Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE CLINICAL POLICY DOCUMENT

Policy for the Management and Reduction of Slips, Trips & Falls

Policy Number:	**SA30**
Scope of this Document:	**This procedure applies to all staff; including permanent, seconded and temporary staff and those undergoing training and work experience.**
Recommending Committee:	**Trust Falls Group**
Approving Committee:	**Executive Committee**
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Lead Executive Director:	**Executive Director of Nursing**
Lead Author(s):	**Senior Physiotherapist**

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2016-version 5

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS
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Policy for the Management and Reduction of Slips, Trips & Falls

Further information about this document:

Document name	**Policy for the Management and Reduction of Slips, Trips & Falls SA30**
Document summary	**The purpose of this corporate document is to provide information regarding the management and reduction of Slips, Trips & Falls within the Trust.**
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To be read in conjunction with	**•SA02 & SA02A Risk management strategy and risk management policy** **•SA03 Reporting, management and review of adverse incidents** **•SA07 Health, safety and welfare** **•SA10 Clinical risk assessment tools** **•SA11 Manual Handling** **•SA26 Use of bed rails** **•SD29 Physical health care of service users(Local division)** **•HR21 Recruitment and selection** **•HR28 Induction and Mandatory Training including Training Needs Analysis**
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

Version History:		
Version 1	Written by Trust Physiotherapy Lead	October 2010
Version 2	Senior Physiotherapist made changes including alterations to assessment and management.	January 2012
Version 3	Changes included addition of driver documents and inclusion of updated NICE falls guidance (2013).	December 2013
Version 4	Changes included alterations to accountabilities and responsibilities, changes to head injury information and post fall protocol.	August 2014
Version 5	Senior Physiotherapist reviewed policy and included Mersey Care Whalley.	August 2016

SUPPORTING STATEMENTS

This document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1. Purpose and Rationale

1.1 Significant consequences occur as a result of slips, trips and falls every year. Therefore, the aim of this procedure is to ensure efficient and effective management of slips, trips and falls by ensuring appropriate clinical management and to provide clear concise guidance on the management and reduction of falls in order to ensure consistent practice and a reduction in falls. This policy will explain about falls risk factors, what can be done to reduce falls risk and what should be done after a fall.

1.2 This procedure applies to all Directors, Non Executive Directors, medics, including junior doctors, managers and staff; including permanent, seconded and temporary staff and those undergoing training and work experience.

1.3 People fall for many different reasons including physical, mental and environmental reasons. Effective falls management requires multi-professional involvement including medics, nurses, therapists, pharmacists, support staff, facilities services and management. Patients must be involved in falls management to ensure independence, dignity, privacy, rehabilitation and falls risk are all appropriately addressed. (National Institute on Aging, 2016).

1.4 30% of people over 65 years old will fall at least once a year and 50% of people over 80 years old will fall at least once a year (NICE, 2013). Most falls are the result of multiple contributing factors (National Institute on Aging, 2016). Risk factors for falls include previous falls, polypharmacy, certain medications (including antipsychotics), increasing age, balance and mobility problems, cognitive impairment (Tinetti et al., 1988; Perell et al., 2001; NICE, 2013). Environmental factors only contribute to a small proportion of falls (NPSA, 2007). Inpatients are at greater risk of falling than community dwellers this may be because inpatients are more likely to have acute illness, delirium or dementia (NPSA, 2007; NICE, 2013).

1.5 It has been suggested that elderly mental health wards have between 13 to 25 falls per 1000 bed days (Blair & Gruman, 2005). According to the Health and Safety Executive falls are associated with more fatal and major/specified injuries (36%) than any other injury type (Health and Safety Executive, 2014). It is estimated that falls cost the NHS more than £2.3 billion pounds a year (NICE, 2013). Multifactorial clinical and environmental interventions (including factors such as muscle strength, medication, environmental hazards) can reduce falls risk (NICE, 2013). Unfortunately not all falls that occur may have an incident form completed and any interventions designed to raise awareness and reduce falls may initially cause a rise in falls incident forms being completed (Patient Safety First, 2009).

2. Outcome focused aims and objectives

2.1 The aim of this procedure is to ensure efficient and effective management of slips, trips and falls by ensuring appropriate clinical management and to provide clear concise guidance on the management and reduction of falls in order to ensure consistent practice and a reduction in falls.

2.2 The objective of this policy is to ensure that slips, trips and falls are appropriately managed and reduced within the trust. Thus this policy:

- Ensures consistent practice across the Trust
- Manages and where possible reduces falls risk for service users and staff

2.3 All slips, trips and falls (including near misses) will be reported using the Trust's Datix, Ulysses or P.A.C.I.S. electronic incident reporting system. 2.4 The circumstances of falls should be

described completely and meaningfully on the Datix, Ulysses or P.A.C.I.S forms. If known the causes of the fall should be included in the incident form.

2.4 Before the incident can be signed off we must ensure that the circumstances and consequences, including if transferred to an Acute Hospital, have been described completely.

2.5 All inpatients identified as being at risk of falls will have a Falls care plan section (see appendix B) within their acute care plan on epex.

2.6 Community patients identified as being at risk of falling can have falls management included in their statement of care.

2.7 All patients identified at risk of falling on elderly wards will have comfort checks/intentional rounding.

2.8 All patients at high risk of falling on the ward should have the following:

a. Physiotherapy assessment including physiotherapist judgement on future physiotherapy input (if physiotherapy available)
b. Care plan including falls risk factors e.g. mobility, footwear, medication, health conditions.
c. Communication with family members to formulate a contact plan inclusive of:
    - Consent to being contacted out of hours in the event of a fall
    - Clarify the conditions of contact regarding situation
    - Details of person to be contacted
d. A trust falls leaflet provided to service user and/or carers
e. Review of previous falls assessment and management to check if previously reviewed by Falls Clinic/Falls Team
f. Awareness raised at the surveillance meeting that patient is at high risk of falling.
g. Falls warning symbols used by bedside, in nurses office and on medication card.
h. Falls risk discussion at handover.
i.

2.9 All wards and departments will need to carry out an assessment of the environment, activities and staff awareness to identify any factors that constitute a slip or a trip hazard. This will be done via completion of the Workplace Inspection risk assessment pro forma (see Health, Safety and Welfare Policy) and the appropriate action taken to reduce the risk so far as is reasonably practicable.

3. Scope

3.1 This procedure applies to all staff; including permanent, seconded and temporary staff and those undergoing training and work experience.

3.2 Therefore, those responsible for engaging and / or supervising individuals in such roles should ensure that the individuals are familiar with both the policy and acknowledge their obligations under them.

4. Definitions

4.1 **Fall:** A fall is when someone unexpectedly comes to rest on the ground, floor or other lower level with or without injury (Kellogg International Work Group on the Prevention of Falls by the Elderly, 1987; Lord et al., 2007; WHO, 2007; AGS, 2010).

4.2 Where a fall is prevented e.g. they are lowered to the ground by staff this should be recorded as a fall on the incident report and classed as a near miss i.e. Datix, Ulysses or P.A.C.I.S dependent on the service.

4.3 When a patient is found on the ground (i.e. placement not observed) it is classed as a fall on the incident report unless **all of** the following three conditions are met:

i. Service user has a history of placing themselves on the ground.
ii. Service user found in a typical position i.e. they are found in a position typical of their recorded behaviour
iii. No harm is sustained

5. Duties

5.1 **Executive Director of Nursing:** Overall accountability for developing nursing practice and accountable officer for Falls policy. Is responsible for Patient Safety and Quality across the organisation and for ensuring that arrangements are in place for the safe and effective prevention and management of service user falls.

5.2 **Patient Safety Group:** Will monitor falls incidence and management as part of trust patient safety.

5.3 **Trust wide Falls Group:** To develop and implement a corporate strategy to reduce falls across services

- Review falls incident patterns and make recommendations for practice
- Report to Patient Safety Group

5.4 **Patient Safety Team:** Will monitor falls incidence and management as part of trust patient safety.

5.5 **Health and Safety Committee/Forums:** To monitor falls management as part of overall trust health and safety.

5.6 **Corporate Director of Estates** will ensure that industry specific guidance and best practice is followed when refurbishing wards or developing new buildings (i.e. flooring, lighting, ward design).

