting (or setting where flat lifting equipment and medical cover is available):

- consider using flat lifting equipment if a humeral, rib or pelvic fracture is suspected.
- for other fractures the patient can be moved from the floor using the most appropriate method (accounting for other injuries and their ability to get up independently)
- conduct urgent medical assessment (within 30 minutes of the fall)
- give analgesia within 30 minutes.
- if humeral fracture suspected, arrange for chest X-ray, in addition to humeral X-rays, to check for rib fractures.

In a Community setting (without access to flat lifting equipment or medical cover):

- call for an emergency ambulance on 999
- consider keeping the patient comfortable on the floor if ambulance transfer is likely to be rapid to avoid unnecessary transfers
- consider giving analgesia if ambulance support is likely to take longer than 30 minutes.
- if a prolonged wait for ambulance support is anticipated, consider the risks of moving the patient (increased pain) against the risks of a prolonged period on the floor (pressure ulceration, hypothermia, rhabdomyolysis) and if indicated, arrange to use an alternative safe moving and handling technique to move the patient into bed

Appendix 13

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) 2018 and UHL Neuro Obs in Adults: Indications and required frequency October 2023 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 2023).

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 (2023), 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 2023)

b) Loss of consciousness
c) Focal deficit
d) Suspected skull fracture
e) Amnesia of events before or after
f) Persistent headache / 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 2023)

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 13a)

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 2021)*. 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 2021)*

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.

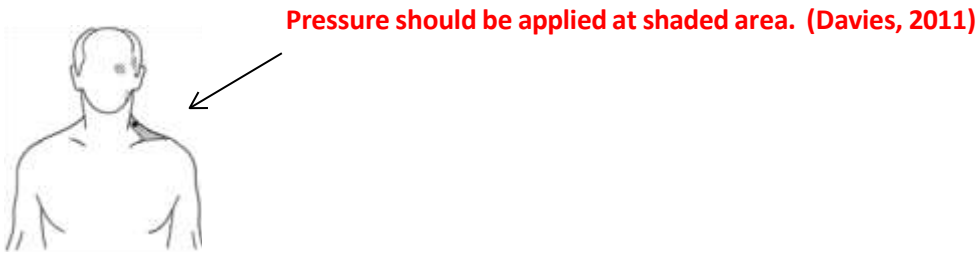
3 = Flexion to pain – patient bends the arms and there is internal rotation i.e. the knuckles of each hand rotate to face inwards.

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.

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



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.

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

b) 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.

c) 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.

d) Repeat this with the right eye.

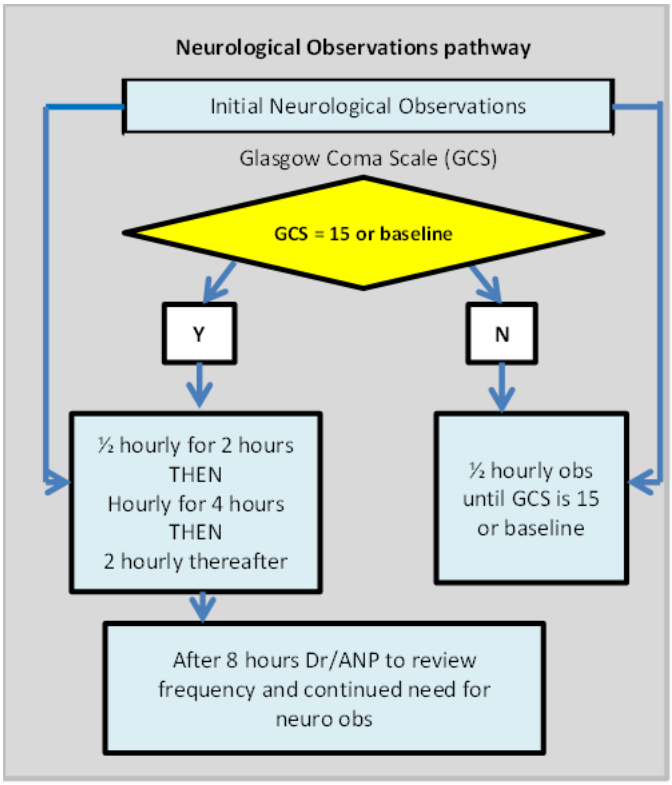
e) A pupil size guide should be available on the GCS observation chart

f) 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

- 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

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 (2023) Prevention and Management of Slips, Trips & Falls Policy, Leicestershire Partnership NHS Trust

NICE (2023) Head injury: assessment and early management (NG 232) https://www.nice.org.uk/guidance/ng232/resources/head-injury-assessment-and-early-management-pdf-66143892774085 online Accessed October 2023

Resuscitation Council (UK) The ABCDE Approach 2021 https://www.resus.org.uk/library/2021-resuscitation-guidelines

UHL Guideline for the Escalation of Deteriorating Glasgow Coma Scale (GCS) 2018

UHL Neuro Obs in Adults: Indications and required frequency October 2023 http://www.library.leicestershospitals.nhs.uk/PAGL/Shared%20Documents/Neurological%20Observations%20in%20Adults%20UHL%20Emergency%20Department%20Guideline.pdf

Appendix 13a

Leicestershire Partnership NHS
NHS Trust

Full Name

Patient ID Label

Date of Birth

NHS Number

Neurological Observation Chart Adult

Glasgow Coma Scale

			Date																
			Time (24hr) Clock																
Best **Eye** Response Record 'C' if no response possible due to bilateral periorbital swelling	Eyes Open spontaneously	4																	
	Eye opening to verbal stimuli	3																	
	Eye opening to pain	2																	
	No eye opening	1																	
Best **Verbal** Response Record 'D' if dysphasic	Orientated	5																	
	Confused	4																	
	Inappropriate words	3																	
	Incomprehensible sounds	2																	
	No verbal response	1																	
Best **Motor** Response See reverse for guidance on how to determine best motor response	Obeys commands	6																	
	Localising pain	5																	
	Withdrawal from pain	4																	
	Abnormal flexion to pain	3																	
	Abnormal extension to pain	2																	
	No motor response	1																	
Total score • 15 = fully conscious • <9 = comatose • 3 = unresponsive																			

If first recorded GCS is less than 15 and if the cause is unknown ask a Doctor / ANP to determine a cause and if old or new. (e.g. a lower GCS baseline due to a person's Learning Disabilities, an acute psychotic episode, both old and new strokes may result in a reduced GCS if patient is dysphasic). **Any further drop in total score by 2 points or more (or at least 1 point in motor score) after initial assessment should usually prompt urgent medical review**.

Limb Movements

Arms Record findings for RIGHT ('R) and LEFT ('L') separately if different	Normal power																		
	Mild weakness																		
	Severe weakness																		
	Spastic flexion																		
	Extension																		
	None																		
Legs Record findings for RIGHT ('R) and LEFT ('L') separately if different	Normal power																		
	Mild weakness																		
	Severe weakness																		
	Extension																		
	None																		

Pupils

Right eye **Left eye** Record Reaction to light as '+' if normal 'S' if sluggish '-' if none 'C' if eye closed by swelling	Size (mm)																		
	Reaction																		
	Reaction																		
	Size (mm)																		

Nausea / Vomiting experienced	**Y / N**																		
Persistent headache present	**Y / N**																		
	Initials																		
	Designation																		

Neurological Observations – How Long and How Often?

Appropriateness, frequency and duration of neurological observations must be specified by medical staff/nurse in charge.

These will depend on the nature and expected time course of the patient's illness or injury as well as on other factors such as end of life care decisions.

For example, acutely intoxicated patients will require a shorter period of observation than those at risk of raised intracranial pressure from brain malignancies.

For acute head injuries (e.g. after an inpatient fall the following minimum 8 hour schedule is advised.