5.7 **Managers, Modern Matrons and Lead Clinicians** will ensure that:

- Risk assessments are carried out which cover their areas of responsibility and that appropriate actions are taken
- Care plans are developed and implemented to manage identified risks. (Appendix B).
- Where appropriate a Bedrails risk/benefit assessment will be completed (See Policy SA 26).
- Falls hazards and associated risks are identified.
- Identified Falls risks and their management must also be communicated verbally at handovers.

- Falls warning signs will be used at the person's bedside and on the bed state board and prescription card

5.8 **Employees** will:

- Monitor for any slips, trips and falls hazards.
- Implement monitor and measure falls standards.
- Ensure the environment is safe
- Visitors to the ward are orientated to environments.
- They advise / ensure service users wear suitable clothing / footwear (i.e. well-fitting slippers/shoe with a back)
- Receive falls awareness training where relevant.

6. Process

Quality Governance

6.1 Health and Safety (Trust committee and local forums) will review adverse incident data with a focus to ensure any trends and learning from clinical and non-clinical falls are identified and appropriate action taken. This includes raising awareness of incidents and ensuring fall prevention features heavily in communication to staff including Quality Practice Alerts.

6.2 The Patient Safety department will ensure regular incident reports are provided to the Patient Safety Committee highlighting areas of concerns regarding Slips, Trips and Falls.

Environment

6.3 Environmental factors that may impact on falls risk include:

- Trip hazards-medical devices, cables, clutter
- Flooring-density, sheen, surface and pattern can either be slippery or cause an illusion of steps or obstacles to patients with impaired vision or cognitive impairment.
- Spillages-ensure that spillages are promptly cleaned
- Cleaning timing and methods-ensure cleaning is done at quieter times and that when mopping there are still dry routes
- Lighting-light gradients when moving from brightly lit to dimly lit areas and daylight glare from windows
- Call bells/sensors/patient alarms-availability, visibility and location.
- Doors-including how they close
- Distance between hand holds-rails, chairs, beds and toilets.
- Staff locations for observing patients.
- Signposting-particularly for toilets

- Furniture stability when leaned on.
- Clutter should be avoided
- Cable covers should be used when suitable.
- The range of equipment-different patients have different needs and sizes and so may require different equipment including beds, mattresses, commodes, wheelchairs and chairs. (Patient Safety First, 2009; NICE, 2013).

6.4 In both existing and new buildings the environment including repair/modification of the environment should be considered (Patient Safety First, 2009). The workplace inspection is carried out quarterly.

Relevant Legal, Statutory and Professional Requirements

6.5 The Health and Safety Executive offers advice on managing falls in the workplace http://www.hse.gov.uk/slips/index.htm

6.6 The Management of Health and Safety at Work Regulations (1999) states that every employer must make a suitable and sufficient assessment of the risks to employees' health and safety whilst they are at work. Every employer must also make a suitable and sufficient assessment of the risks to people who although not in their employment are affected by their conduct. Every employer needs to make and give effect to suitable preventative and protective measures including review of these measures.

6.7 The Workplace (Health, Safety and Welfare) Regulations (1992) require that as far is reasonably practical suitable and effective measures are taken to prevent people falling or being injured by a falling object.

6.8 The Work at Height Regulations (2005) requires that when work is carried out at height every employer implements suitable and sufficient measures to prevent people falling a distance likely to cause personal injury.

6.9 Nursing and Allied Health Professionals:

- The registered nurse has personal accountability for his/her own practice and should acknowledge limitations of professional competence and only undertake and accept responsibility for those activities for which he/she is competent (NMC, 2015).
- All Allied Health Professionals (AHP) are state registered with the Health and Care Professions Council and are thus required to keep their professional knowledge and skills up to date and to act within their limits and refer on if necessary (HCPC, 2016).

Reporting of Slips, Trips and Falls

6.10 All slips, trips and falls (including near misses) will be reported **using** the Trust's Datix, Ulysses or P.A.C.I.S. electronic incident reporting system. The circumstances of falls should be described completely and meaningfully on the Datix or P.A.C.I.S forms. If possible the causes of the fall should be included in the incident form.

6.11 The free text section could include the following information:

- Witnessed/unwitnessed fall
- Outcome of investigations
- Type of injury
- Call bell within reach before fall

- If a fall from bed, were there bedrails
- Floor wet/dry
- Footwear
- Walking aid in use
- Mental state
- First fall this admission or repeat fall
- Days since admission
- Medication affecting risk of falls

6.12 The DATIX administrator decides the level of severity as follows:

- No harm: Where no harm came to the patient.
- Low harm: Where the fall resulted in harm that required minor treatment, first aid, extra observation or medication
- Moderate harm: Where the fall resulted in harm that was likely to require outpatient treatment, hospital admission, a longer hospital stay or surgery.
- Severe harm: Where permanent harm, such as disability or brain damage, was likely to result from the fall.
- Death: Where death was the direct result of the fall. (NPSA, 2007)

6.13 The incident description should include the antecedents, behaviours and consequences.

6.14 When reporting falls we should consider if this was as a result of defective medical equipment (e.g. walking aids, wheelchairs) . If medical equipment was a contributing factor then it should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) (Medicines and Healthcare Products, 2014).

6.15 Staff who are injured as a result of a fall, and are off work for more than 7 days may be subject to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Go to http://www.hse.gov.uk/riddor/index.htm Contact the Patient Safety team for advice on reporting.

6.16 Football tackles and falls due to epilepsy do not need to be classed as falls.

Risk Assessment

6.17 All wards and departments will need to carry out an assessment of the environment, activities and staff awareness to identify any factors that constitute a slip or a trip hazard. This will be done via completion of the Workplace Inspection risk assessment quarterly in line with policy SA07 (Health Safety & Welfare Policy) and the appropriate action taken to reduce the risk so far as is reasonably practicable.

6.18 A full risk assessment must be carried out for all tasks or identified risks that could lead to a fall from height.

6.19 ***Height hazards include****:*

- Working alone at height (e.g. up a ladder).
- Deep holes.
- Stairs/staircases without appropriate railings
- Low retaining walls within garden/ward areas that can be easily scaled.
- High shelving.
- Windows.

- Window ledges.
- Beds.
- Chairs.
- Tables/Plinths/Hoists.

6.20 The Work at Height Regulations requires employers to ensure that:

- All work at height is properly planned and organised.
- A risk assessment is carried out for all work conducted at height.
- Appropriate work equipment is selected and used.
- People working at height must receive appropriate training, instruction and supervision as required ensuring they are able to undertake the work in a safe and competent manner.
- Equipment used for work at height is properly inspected and maintained
- Risks from fragile surfaces are properly controlled.

6.21 The risk assessment should include a careful examination of what harm could be caused from working at height with a view to taking steps to reduce the likelihood of this harm occurring, either through avoiding the activity or, where this is not reasonably practicable, by carrying it out in a safe manner using work equipment that is appropriate to the task and level of risk.

6.22 Where work is undertaken at height or involves excavations, robust control measures must be in place to secure the area from unauthorised access at all times.
Access to roof spaces, flat roofs and other areas deemed to be at height should be controlled so as to prevent access by unauthorised personnel.

Service User Falls

6.23 This policy is has had confirmation that the process fits in relation to Specialist Learning Disabilities Division.

6.24 It is important that falls management balances rehabilitating patients with their right to make their own decisions about what they are willing to do to manage their falls risk.

6.25 NICE CG161 (2013) state that all inpatients aged 65 years or older should be regarded as at risk of falling. All inpatients aged 50-64 judged by a clinician to be at higher risk of falling due to an underlying condition will also be regarded as being at risk of falling.

6.26 **Older Peoples Wards / Addictions Inpatient Units / Brain Injury Unit** - On admission all service users will be assessed using the Falls Risk Assessment Tool (FRAT) within 24 hours of admission or as soon as is reasonably practicable to help guide clinician judgement with regard to identifying those at higher risk of falling. Appropriate completion of FRAT and falls care plan for those at risk of falling are KPIs.

6.27 **All Other In-patient Areas** - All wards will use FRAT with all service users aged 50 years old or older to help guide clinician judgement with regard to identifying those at higher risk of falling. All wards will ask patient if they have fallen in previous 12 months either in FRAT or inpatient physical health nursing assessment. Appropriate completion of FRAT and falls care plan for those at risk of falling are KPIs.