- ½ hourly until GCS 15
- ½ hourly for the next 2 hours
- 1 hourly for the next 4 hours
- 2 hourly thereafter (i.e. Usually just once more)

N.B. Revert to ½ hourly should GCS fall below 15

Determining Best Motor Response

STEP 1

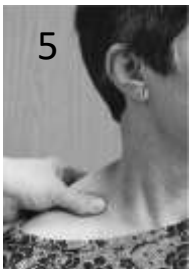
Ask the patient to "obey" a command that requires a specific response, such as "please wriggle the fingers of your left hand"

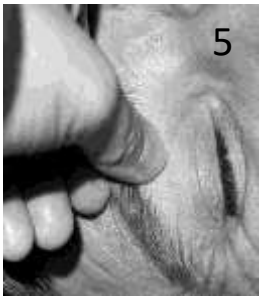
N.B. Do not ask the patient just to squeeze your hand as this may be a mere reflex action.

If an appropriate response is seen the patient's motor score is 6. If not move onto step 2.

STEP 2

Squeeze the patients trapezius muscle hard or press on the superior margin of an orbit (if there is no clear facial injury). Patients able to localise pain will respond by moving a hand above the level of the clavicle.



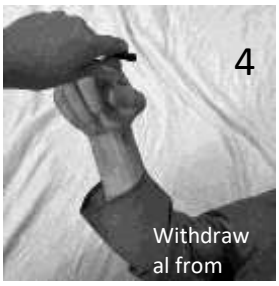


N.B. Intoxicated patients will often require sustained stimuli to elicit a response.
If an appropriate response is seen the patient's motor score is 5. If not move onto step 3.

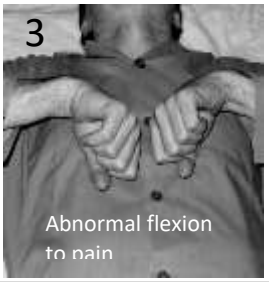
STEP 3

Apply firm pressure to a fingernail bed (e.g. by using a pen as shown on the right) and look for the responses simulated below

N.B. rubbing the sternum is not a good way to determine best motor response as it does not distinguish between "localising pain" and "abnormal flexion".



Withdrawal from pain by flexion at the elbow and external rotation at the shoulder joint.



Abnormal flexion to pain at elbow and wrist with internal rotation at the shoulder (usually both arms) and concomitant extension of the legs. Known as "decorticant response"

Abnormal extension to pain of (usually both) arms and legs. Known as "decerebrate response"

If no response is seen the patient's motor score is 1.

STANDARD OPERATING PROCEDURE FLAT LIFTING EQUIPMENT Revised January 2023	
	
PURPOSE OF EQUIPMENT	*A two-piece air assisted device designed to lift a patient from the floor in a supine position and transfer laterally on to a bed /trolley*
BENEFITS	*The equipment* • *will potentially reduces the need for a fallen injured patients to remain on the floor, whilst awaiting transport to an external medical assessment site.* • *enables the patient to remain in a supine position, preventing any further pain or injury* • *can also be used for assisting an individual out of a confine space or undertaking a lateral transfer* • *can reduce the risk of a staff injury due to less physical effort and strain*
SPECIAL INSTRUCTIONS & Evidence	If the patient has fallen, prior to the use of this equipment, the Leicestershire Partnership NHS Trust Inpatient falls flowchart (appendix 1) must be adhered too. This will identify the suitability of using the equipment. To be used instead of hoisting from the floor, whenever possible, in order to avoid pain and/or further injury to the patient The Nice Quality standard QS86 Falls in Older People: March 2015, updated January 2017 indicate when a patient falls, it is important that safe methods, such as flat lifting are used to move them, in order to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery The national Audit of Inpatient Falls 2022, recommend Trusts should have access to flat lifting equipment.
WHATS INCLUDED	A yellow push able trolley for storage of the equipment and transportation to the area for use. A flojac (inflatable air assisted device consisting of 4 height layers) An air supply pump A battery power pack Reusable flow mat Patient specific flow mat- for infection control issues, where transfer to another hospital site is required and if wider/narrower flow mats are required
USER INSTRUCTIONS	*User instructions are available within the yellow trolley.* *A pictorial step by step guide can be accessed at the side of the trolley* Online user videos can be found at Banana Flojac (gbukgroup.com) *QR codes are also included on the side of the yellow trolley* *Practical training prompts are available as part of training* *Bite sized instruction videos are also available on Ulearn* *https://lptulearn.co.uk/totara/dashboard/index.php*