6.28 **High Falls Risk Identified** - If a patient is identified as being at high risk of falling (i.e. either through clinician judgement, having fallen in previous 12 months or answering yes to 3 FRAT

questions) then a multifactorial falls assessment and management plan based on the patient's risk factors will be completed (i.e. using the falls policy for guidance).

6.29 Whilst NICE CG161 (2013) does not recommend the use of falls risk prediction tools to predict patients' risk of falling Mersey Care NHS Trust will continue to use FRAT because

- It helps clinicians to identify which patients aged 50+ would benefit from a multifactorial falls assessment and multifactorial falls interventions.
- Use of FRAT also helps healthcare professionals meet NICE (2013) guidelines as healthcare professionals should ask older people if they have fallen in the previous 12 months

6.30 The Falls Risk Assessment Tool (FRAT) is available in 'Documents' and as a report in 'Clinical Pathways' in epex. Please see Appendix: A. A Falls Risk Assessment Tool (FRAT) can be repeated at anytime if ward or community staff are particularly concerned about a service user's falls risk.

6.31 Older people who present for medical attention because of a fall, report multiple falls in previous 12 months or have abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment (NICE, 2013).

6.32 Older people who have fallen or ARE at risk of falling should be observed for balance and gait problems and considered for their ability to benefit from interventions to improve their strength and balance. Tests of balance and gait commonly used in the UK:

- Timed up and go test
- Turn 180º
- Performance-oriented assessment of mobility problems (Tinetti scale)
- Functional reach
- Dynamic gait index
- Berg balance scale (NICE, 2013).

(NB: These tests may be undertaken by Trust physiotherapists)

6.33 A multifactorial assessment aims to identify the patient's individual falls risk factors that can be improved and managed. A multifactorial falls assessment may include:

- Cognitive assessment
- Continence assessment
- Falls history assessment including causes and consequences such as injuries and fear of falling.
- Footwear assessment
- Assessment of physical and mental health issues that may increase falls risk
- Medication review
- Physiotherapy assessment regarding mobility and balance
- Postural instability assessment possibly including lyingand standing blood pressure and physiotherapy assessment.
- Syncope assessment for those who have had unexplained falls.
- Visual assessment.

6.34 Service users identified as being at risk of falls or their carers will be provided with a falls leaflet when appropriate. A Trust falls leaflet is available which provides information about: falls risk factors, what to do to reduce falls risk, how to stay motivated in reducing falls risk, how some falls can be prevented, the benefits of reducing falls risk, what to do in the event of a fall, what Mersey Care NHS Trust do about falls and who can provide more information

(NICE, 2013). Falls management information will also be provided for the patient and family members and carers (if appropriate and patient agrees) (NICE, 2013). Falls information provision will take into account the patient's ability to understand and retain the information (NICE, 2013). Ward staff should also explain about the nurse call system if appropriate (NICE, 2013).

6.35 Multifactorial falls interventions targeting the reasons people are falling are most effective at managing falls (Haines et al., 2004; Healey et al., 2004; Fonda et al., 2006; Stenvall et al., 2008; NICE, 2013).

6.36 Treatment and care should be individualised to the patient (NICE, 2013). Patients, in partnership with their healthcare professionals, should have the opportunity to make informed decisions regarding their falls management (NICE, 2013).

6.37 Healthcare professionals should follow Department of Health guidelines on consent and should appropriately follow the Mental Capacity Act and deprivation of liberty safeguards (NICE, 2013).

6.38 Interventions should be developed by a team that includes nurses, physicians, psychiatrists, physiotherapists, occupational therapists and pharmacists. Managers and facilities staff should also have a key role in providing a safer environment. Healthcare professionals should discuss with the patient what changes they are willing to make to reduce falls risk (NICE, 2013).

6.39 Effective falls management interventions include:

- Reviewing medication associated with a risk of falls particularly psychotropic medication.
- Detecting and treating causes of delirium
- Detecting and treating cardiovascular illness
- Detecting and treating or managing incontinence or urgency
- Detecting and treating osteoporosis
- Detecting and treating eyesight problems and having the right glasses
- Providing safer footwear
- Physiotherapy, exercise (strength and balance training individually prescribed by an appropriately trained professional) and access to walking aids. Strength and balance training is particularly useful for older people living in the community with a balance and gait problem and/or recurrent falls.
- Improvements to floor cleaning, spillages, lighting and call bells/sensors/alarms
- Increasing the range of beds and chairs to suit different needs
- Using bedrails if the benefits outweigh the risks.
- Assessing and managing person's perceived functional ability and fear of falling.
- Assessing and managing cognitive impairment and neurological examination.
- Home hazard assessment and intervention.

(Fonda et al., 2006; Haines et al., 2004; Healey et al., 2004; NICE, 2013).

6.40 Any falls prevention programmes that are developed should be relevant, flexible to accommodate different peoples views and needs, should promote the social aspects of group activity, should address potential barriers like low confidence and fear of falling, should encourage activity change and should be available in languages other than English (NICE, 2013). Unfortunately there is less evidence regarding the effectiveness of falls management in mental health settings particularly with regard to people with dementia (NPSA, 2007).

6.41 Unwitnessed falls do not necessarily mean that inappropriate care is occurring. Even if staff are with a patient they are not always able to prevent falling (NPSA, 2007).

6.42 Patients who are found on the floor should be treated the same as someone who has had an observed falls unless it is definitely known that the patient deliberately put themselves on the floor.

6.43 Community staff should complete a datix form for any falls that occur whilst they are with the service user.

6.44 If a service user reports falls at any time during an open episode of care a datix form should be completed for that fall.

6.45 Falls can be a symptom of underlying illness (Patient Safety First, 2009). Following a fall early detection, effective injury treatment, consideration of why the patient fell and application of measures to reduce the risk of further falls or injury is required to reduce the degree of harm (NPSA, 2007).

6.46 A Falls Huddle (See appendix G) is a useful way for the team to examine why someone fell and to implement remedial actions

6.47 All patients who have fallen are to be reviewed at the Multi disciplinary Team re Falls management

6.48 Movement sensors can be used as part of inpatient or community falls management.

6.49 Suitable observation levels should be used. Patients should be encouraged to stay in well staffed communal areas. 1:1 observation levels are not necessarily needed in falls management as although it might be natural instinct to try and catch someone falling there is a risk of serious injury when trying to stop someone falling (NPSA, 2007).

6.50 A copy of the post fall protocol will be displayed in the nurses' office to make easy to find (Patient Safety First, 2009). The post fall protocol is part of appendix B.

6.51 For multiple fallers, consider discussing the case with more senior staff or peers from a neighbouring ward; fresh eyes might identify further potential interventions (Patient Safety First, 2009).

6.52 Need to consider interventions post discharge to help prevent falls such as home adaptations (NPSA, 2007).

6.53 All falls resulting in moderate harm will have a 72 hour review completed (and if appropriate, a level 1 investigation instigated). All falls resulting in severe harm or death will have both a 72 hour review and a level 1 investigation instigated.

6.54 A 72 hour report will be completed online following three falls in 30 days for inpatients. Risk and Governance will be informed of this.

6.55 Non service user falls

6.56 A Datix incident form will be completed for non-service user falls e.g. visitors visiting inpatients, staff, volunteers, other visitors. The Health and Safety Advisor will monitor the number of non service user slips, trips and falls incidents, occurring within the Trust. They will identify patterns and trends and will liaise with relevant parties (e.g. Estates, Hotel Services and location Managers) as necessary and provide a report to the Trust Health & Safety and Infection Control Committee on an annual basis.

6.57 HSE have created STEP an eLearning package about reducing falls in the workplace http://www.hse.gov.uk/slips/step/index.htm

7. Consultation

7.1 This policy is based on guidance from:

- National Institute for Clinical Excellence (2013) Falls: assessment and prevention of falls in older people.
- National Patient Safety Agency Slips, trips and falls in hospital report (2007)
- Patient Safety First The 'How to' guide for reducing harm from falls (2009)
- National Service Framework for Older People (2001)
- Management of Health and Safety at Work Regulations (1999)
- Work at height Regulations (2005)
- Falling standards, broken promises Report of the national audit of falls and bone health in older people 2010 (2011)
- Associated Trust policies and procedures listed in section 19
- Human Rights Act of (1998)
- Clinical Directors
- Director of Estates and Facilities
- Risk Manager
- Acute Service Mangers
- Community Service Managers
- Modern Matrons
- Community Mental Health Team Managers
- Ward Managers
- Physiotherapists
- Occupational Therapists
- Manual handling

8. Training

8.1 A training programme has been developed in line with the Nice Falls guidance (2013) to raise awareness of falls assessment and management. Level 1 training will be online for all clinical staff and level 2 will be for complex care inpatient staff and provided as part of manual handling training.

8.2 Falls awareness is also included within manual handling training which is delivered according to the risks staff encounter. Junior Doctors also receive falls training as part of their online training.

8.3 For more information regarding training please refer to the organisational 'Training Needs Analysis'. Policy HR28 Induction and Mandatory Training including Training Needs Analysis

9. Monitoring

9.1 Services will monitor the number of incidents within their area and review risk assessments, actions taken, interventions and care plans as appropriate. This will be reported to the Trust wide falls group.

9.2 The Trust wide Falls Group will examine best practice across disciplines and monitor compliance against NICE clinical guideline CG161.

9.3 The Patient Safety team will assess local services against best practice guidance yearly and make recommendations for improvement as appropriate

9.4 These audits will be reviewed at local Health & Safety sub group meetings and assurances regarding compliance with this policy will be provided to the trust health & safety and infection control committee and the executive committee on an annual basis.

9.5 The Health and Safety Advisor will monitor the number of non service user slips, trips and falls incidents, occurring within the Trust. They will identify patterns and trends and will liaise with relevant parties (e.g. Estates, Hotel Services and location Managers) as necessary and provide a report to the trust health & safety and infection control committee on an annual basis.

9.6 The Trust will undertake the following actions / processes to learn from each incident and appropriately change practice to reduce similar incidents.

9.7 Each incident will be reviewed to identify the causes and remedial action required to prevent further incidents. The level of incident review to be undertaken will be considered by the appropriate Managers. All review data will be shared with the services' governance committee and the trust health & safety committee.

9.8 Each service /department shall have a lead clinician/ Manager, who will oversee the implementation of changes to practice and report via local governance meetings on progress made.

9.9 Each service/department will review the number and severity of incidents on a monthly basis, trends will be identified and remedial action agreed and implemented.

9.10 The governance meeting of each service, including corporate services, will on an annual basis consider whether a formal audit of the efficacy of the implementation of the safety measures in place should be undertaken.

9.11 Falls incidents are examined at the Trust Patient Safety meetings as well as the health and safety committee who will look at Trends, levels of harm and remedial actions. Services may further examine specific events at Oxford Model Events.

System for the Monitoring of Compliance with the Falls Policy	
Monitoring of compliance with this policy will be undertaken by:	Audits will be completed regarding the completion of the FRAT, appropriate care plans and other appropriate falls risk assessments. These audits will be reviewed at local health & safety sub group meetings and assurances regarding compliance with this policy will be provided to the trust health & safety and infection control committee and the executive committee on an annual basis.
Monitoring will be performed:	On a yearly basis
Monitoring will be undertaken by means of:	Clinical services will monitor the number of

	incidents within their area and review risk assessments, actions taken, interventions and care plans as appropriate. The BiT can be used to monitor falls incidences.
Should shortfalls be identified the following actions will be taken:	Failure to comply with the policy will be addressed in accordance with appropriate Trust policy. Dealing with breaches of the policy will form part of the regular update reports presented to the trust health and safety committee by the Health and Safety Advisor. Known breaches will be discussed at the trust health and safety committee where any necessary action will be recommended to the trust board.
The results of monitoring will be reported to:	Patient Safety Meeting
Resultant actions plans will be progressed and monitored through:	Governance meetings in services.
The auditable standards of the procedure are:	Service users' frailty care plans and a reduction in falls.

10. Equality and Human Rights Analysis

Title: Policy for the Management and Reduction of Slips, Trips & Falls
Area covered: Trust wide.

What are the intended outcomes of this work? At Review Sept 2016- no change found The aim of this procedure is to ensure efficient and effective management of slips, trips and falls. Developed in line with guidance from NICE (2013; 2015), Management of Health and Safety at Work Regulations (1999), Work at height Regulations (2005).
Who will be affected? At Review Sept 2016- Including Mersey Care Whalley. All service users, staff, visitors and contractors.

Evidence
What evidence have you considered? At Review Sept 2016- no change found Policy only …This is a policy review
Disability (including learning disability) At Review Sept 2016- Including Mersey Care Whalley and we will need to monitor the transition to Mersey Care NHS Trust for people within the specialist learning disability service. The reference to the application of a FRAT with Brain injury services is due to research and internal falls analysis. Any information must be given in a format that can be understood by the person receiving the information.
Sex At review September 2016 need to review falls management and falls incidence by gender to ensure proactive actions are gender sensitive.
Race No significant issues. At review September 2016 need to review falls management and falls incidence by race to ensure proactive actions are culturally sensitive. Any information must be given in a format that can be understood by the person receiving the information.

Age At review September 2016 include Mersey Care Whalley. The reference to the application of a FRAT for anyone over 50 is due to specific NICE guidance. Need to review falls incidence by age every 6 months.
Gender reassignment (including transgender) At review September 2016 See cross cutting below.
Sexual orientation At review September 2016 See cross cutting below.
Religion or belief At review September 2016 See cross cutting below.
Pregnancy and maternity At review September 2016 See cross cutting below.
Carers At review September 2016 Need to include a monitoring process to ensure the requirement below is met. Requirement to discuss falls issues with carers. Communication guidance available for how and when family wish to be contacted regarding ward falls in falls policy. Patient care plan and notes may include further information on liaising with carers.
Other identified groups At review September 2016 People within addictions services, brain injury falls incidence will be analysed once a year. The reference to the application of a FRAT with addiction in patient beds is due to research and internal falls analysis.
Cross Cutting At review September 2016 People who have multiple falls risk factors e.g. increased age, frailty, cognitive impairment and physical disability are more likely to fall (NICE, 2013). Will analyse at least once a year protected characteristics.

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	Supportive of HRBA.
Right of freedom from inhuman and degrading treatment (Article 3)	Supportive of HRBA.

Right to liberty (Article 5)	Supportive of HRBA.
Right to a fair trial (Article 6)	Supportive of HRBA.
Right to private and family life (Article 8)	Supportive of HRBA.
Right of freedom of religion or belief (Article 9)	Supportive of HRBA.
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	Supportive of HRBA.
Right freedom from discrimination (Article 14)	Supportive of HRBA.

Engagement and Involvement
No engagement undertaken as this was a review of a policy.

Summary of Analysis

Eliminate discrimination, harassment and victimisation

Policy is supportive.

Advance equality of opportunity

At review September 2016
The monitoring process will identify within the equality analysis seeks to ensure quality of opportunity in relation to awareness, support and guidance in relation to falls.

Promote good relations between groups

Not engaged.

What is the overall impact?

Addressing the impact on equalities

At review September 2016- no change.

There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups.
The aim of this policy is aimed to target individuals and provide with additional resources those at higher risk of falling.

Action planning for improvement

At review September 2016 Action Plan has been updated to represent all protected characteristics and changes within the trust.

Gender in relation to falls will be discussed and monitored in the trust falls meetings. The trust falls group will review falls incidence prevalence in relation to gender in the appropriate forum at least once a year. This is to ensure activities are directed where relevant.

For the record

Name of persons who carried out this assessment:
Vicky Glaze and Anne Wilson Senior physiotherapists
Graeme Scott manual handling trainer
Tony Crumpton Head of safety and security

Review carried out by
Vicky Glaze Senior physiotherapist
Meryl Cuzak Equality and Human rights Lead

Date assessment completed: 9/9/15
9/9/15
Review date 7/9/16

Name of responsible Director:
Executive Director of Nursing

Date assessment was signed:
9/9/15
September 2016

Action plan template

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring	**To analyse the falls data at least once per year re the protected characteristics with particular reference to the comparison re sex and admission numbers.**	April 2016	Tony Crumpton

At Review September 2016

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring	**Establish a system within the trust falls group to ensure effective analysis and identification of action where needed for all protected characteristics.** **6 monthly** / **12 monthly** **Disability- complex care, Whalley, STAR unit** / **Brain injury** **Age** / **Sexual orientation** **Gender** / **Religion and belief** **Race** / **Addictions** **Community**	December 2016	Anne Wilson Senior Physiotherapist
Monitoring- Carers	**Providing carers with information on how they want to be contacted regarding falls and falls information. To include into frailty review.**	November 2016	Frailty review meeting members.
Accessible information	**To develop and provide falls information that is accessible.**	September 2017	Trust falls group

11. Implementation Plan

11.1 See process. Continue with frailty reviews and trust falls meetings.

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Appendix A

Fall Risk Assessment Tool (F.R.A.T.)