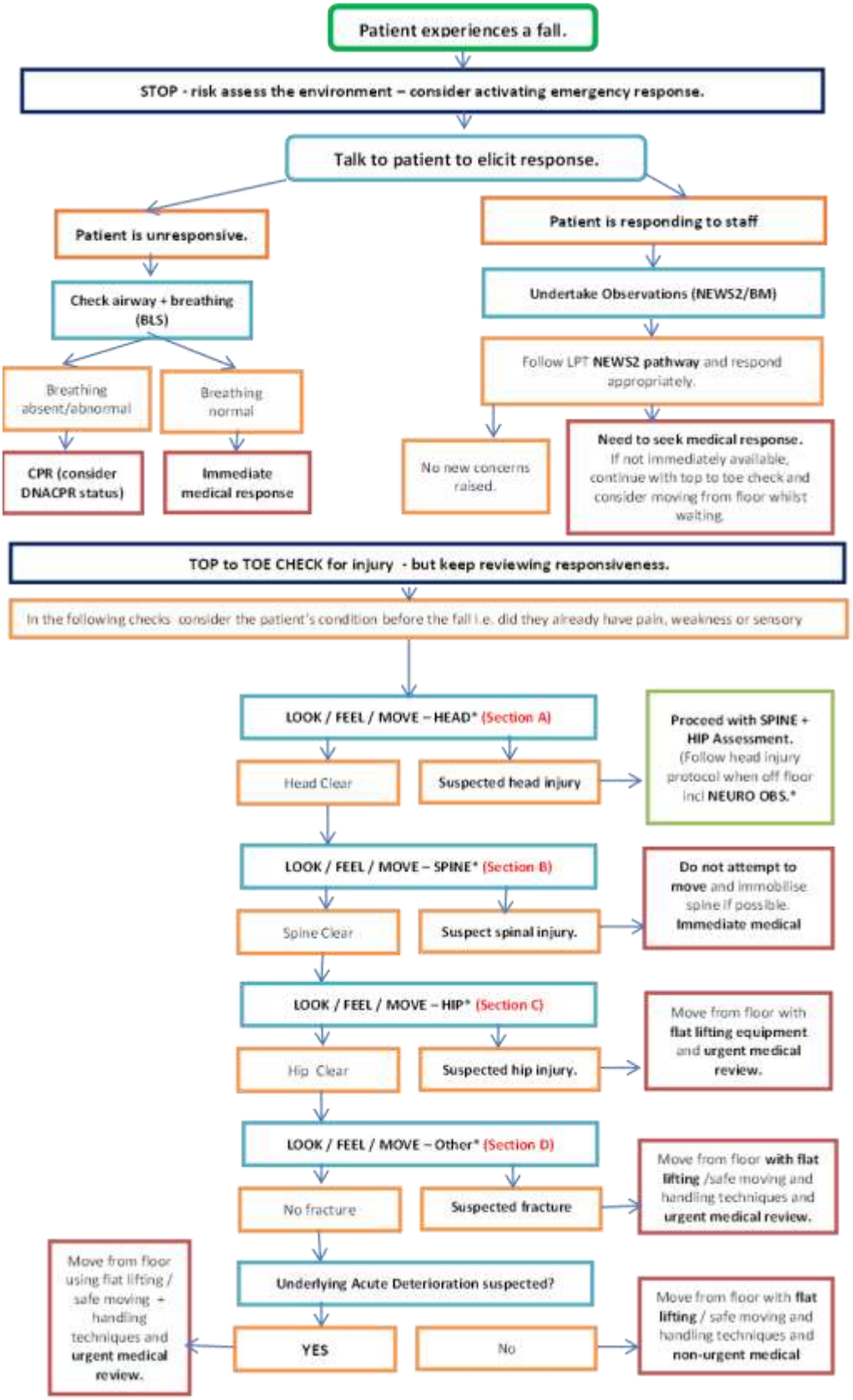
SAFE WORKING LOAD (SWL)	*SWL is 450 kg for the flow mat and 500kg for the flojac*
TRAINING	• The equipment is to be used by any healthcare staff who are required to undertake Moving and Handling Level 2 training. • Staff are required to undertake initial equipment training prior to using the equipment (appendix 2) • Equipment training to be delivered by Moving & Handling Advisor/Banana UK representative/ Manual Handling Keyworker or nominated representative. Each individual will undertake the trainer competency checklist prior to delivering training (appendix 3) • Update training is not required; however it is the responsibility of any individual to request an update if they have any concerns using the equipment safely. • The equipment will be included as a scenario in Moving and handling Level 2 update, this will not replace the initial equipment training required. • Ward drills are recommended to keep to kept staff knowledge refreshed • Records of staff training to be kept locally by each ward • In any event where it required for the flat lifting equipment to be used and there are not 3 persons who have undertaken the training identified in appendix 2. A dynamic risk assessment may be undertaken by the person/persons who have received the training, in order to decide whether they feel confident supervising and directing any staff members who have not received the training. This event may include supervising agency or bank staff.
LOLER REQUIREMENT	Not required
ASSET/ SERVICE REQUIREMENT	YES – requires an in date service sticker and LPT asset number which will be placed on the battery pack and also the air pump
GENERAL MAINTANANCE	Flat lifting general maintenance checks to be undertaken on a monthly basis by ward staff (appendix 4)
FAULT REPORTING	Telephone the Medical Devices Team 07827807819/07880081494
CLEANING INSTRUCTIONS	Refer to Cleaning & Decontamination of Equipment, Medical Devices and the Environment Policy. To be wiped down between use with clinell wipes or Chlorclean (if blood or bodily fluids present) The patient specific flow mat can also be used as an additional infection control measure, and then disposed off in clinical waste. As the equipment will be shared amongst some ward areas: in the case of infection outbreaks, the equipment should be considered for use, assessing the risk of <u>not</u> using the equipment. In cases where it is used, stringent cleaning should be adhered to in line with the infection control risk assessment
AUDIT REQUIREMENTS	The flat lifting equipment maintenance checks (appendix 4) will be undertaken on a monthly basis. Assurance that checks are being undertaken will be provided to the Moving and Handling Steering Group. Monitoring of the appropriate use of the equipment, and training compliance will be undertaken by the Trust Falls Steering Group
STORAGE REQUIREMENTS	Equipment to be stored on accompanying trolley for easy transportation and to reduce manual handling requirement. Each dual site to identify where trolley is located