Falls Risk Assessment Tool (F.R.A.T.) is available on epex for all service users and in the Getting it Right assessment which is available for dementia inpatients.

Patient's Name……Ward/Unit……

Named Nurse…… Diagnosis……

D.O.B…… Hospital Number……

Date of Admission……

		Yes	**No**
1.	Is there a history of any falls in the last 12 months? *Ask service user, or their carer/relative about frequency, context, if resulted in a fragility fracture and characteristics of any fall.*		
2.	Is the patient on four or more medications?		
3.	Does the patient have epilepsy, seizures or a neurological condition, i.e. Stroke or Parkinsonism?		
4.	Does the patient (or carer) report any problems with their balance?		
5.	Is the patient unable to rise independently from a chair of knee height?		

Name of Assessor…….....(Print)

Signature Assessor……..

Designation Assessor……..

Date……

If there is a Yes answer to three or more of the questions above or yes to question 1, this indicates the service user is at risk of a fall and must therefore receive a multifactorial falls assessment and management.

(Nandy et al, 2004).

Appendix B

An individualised falls risk assessment could include assessment of:

- Balance and mobility-physiotherapy
- Sensation
- Osteoporosis/fractures
- Physical health e.g. cardiac issues, pressure care, infections, arthritis.
- Dizziness or blackouts-lying and standing blood pressure, cardiac and vestibular investigations.
- Vision
- Feet issues-podiatry/chiropody
- Footwear
- Mental health e.g. elated mood
- Activities of Daily Living-OT
- Continence and toileting
- Fear of falling
- Bed rails
- Medication
- Environment
- Use of Lifeline/pressure sensors.

Pre Fall

Patient based:

Identification of risks:

Admission
Asking service user if they have fallen in previous 12 months
FRAT assessment

If someone reports a fall in previous 12 months the following algorithm can be used to guide assessment and management.

Need The service user is at risk of falls
Aims and Objectives For the person not to have a fall. To have in place a care plan that reflects the individual's needs. To have in place strategies that will reduce the person's risk of falling.
The causes of a fall are unique to that individual and therefore so are the solutions to preventing that person from falling or having repeated falls. This guide is not designed as a care plan, but as a prompt for the staff that will be completing care plans. Try and include the frequency/intensity with which interventions will occur. With each patient: • On admission a multifactorial falls assessment should be completed based on the patient's risk factors for falls. • Falls risk and falls management should be discussed with family on admission, after a fall and in ward rounds.

• The environment should be monitored and it should not have any significant trip hazards. • They should have appropriate walking aid/support to help them mobilise. • They should have appropriate help with activities of daily living (ADLs). • They should ensure that the patient has appropriate footwear (which has good grips and backs). • They should have their medication reviewed regarding falls risk on admission and after a fall.	
Risk Factors	**Management**
The person has mobility or balance problems i.e. unsteadiness, weakness.	Ensure person always walks with appropriate walking aid/support. If physiotherapy available refer to physiotherapy. Encourage person to do exercises as recommended by physiotherapy e.g. daily. Refer to moving and handling
The service user experiences sensation problems i.e. peripheral neuropathy, neglect	Arrange medical review by appropriate Doctor. Refer to physiotherapy if physiotherapy available.
The service user has had a previous fracture or osteoporosis	Check if patient on appropriate osteoporosis medication or had appropriate osteoporosis assessment e.g. referring for DEXA scan or use of FRAX (Fracture Risk Assessment Tool) or QFracture.
The service user has physical health problems i.e. cardiac problems, breathlessness, osteoporosis, postural hypertension and pressure ulcers	Arrange medical review on admission and if patient deteriorates. Refer to physical health nurse on admission and if patient deteriorates.
Dizziness or blackouts	Check lying and standing blood pressure for postural hypotension. Get medical review.
Visual impairment	Ensure service user is wearing correct glasses on admission, during intentional rounding and during therapy. Refer to optician.
The service user has new or existing problems with their feet. The service user is wearing inappropriate footwear i.e. ill fitting, poor grip, backless or worn.	Obtain medical review on admission and if patient deteriorates. Refer to Podiatry Service. Ask carer or family members to supply appropriate footwear on admission or if footwear becomes inappropriate due to damage or foot changes. If necessary ward to supply slippers or non-slip socks.
There is a deterioration in mental	Nursing and medical review

health	Arrange investigations for under lying physical health problem i.e. infection.
The service user has difficulty in meeting activities of daily living	Appropriate nursing and nursing assistant management Refer to OT if OT available
The service user experiences continence problems Increased urination/pain when urinating	Perform urinalysis Refer to continence adviser Refer to Doctor Refer to physical health care nurse Ensure person has appropriate incontinence wear and appropriate help with toileting.
The service user a fear of falling	Consider referring to psychology. Fear of falling advice from physiotherapy, OT or psychology.
The service user may fall from bed Patient is at risk of falling in their bedroom/needs assistance in their bedroom.	Assess for the use of bed sensors, call system or falls sensors on admission with nursing, OT and physiotherapy input. Service user to have bed that height can be adjusted so that it is appropriate from them.
Patient is on their own sometimes at home or lives with other frail people and so would benefit from Lifeline.	Refer to OT Refer to advocacy if there are no appropriate relatives to help with Lifeline referral.
The service user is on 4 or more medication. They have been prescribed medication which may contribute to them falling.	Medication to be reviewed regularly by medical and pharmacy staff on admission and at every ward round. Place fall symbol sticker on medicine card.
Environmental Poor lighting Flooring that is damaged or wet. Cables from equipment Unnecessary furniture or equipment For service users in their own home Floor coverings i.e. worn carpets or rugs	Staff to ensure adequate lighting in all areas. Any damage to flooring to be reported. Spillages to be cleaned up as soon as possible, wet floor signs to be used and removed when floor has dried. Any cables from medical equipment secured properly to prevent them trailing. Any equipment or furniture not needed to be removed. For hazards in their own home please refer to OT for home assessment.
Lack of information	Use fall symbol on service user information board Ensure fall prevention plan in bed space or inside wardrobe. Fall symbol to be placed on medicine card.

	Information leaflet to be given to service user/relative or carer. Discuss incident of falls at MDT meeting.

In cases of elevated risk identified:

- Physiotherapy assessment including physiotherapist judgement on future physiotherapy input (if physiotherapy available)

9.12 Care plan including falls risk factors e.g. mobility, footwear, medication, health conditions.

9.13 Communication with family members to formulate a contact plan inclusive of:

9.13.1 Consent to being contacted out of hours in the event of a fall

9.13.2 Clarify the conditions of contact regarding situation

9.13.3 Details of person to be contacted

9.14 A trust falls leaflet provided to service user and/or carers

9.15 Review of previous falls assessment and management to check if previously reviewed by Falls Clinic/Falls Team

9.16 Awareness raised at the surveillance meeting that patient is at high risk of falling.

9.17 Falls warning symbols used by bedside, in nurses office and on medication card.

9.18 Falls risk discussion at handover.

Ward based:

Identification of risks:

Quarterly Workplace Inspection

Minimisation of risks:

Ward manager review of Datix incident forms and actions

Falls Training

Post Fall Protocol

Patient falls

Witnessed or unwitnessed

Ensure Nurse in charge and Doctor aware of fall and subsequent actions

Complete physical observations including AVPU and MEWS.

All inpatient falls should be reviewed by a Doctor as soon as possible.

If balance/mobility issues refer to physiotherapy for review

No injury

No pain

No mobility changes

No change in current presentation

No pain

Encourage patient to get up independently or using correct manual handling techniques.

Monitor patient and get them reassessed by Doctor and MDT if they deteriorate.

Suspected injury

Pain, deformity,loss of senation, visible injury, reduced movement, swelling, bruising, difficulty wieght bearing.

If problems with activities of daily living refer to OT.