DATE PRODUCED	January 2022/ Revised January 2023
GOVERNANCE REVIEW DATE	Annually by the Moving & Handling Steering Group & Falls Group
CONTACT DETAILS	***Medical Devices Team*** *(07827807819/07880081494) for servicing &maintenance enquiries* ***Moving and Handling Advisor (****07767006343) any general enquiries*

Appendix 14a

Leicestershire Partnership NHS Trust

Leicestershire partnership NHS Trust Managing Falls in Inpatient Settings Flowchart (taken from LPT Falls Policy)



Appendix 14b

Leicestershire Partnership NHS Trust

EQUIPMENT TRAINING CHECKLIST

EQUIPMENT	Flat Lifting Equipment	
Prior to undertaking the training, the trainer will establish with the individual that they have no underlying conditions or concerns that may affect their ability to undertake the training		
Activity	**Received demonstration (✓)**	**Practiced and Demonstrates safe use of equipment (✓)**
Purpose of the equipment & reference to inpatient falls flowchart	Discussion **(✓)**	
Mobilising the trolley to the patient & preparing the environment	Discussion **(✓)**	
Preparing the flow mat and flojac ready for use & battery check/ safe working load check		
Inserting a flow mat by rolling the patient		
Inserting a flow mat under patient by panelling (feet first)		
Attaching the safety straps on the flow mat		
Connecting the air pump to the flow mat & switching on/off		
Acquiring user positions (minimum of 3) for transfer onto flow mat onto flojac		
Attaching the safety straps for the flowjac		
Inflating each flojac chamber ensuring airflow clip is turned anti clockwise		
Preparing the environment for flojac transfer to bed		
User positions (minimum of 3) & for transfer onto bed using flo mat		
Removing flow mat from patient		
Inflating back rest to flojac (not required for lateral transfer)		
Transporting patient from a confined space and through doorway using a flow mat		
Cleaning equipment		
Deflating flojac and returning to trolley		
Discuss reasons for using patient specific flow mat	Discussion **(✓)**	
Recording the use of the equipment on incident reporting database	Discussion **(✓)**	
Manufacturer's instructions are accessible	Discussion **(✓)**	
STAFF MEMBER/TRAINER DETAILS		
Name of person receiving training (Capitals)		
Assignment number		
Job title		
Area of work		
Date		
I certify that I have received the equipment demonstration & can use the equipment safely. I have no concerns/conditions which may affect my ability to undertake the training	(Staff signature)	
I certify the member of staff has received the training and demonstrates safe use of the equipment	(Trainer name & signature)	
Comments (if required)		