Head injury/Spinal Injury/Hip fracture

(Severe pain, difficulty weightbearing, limb shortening, rotation, deformity, loss of sensation).

DO NOT MOVE

AVPU

If unconscious do ABCDE

Contact ambulance and transfer to A&E.

Other injury including soft tissue injuries, suspected fracture

Assist patient up using correct manual handling techniques

Nursing staff to monitor physical obs until medical review.

Medical staff to review and send to acute hospital if needed e.g. suspected fracture.

Offer pain relief if necessary

Clean and dress any wounds.

- Complete Datix form including information such as location, equipment involved, patient and witness accounts, any predisposing factors.

-Ensure environment safe -Inform Family - Complete epex entry -Determine cause of fall - Update care plan - Monitor patient and get them reassessed by Doctor and MDT if they deteriorate - Discuss in MDT -Ensure causes of falls are managed and reduced if possible

Physical Observations

Respiration, temperature, pulse, respiratory rate, blood pressure oxygen saturations, blood glucose.

Consider use of a body map to help identify injuries.

Any signs and symptoms of agitation, confusion, delirium, drowsiness, nausea.

Ensure patient gets adequate pain relief, pressure care, fluid balance. Ensure patient is kept informed of what is happening.

AVPU

AVPU is used to assess a person's consciousness and thus their Central Nervous System (CNS) function level. Any response less than alert can signify head injury and should result in transfer to an acute hospital.

A – Alert and awake.

V – Responds only to voice. Not fully awake and only responds to verbal stimuli.

P – Responds only to pain. Difficult to rouse and only responds to painful stimuli such as nail bed pressure or trapezius pain.

U – Unconscious and unable to be roused.

- Check physical health observations including AVPU and MEWS half-hourly for 2 hours then 1-hourly for 4 hours and then 2-hourly thereafter, unless clinically indicated otherwise. If any concerns transfer to acute hospital.

ABCDE

A – Airway

B – Breathing

C – Circulation

D – Use AVPU or GCS at this point

E – Expose body for thorough examination for injuries (as appropriate in ward environment ensuring respect and dignity are maintained).

Head Injury

Signs and symptoms may include loss of consciousness, haemorrhage,

Do NOT move patient. Keep patient still until emergency services arrive. Specialist equipment required to move patient provided by paramedics. Only move patient if there is a significant risk to them if they remain in that position.

Call for ambulance. If medic available within less than 10 minutes they should see the patient but if medic unavailable within 10 minutes ensure referred to acute hospital via ambulance. Ensure you have handover ready for ambulance team.

If neuro obs are required over a sustained period of time please transfer to acute hospital.

Take immediate action to prevent further falls/worsening injuries by moving hazards or other patients as appropriate.

Spinal Injury

Signs and symptoms may include pain, loss of sensation, difficulty moving or weightbearing, circulation changes, breathing difficulties, loss of bladder/bowel control.

Do NOT move patient. Do NOT use hoist as could worsen spinal injury. Keep patient still until emergency services arrive. Specialist equipment required to move patient provided by paramedics. Only move patient if there is a significant risk to them if they remain in that position.

Call for ambulance. If medic available within less than 10 minutes they should see the patient but if medic unavailable within 10 minutes ensure referred to acute hospital via ambulance. Ensure you have handover ready for ambulance team.

Take immediate action to prevent further falls/worsening injuries by moving hazards or other patients as appropriate.

Hip Fracture

A hip fracture may present with the following signs and symptoms:

- Fallen onto the side of the body or twisting fall

or

- Hip/groin/upper leg pain (including patient complaining of pain more than normal, increased agitation, pain worse with weight bearing)

or

- Inability to weight bear on affected leg (including difficulty getting up after fall, difficulty standing or walking)

or

- Shortening of the leg

or

- Rotation of the leg

or

- Inability to do straight leg raise

or

- Stiffness, swelling or bruising in and around hip area.

If a hip fracture is suspected do NOT move the patient (except out of immediate danger by moving hazards or other patients as appropriate) until you have guidance from paramedics. Do NOT use hoist as could cause hip displacement, internal bleeding and make surgery more complex. Only move patient if there is a significant risk to them if they remain in that position.

Immediate medical attention should be sought if a hip fracture is suspected and if medic cannot attend within 10 minutes then call for a paramedic immediately. Ensure you have handover ready for ambulance team.

If any of the above signs and symptoms occur then a hip x-ray should be obtained. If ward staff have persistent concerns following medical review regarding the service user then an ambulance should be called via 999 or 9999 (depending on phone system).

Staff should be aware of increased risk of fracture in people with osteoporosis.

For all falls resulting in severe harm (such as a hip fracture) or death a 72 hour review and a level 1 investigation need to be instigated.

Undisplaced fractures may only experience pain on movement.

Other Fractures

Other fractures may include fractured humerus/elbow/wrist/pelvis/ankle

Symptoms may include pain, deformity, pins and needles, numbness, altered sensation, bruising, swelling, decrease in movement, pain worse with movement, altered circulation,

Take immediate action to prevent further falls/worsening injuries by moving hazards or other patients as appropriate.

All fractures are confirmed by an x-ray.

Other Injuries

Consider whether the patient fell due to a heart attack/stroke.

Ensure urgent transfer via ambulance to acute hospital.

Take immediate action to prevent further falls/worsening injuries by moving hazards or other patients as appropriate.

No Injury

Take immediate action to prevent further falls/worsening injuries by moving hazards or other patients as appropriate.

Continue to monitor patient and refer them for medical review or to acute hospital if they deteriorate.

Getting up after a fall

Encourage patient to get up independently if they are able. Encourage patient to get onto all 4s and use sturdy furniture to help themselves up. Use hoist or sliding sheets as appropriate. Patient may need to be helped up using personal safety/manual handling techniques.

Appropriate manual handling techniques are needed to prevent further complications arising e.g. if a patient had an undisplaced fracture moving them wrongly could cause internal injuries.

Complete Datix report

The circumstances of falls should be described completely and meaningfully on the Datix or P.A.C.I.S forms (NPSA, 2007). If possible the causes of the fall should be included in the incident form.

The free text section could include the following information:

- Witnessed/unwitnessed fall
- Outcome of investigations
- Type of injury
- Call bell within reach before fall
- If a fall from bed, were there bedrails
- Floor wet/dry
- Footwear
- Walking aid in use
- Mental state
- First fall this admission or repeat fall
- Days since admission
- Medication affecting risk of falls

The DATIX administrator decides the level of severity as follows:

- No harm: Where no harm came to the patient.
- Low harm: Where the fall resulted in harm that required minor treatment, first aid, extra observation or medication.

- Moderate harm: Where the fall resulted in harm that was likely to require outpatient treatment, hospital admission, a longer hospital stay or surgery.
- Severe harm: Where permanent harm, such as disability or brain damage, was likely to result from the fall.
- Death: Where death was the direct result of the fall. (NPSA, 2007)

The incident description should include the antecedents, behaviours and consequences.

Contacting family

Category of fall	**Contact to be made via telephone**			
	9am-5pm	**5pm-10pm**	**10pm-9am**	**After 9am next day**
Minor fall, no injuries				
Fall with minor injuries requiring no intervention (bruise)				
Minor fall, first aid applied (cut/graze)				
Fall requiring medical review but no change in care plan (e.g head injury)				
Fall requiring medical review requiring some investigations				
Fall requiring medical review, resulting in transfer to A+E				
Fall with major concerns by staff resulting in emergency services				

In order of preference

Person to be contacted	Relationship	Telephone number	Notes (e.g. Availability)

Determine cause and update care plan

Including MDT determine cause of fall and what future actions are needed to reduce falls risk. Consider use of falls huddle form, encouraged to be used for older peoples ward falls and can be used with other falls if it is felt appropriate.

Medical Assessment

Doctor to assess as soon as possible.

- Post fall assessment should include:
- Obtain history from patient and staff .
- Consider underlying causes such as postural hypotension. If a fracture has occurred consider whether it could be due to osteoporosis, metastatic bone disease.
- Check for injuries. Review and prescribe analgesia if necessary.
- Assessment of observations for haemodynamic stability
- Neuro observations
- Musculoskeletal examination
- Neurological examination (as appropriate)
- Review of medications
- If restriction of movement or mobility/problem continues after 24 hours consider further investigation such as X-ray

Capacity

- A patient's capacity regarding treatment regarding the fall should be assessed specific to decision and time
- In the case of a refusal of treatment the capacity assessment should be clearly documented and decisions based on the capacity assessment should be justified

- The designated relative should be informed and their views sought to contribute to decisions

Post fall assessment should include:

Mobility

If patient has balance and/or mobility issues then refer to physio. If fall occurs when physiotherapy staff are not available and patient is unsteady and/or normally mobilises with a walking aid that they do not currently have consider use of wheeled walking frame and supervision/assistance when walking until patient can be reviewed by physio.

Physiotherapy (if physiotherapy available and if patient has balance/mobility issues):

- Physiotherapy assessment may include assessment of balance and mobility, walking aid review.
- The following may be used based on physiotherapy clinical judgement:
    - Standard assessment procedures (Timed Unsupported Stand, Walk and talk, Timed Up and Go, Forward reach, 180 degree turn);
    - Non-standardised assessments e.g. (Sternal nudge, picking an object up off the floor);
    - Formal balance assessment scales e.g. (Tinetti, Berg, ConfBal etc).
- Consider use of walking aids, 1:1 and group strength and balance exercises.

Occupational Therapy (if Occupational Therapy available and if patient has difficulty with activities of daily living):

- To assess and appropriately treat/manage patient if fall was related to bed, toileting, washing, dressing or other activity of daily living.

Moving and Handling:

- Selecting most appropriate moving and handling approaches to use.
- Also identifying equipment and highlighting any training for use of equipment.

Nursing assistants

- To follow Care Plan regarding how the patient walks, toilets, gets washed and dressed.
- To ensure patients wear suitable footwear.
- To assist patients if they appear unsteady.

Glasgow Coma Scale

Due to the nature of Mersey Care NHS Trust most clinical staff would not have the opportunity to use the Glasgow Coma Scale (GCS) assessment tool on a regular enough basis to be competent in its use. Also the GCS can be difficult to calculate with some mental health and learning disability patients. Therefore Mersey Care NHS Trust uses AVPU to assess levels of consciousness and any change in AVPU should be assessed and the patients should be transferred to an acute hospital for further assessment, diagnosis and treatment

NICE Head Injury Guidelines

In line with NICE CG176 (Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults) all patients who have sustained a head injury should be transported directly to a hospital with the resources to further resuscitate them and to investigate and initially manage multiple injuries. Thus Mersey Care NHS Trust would ensure patients transferred to an acute hospital either using an ambulance or other forms of transport provided patient is accompanied by a competent adult. The referring professional should determine what transport is required based on the patient's clinical condition. Transfer to acute care due to possible head injury should occur in the following situations:

References

NICE (2014) Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults CG 176
http://www.nice.org.uk/guidance/CG176

National Patient Safety Agency (NPSA), (2007), Slips, Trips and Falls,
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59821

NPSA (2011) Essential care after an inpatient fall
http://www.nrls.npsa.nhs.uk/alerts/?entryid45=94033Royal College of Physicians, (2012), Implementing Fallsafe Care bundles to reduce inpatient falls,
https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original

Appendix C

Community Falls Algorithm

If someone reports a fall in previous 12 months this falls algorithm can be used to guide assessment and management.

Please provide service users who have fallen with a trust falls leaflet.

Falls risk factor	**Community**
Unsteadiness, weakness or other walking problems	Refer to physiotherapy
Osteoporosis or previous fracture	If patient not on osteoporosis medication consider their use. Please ask GP to review.
Difficulty doing activities of daily living e.g. getting dressed, going to the toilet, getting in and out of bed etc.	Refer to OT
Patient is on their own sometimes or lives with other frail people and so would benefit from Lifeline.	Refer to OT
Vision problems	Encourage to be reviewed by opticians.
Dizziness or blackouts	Check lying and standing blood pressure for postural hypotension. Ask GP to review. (Consider referral to Physiotherapy)
Increased urination / pain when urinating	Ask GP to review.
Continence problems	Refer to continence service
Taking medication associated with falls risk (e.g. sedation, antidepressants, sleeping tablets, anti-psychotics, diuretics, 4 or more medication)	Doctor or pharmacist to review.
Fear of falling	Consider referral to psychology.
Foot pain / problems	Refer to chiropody / podiatry
Poor footwear e.g. backless, poor grip, ill fitting	Encourage to buy more suitable footwear.
Patient reports rugs/obstacles at home that they have fallen over	Refer to OT. Advice about moving rugs and having clear pathways.

Appendix D Risk Control Checklist for Slips, Trips, Falls and Falls from Height.

RISK ASSESSMENT CHECKLIST		
Slips – Common Hazards	***Examples***	***Tick if present***
Inappropriate floor surfaces	▪ Slippery surfaces that require anti-slip coating; ▪ Inappropriate cleaning/polishing; ▪ Unsuitable surfaces on external fire escapes	
Areas that may have liquid on the floor	▪ Wet surfaces near external doors where traffic and weather brings in rain; ▪ Areas around sinks/toilets/showers etc; Polishing/wet cleaning of floors ▪ Inadequate barrier matting around entrances	
Wet spills and contamination of floors	▪ Spillage of drinks and food; Spillage from the carriage of chemicals/specimens; ▪ Contamination of floor with blood and body fluids; ▪ Spillage of oil etc in workshops	
Dry contamination of floors	▪ Accumulation of lint or dust; Spillage of talcum powder	
Inadequately drained floor surfaces in wet areas	▪ Toilets, washrooms and bathrooms	
Sudden changes in floor surfaces	▪ Carpeted offices to polished floors	
Snow/ice on external approaches	▪ Car park areas, external pathways and steps ▪ Poor gritting and salting procedures that react too late to the hazard	
Growth over floor surfaces	▪ Moss on external pathways, mould in showers or toilets ▪ Decking areas becoming slippery due to algae growth	
Slips - Footwear	***Examples***	***Tick if present***
Safety footwear is used to protect Against crushing hazards without consideration of slip resistance	▪ Worn treads on soles of shoes or boots; No risk-based procedure for ordering safety footwear that considers the area and type of use	
Inappropriate footwear worn for the task	▪ High heeled shoes worn on step stools or step ladders to access storage or filing ▪ “Flip flop” type shoes ▪ Smooth soled slippers	
Slips – Ramps	***Examples***	***Tick if present***
Ramps that are too steep or with slippery surface	▪ External concrete ramps	
Hand trucks and trolleys used on ramps	▪ Hand trucks, trolleys and roll cages used on ramps without edge protection	
Trips – Common Hazards	***Examples***	***Tick if present***
Internal floor surfaces	▪ Broken tiles; Worn floor coverings; Uneven floor surfaces; ▪ Poorly maintained access routes; Changes in level	
External access or egress to the workplace	▪ Uneven or loose paving; Footpaths and garden edging poorly maintained; ▪ Car parks in poor condition	
Storage of equipment in aisles and walkways	▪ Surplus equipment; Trolleys and wheelchairs; Stores deliveries (roll cages); Laundry bags; Boxes of medical records etc.	
Storage of personal items around workstations	▪ Handbags, briefcases on floor by desks	

Trips – Common Hazards continued	***Examples***	***Tick if present***
Low obstacles where employees need to walk	▪ Protruding items from shelves at low levels; Desk/filing draws left open ▪ Dishwasher doors left open	
Trailing cables	▪ Use of vacuum cleaners/polishers; Computer equipment; ▪ Inspection lamps, Medical devices in use on ward	
Unsuitable carpets/matting	▪ Carpets that have stretched causing 'ripples', Entrance mats with turned up edges; Loose or unsecured mats on polished floors	
Untidy work areas	▪ Workshop with tools, waste or materials on floor; ▪ Cluttered storage areas	
Trips – Steps and Stairs	***Examples***	***Tick if present***
Condition of steps and stairs	▪ Steep or slippery steps and stairs	
Inappropriately designed steps and stairs	▪ Steps with inadequate foot space; ▪ Rise and going of steps in staircase inconsistent in size; ▪ Slip resistant nosing creating a heel-catch hazard ▪ Round edged metal nosings	
Steps and stairs that have poor lighting	▪ Nosing or treads poorly defined visually	
Landings	▪ Small or missing landings where doors open directly onto stairs	
Isolated low steps	▪ Isolated low steps particularly at doorways and entrances	
Hand or guard rails	▪ Lack of suitable handrails or guardrails on steps or stairs	
Carrying loads on stairs	▪ Carrying a load which prevents an employee from gripping a handrail; ▪ Carrying a large load that prevents the employee seeing the steps beyond the load	
Falls from height	***Examples***	***Tick if present***
Un-protected windows	▪ Windows without restrictors or restrictors with inadequate strength	
Balconies	▪ Access to unprotected balconies and areas with significant drops	
High shelving	▪ Inappropriate items used to stand on ▪ Steps without handrails, kick stools	
Cleaning at high level	▪ Inappropriate items used to stand on ▪ Steps without handrails, kick stools ▪ Inappropriate tools to reach high areas	
Retaining walls	▪ Low retaining walls easily scaled with significant drops, un signed if unsighted	
Maintenance work	▪ Use of inappropriate access equipment, ladders and steps ▪ Roof work without edge protection ▪ Fragile roofing materials and skylights ▪ Lack of fall arrest equipment ▪ Adverse weather	
Falling materials	▪ Building materials, tools etc. falling down onto workers and public below	