Appendix 14c

Leicestershire Partnership NHS Trust

TRAINER COMPETANCY CHECKLIST

This piece of equipment is a bespoke piece of equipment for some areas. Therefore, training on the use of this piece of equipment will be required to be undertaken within the local area.
In order to train other persons on the use of the equipment the following criteria stated below needs to be met.

Criteria	**Demonstrated by nominated trainer**	**Observed by M&H Advisor**
Individual has received a demonstration of the equipment		
Individual has access to the Standard operating procedure and user manual prompts video refreshers		
Individual can demonstrate the equipment to another person covering the equipment checklist, and can demonstrate responding to queries		
Individual aware of record keeping process		
Comments		

STAFF MEMBER/TRAINER DETAILS	
Name of person receiving training (capitals)	
Assignment number	
Job title	
Area of work	
Date	
I certify that I have undertaken the trainer checklist criteria I have no concerns/conditions which may affect my ability to undertake the training	(Staff signature)
I certify the member of staff has received the training and demonstrates safe use of the equipment	(Trainer name in capital & signature)
Comments (if required)	

Appendix 14d

Leicestershire Partnership NHS Trust

FLAT LIFTING EQUIPMENT MAINTANANCE CHECKS

To ensure the equipment is well maintained and the battery does not lose charge if not used it is commended that the following checks are undertaken on a monthly basis: 1.**Checking battery charge** (if all bars on are not green put on charge until 100%, ensuring battery is switched off when you commence charging) 2. **The contents of the trolley are visibly clean/ dust free. 3. The flow mat/flojac and pump are in good working order with no signs of deterioration (inflate each item as part of checking procedure) 4. There are patient specific reusable flomats available 5. Check that the equipment's annual service date has not expired. 6. The user guide and Standard Operating Procedure is accessible.**
Report any issues to the Medical Devices Team 07827807819/07880081494

DATE OF INSPECTION	INSPECTED BY	ANY ISSUES TO REPORT Y/N	COMMENTS

APPENDIX 15: **EXAMPLE OF POST FALLS HUDDLE – PROMPT QUESTIONS**

Name of Patient:	**Date, Time and Place of Fall:**
Huddle team:	**Site:**
	• Admitted in the last 3 days? Y ☐ N ☐ • Is this a repeat fall? Y ☐ N ☐ • Less than 3 days before discharge? Y ☐ N ☐

SITUATION

- What was the patient doing at the time of the fall?
- What happened this time that was different from other times of doing the same activity?
- What were staff caring for the patient doing when the patient fell?
- What factors contributed to the fall?
- What did the patient think was the cause of their fall?

BACKGROUND

- Has the patient been safe in the past? – E.g. previous falls, common triggers, themes?
- Did the Falls Risk assessment identify falls risks? Yes ☐ No ☐
  If yes what were those risks?