RISK CONTROL EXAMPLES

Slips – Common Hazards	▪ Increase micro-roughness of surface of existing floors; acid etching, sandblasting, grinding or replacement ▪ Use slip resistant floor surface in areas where ice, grease or dust create a slipping hazard ▪ Establish an effective cleaning and maintenance program ▪ Ensure system for hazardous warning signs and procedures for the immediate management of spills ▪ Maintain equipment to prevent leakage or repair any leakage immediately ▪ Cleaning of floor surfaces outside working hours OR, if not practicable, use an effective system to exclude personnel from floors that may be hazardous until dry after cleaning ▪ Ensure effective drainage of outdoor ground surfaces ▪ Abrasive materials can be applied to concrete, metal and wood surfaces to reduce slips and falls ▪ A number of slip-resistant products can be purchased in strips and rolls and can be applied to stair treads, ramps and other hazardous walking or working surfaces ▪ Ensure that suitable mats are located at entrances ▪ Install suitable drainage in wet areas ▪ Keep outside areas free of leaves, mud clipping, paper and gravel; remove moss or slime with suitable cleaner ▪ Establish a procedure for cleaning and gritting of snow/ice during winter months
Slips - Footwear	▪ Ensure suitable footwear is chosen using a risk-based procedure that considers the area of use – refer to supplier and manufacturer specifications for selection of footwear for different surfaces and risk factors ▪ Ensure suitable footwear is worn when doing the task
Slips - Ramps	▪ Ramps should be made slip resistant with foot grips or textured surfaces ▪ Ensure the slope of a ramp is no more than 1 in 8. If the ramp is accessed by wheelchair users then the maximum slope should be 1 in 12 ▪ Ramps should be fitted with handrails, and have mid-rails and kick rails to prevent trucks and trolleys running off the edge
Trips – Common Hazards	▪ Regularly inspect and maintain uneven, worn or damaged surfaces ▪ Regularly inspect and maintain external access areas ▪ Designate safe areas for storage of trolleys and equipment ▪ Provide adequate storage facilities for goods ▪ Ensure aisles and passageways remain clear at all times ▪ Keep work areas tidy ▪ Slip resistant doormats at entrances should be secured or large enough to remain in place
Trips – Steps and Stairs	▪ Use non-slip bull nose finish on steep or slippery steps and stairs ▪ Only use steep stairways for secondary access and ensure they have sturdy handrails on both sides ▪ The rise and going of each step in a stair should be consistent in size ▪ Paint or fix a high-visibility strip on the nosing of steps/stairs that are poorly lit ▪ Ensure there are sturdy handrails or guardrails on all platforms, steps or stairs ▪ Use lifts for the carriage of goods upstairs where possible
Falls from height	▪ Fitting of robust window restrictors ▪ Securing access to roofs, balconies etc. ▪ Planning of any work at height which cannot be avoided ▪ High signed fencing of areas with significant drops ▪ Removing high shelving or providing appropriate access equipment with handrails ▪ Avoidance by using reach handles etc. or provision of appropriate access equipment for high cleaning where unavoidable ▪ Appropriate access equipment for maintenance work ▪ Edge protection on roofs, voids and trapdoors ▪ Provision of fall arrest equipment such as lanyards and safety netting to limit the distance of any fall ▪ Toeboards, coverings and netting to prevent tools and materials falling onto persons below

Appendix E Ward Falls Driver

Primary drivers describe the systems / larger components which will contribute to achieving the overall aim. Each usually has an associated measure

Secondary drivers are elements of the associated primary driver. They are interventions which can be used to create projects or change packages that will affect the primary driver.

GOAL

To reduce falls by avoidable falls by 50%.

Balancing Measure
Ensure the overall incident reporting level does not fall across wards

1 **ASSESSMENT**
Every service user over 50 yrs old is assessed for risk of Falls (FRAT)

- All patients identified as high risk of falls receive individual Falls risk care plan

2 **LEARNING / DEVELOPMENT**
The multi-disciplinary team have clear roles and responsibilities and there is family involvement

- Roles and Responsibilities of all stakeholders are understood by all
- Staff Training
- Communication at Handover
- Visual reminders of Falls risks
- Identify Falls Champions

3 **TREATMENT**
to reduce the risk of falls

- Assess patients
- Vision
- Postural Hypotension
- Intentional rounding comfort checks
- Continence / toileting

4 **MONITORING**
Identify improvement

- Zonal Obs
- Falls Dashboard
- Datix Reports
- Safety Thermometer
- Medication / changes
- Policy compliance / standards
- PDSA measures
- Falls Checklist
- Mini RCA / Audit against stds
- Pharmacy advise / flag medication
- Process for stopping / starting psychotropic meds
- Care Zoning

5 **PHYSICAL ENVIRONMENT**
Ensure free from hazards

- Environmental checks (LEAN)
- Footwear review
- Check walking aids
- Assisted Technology
- Lighting

Appendix F Community Falls Driver

Primary drivers describe the systems / larger components which will contribute to achieving the overall aim. Each usually has an associated measure

Secondary drivers are elements of the associated primary driver. They are interventions which can be used to create projects or change packages that will affect the primary driver.

GOAL

To measure falls using the safety thermometer and ensure appropriate falls management from Mersey Care Foundation NHS Trust for community patients.

1 **ASSESSMENT**
Identify need for further intervention

- **1st Contact:** All patients to be asked if they have had a fallen in last 12 mths if yes consider further multifactorial falls assessment and management,

2 **LEARNING / DEVELOPMENT**
The multi-disciplinary team have clear roles and responsibilities and there is family involvement

- Roles and Responsibilities of all stakeholders are understood by all
- Staff Training
- Fall leaflet (Community)
- Prompts re falls management in care planning

3 **TREATMENT**
Individualise care plan to reduce the risk of falls

Refer for

- Vision
- Postural Hypotension
- Continence / toileting
- Exercise/strength & balance training
- Home adaptations
- Medication review with modification / withdrawal – RCP guidance

4 **MONITORING**
To identify improvement

- Datix Reports
- Safety Thermometer
- Medication / changes
- Policy compliance / standards
- PDSA measures
- Mini RCA / Audit against standards
- Pharmacy advise / flag medication
- Process for stopping / starting psychotropic meds

5 **PHYSICAL ENVIRONMENT**
Ensure free from hazards

- Home hazards checks – declutter / suggest
- Footwear review
- Check walking aids
- Assisted Technology e.g. medicare
- Lighting

Appendix G Post Fall Huddle Form

Post Fall Huddle Form

Name:

Number: **NHS No.**

Date: **Time:**

How did the service user Fall?			
WHY?			
WHY did this happen?			
WHY did this happen?			
WHY did this happen?			
WHY did this happen?			
Root Cause(s) of Fall determined:			
Measures taken that directly address the root cause(s) of the fall. Post fall actions to be reviewed at weekly falls review.			
Action	**Yes/No**		**Yes/No**
Refer to MDT		**Refer to Physiotherapy**	
Refer to OT		**Refer to Moving & Handling**	
Increased observation		**Medication to be reviewed**	
Physical investigations		**Care plan updated**	
Equipment Review		**Low bed to be provided**	
Bed/Chair sensors provided		**Staff Education**	
Other Actions:			