‘

- Have the patients fall risk factors changed for any reason in the last 24 hours?
- What interventions were in place to manage that risk? Do they need to change?
- Does the patient have capacity? Yes ☐ No ☐ Has an MCA been completed? Yes ☐ No ☐

ASSESSMENT

- As a team what do you think led to the fall in this instance?
- Were appropriate interventions in place to mitigate those risks?
  - If in bed were Bed Rails up or down?
  - Was the bed lowered and crash mats in place?
  - What level of observation did the patient have?
- Has the post falls process been followed? Yes ☐ No ☐

RECOMMENDATION

- What needs to happen to prevent the same outcome happening again?
- What are your Falls Care plan recommendations? – including Board Round MDT huddle follow up
- Do you consider care safe today? Yes ☐ No ☐

APPENDIX 16: **EXAMPLE OF POST FALLS CHECKLIST**

Patient's Name:		**NHS No**	**Incident No**
Date of Fall:	**Time of Fall:**	**Staff name completing checklist**	

INITIAL ASSESSMENT		
Immediate environment made safe for patient and staff?	Yes ☐	No ☐

Patient unresponsive ☐	Patient able to respond ☐
BLS/ALS required? ☐	Did they lose consciousness? Yes ☐ No ☐ Unsure ☐
	NEWS assessment: Yes ☐ No ☐
CPR undertaken? ☐	
Immediate Medical Review ☐	Immediate Medical Review Yes ☐ No ☐
999 called? ☐	

POST FALL NEWS Score

LOOK, FEEL, MOVE CHECK (see flowchart

Suspected	**Yes**	**No**	**Confirmed by Medical review Y/N**	
Head injury	*			*If Yes Neuro Obs completed? yes ☐ no ☐
Spine injury	*			*If Yes Spine immobilised ? yes ☐ no ☐
Hip fracture				
Other Fracture				
Underlying acute deterioration				

TRANSFER FROM FLOOR	
Method	Flat Lift ☐
	Hoist ☐
	Raiser Chair ☐
	Assisted by staff (no equip) ☐
	Independently ☐
	Ambulance Crew ☐ Time
Review by ACP ☐ / Medic☐ / DHU ☐	Time of review

POST FALL PROCESS	
Next of Kin informed?	Yes ☐ No ☐
Huddle undertaken?	Yes ☐ No ☐
eRIF completed?	Yes ☐ No ☐
Falls Risk Assessment updated?	Yes ☐ No ☐
Falls Care Plan updated?	Yes ☐ No ☐
MDT updated? *HOW + WHO*?	Yes ☐ No ☐
ISMR required?	Yes ☐ No ☐
Initial assessment of level of harm	No Harm ☐ Low Harm ☐ Moderate Harm ☐ Severe Harm ☐ Catastrophic Harm ☐

Appendix 17:

Your One Minute Brief on …

Patient fall injuries, reportable under RIDDOR or not?

NHS Leicestershire Partnership NHS Trust

Working together……. Healthy Secure Safe

Introduction

The Trust has a legal duty to report injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 - **RIDDOR .** This includes injuries to others, i.e. Patients, visitors and members of the public that **'arise out of or in connection with work'.** This may include patient falls, the following information will help you decide if the patient fall incident is RIDDOR reportable.

Was the fall due to any of the following?

- Lack of preventive measures? i.e. no falls risk assessment undertaken/patient had a previous history of falls and not assessed or document updated.
- A defect/hazard in the environment? i.e. poor lighting, damaged floor covering.
- Could staff have prevented this fall? i.e. Staff did not follow the falls risk assessment controls - crash mats required and not provided, increased observation levels not undertaken, high low bed not lowered.

NO → Not RIDDOR reportable, regardless of injury – complete **eRIF** and follow local fall's procedures.

YES →

What is the outcome of the patient's fall?

- Death
- Specified Injury
- A Suspected Specified Injury (the patient is referred for further tests)

Definition of **Specified Injuries** most likely to be the outcome of a fall;

- **Fractures**, except for fingers, thumbs or toes
- Any loss of consciousness caused by a head

YES ↓

1. The incident is RIDDOR Reportable and needs to be identified when submitting the **eRIF** online form.
2. Contact the Health and Safety Compliance Team without delay- **0116 295 1662** who will support you and submit the RIDDOR notification to the HSE on your behalf.

The Trust has a legal duty to report incidents to the HSE within a **10 day timeframe**.

Further guidance on RIDDOR in the Healthcare Sector can be found here;
http://www.hse.gov.uk/pubns/hsis1.pdf

If you have any further questions please contact the Health & Safety Compliance Team at:
lpt.healthandsafety@nhs.net