NHS
Mersey Care
NHS Foundation Trust
Community and Mental Health Services

TRUST-WIDE CLINICAL POLICY DOCUMENT

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

Policy Number:	**SA30**
Scope of this Document:	**All Staff**
Recommending Committee:	**Trust Falls Group**
Approving Committee:	**Executive Commitee**
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Lead Executive Director:	**Executive Director of Nursing and Operations**
Lead Author(s):	**Highly Specialist Physiotherapist**

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2019 - Version 6

Striving for perfect care and a just culture

Mersey Care NHS
NHS Foundation Trust

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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 & Risk Management Policy** **•SA03 Reporting, Management & Review of Adverse Incidents** **•SA07 Health, Safety and Welfare** **•SA10 Use of Clinical Risk Assessment** **•SA11 Manual Handling** **•SA26 Use of Bed Rails** **•SD29 Physical Health Care** **•HR21 Recruitment and Selection** **•HR28 Induction and Mandatory Training**
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
Version 6	Reviewed and amended by AHP's and Clinical Leads with updated NICE guidance (2017). Added about managing falls risk when combined with aggression, altered author phone number, updated community falls management, updated trust logo. Updated inpatient falls management.	November 2019

SUPPORTING STATEMENTS

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

SAFEGUARDING IS EVERYBODY'S BUSINESS

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

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / 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 / 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 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 Foundation 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 Foundation 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 Foundation 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 Foundation 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

Contents

1. Purpose and Rationale

1.1 Significant consequences occur as a result of slips, trips and falls every year. 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. Service users 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, 2017). 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 2017). Environmental factors only contribute to a small proportion of falls (NPSA, 2007). Service users in acute settings are at greater risk of falling than community dwellers, this may be because they are more likely to have an acute illness, delirium or dementia (NPSA 2007 and NICE 2017).

1.5 In 2015/16 the National Reporting and Learning System (NRLS) recorded 4.9 falls per 1000 days in mental health settings (NHS Improvement, 2017). It is estimated that falls cost the NHS more than £2.3 billion pounds a year (NICE, 2017). Multifactorial clinical and environmental interventions (including factors such as muscle strength, medication, environmental hazards) can reduce falls risk (NICE, 2017). 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 and objective of this policy 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. Thus this policy:

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

2.2 All witnessed slips, trips and falls (including near misses) be reported by clinical staff using the Trust's Datix or Ulysses, electronic incident reporting system.

2.3 The circumstances of falls should be described completely and meaningfully on the Datix or Ulysses 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. Duty of Candour should be considered and applied where applicable according to Regulation 20 of the Health and Social Care Act. Examples may include death for inpatients; severe harm for inpatients e.g. hip fracture; inpatient or community service users who had a significant gap in our care which caused significant harm.

2.5 All service users identified as being at high risk of falls will have a Falls Care Plan.

2.6 Community service users identified as being at risk of falling and with a history of falling who are not already receiving falls management must be signposted to appropriate falls services.

2.7 All services users identified at risk of falling on elderly wards will have intentional rounding.

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

- Occupational Therapy assessment
- Physiotherapy assessment including Physiotherapist judgement on future physiotherapy input (if physiotherapy available)
- Care Plan including falls risk factors e.g. mobility, footwear, medication, health conditions.
- 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
- A Trust Falls Leaflet provided to service user and/or Carers
- Review of previous falls assessment and management to check if previously reviewed by Falls Clinic/Falls Team
- Awareness raised at the surveillance meeting that service user is at high risk of falling.
- Falls warning symbols used by bedside, in nurses office and on medication card.
- Falls risk discussion at handover.

2.9 All wards and departments will need to carry out a Risk 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 service user 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:

1. Service user has a history of placing themselves on the ground.
2. Service user found in a typical position, i.e., they are found in a position typical of their recorded behavious.
3. No harm is sustained.

5. Duties

5.1 **Executive Director of Nursing and Operations:** Overall accountability for developing nursing practice and accountable officer for Falls policy.

5.2 **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.

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

5.4 **Datix Team** Datix team receive incident reports regarding falls

5.5 **Patient Safety Department** will raise concerns about any significant issues relating to falls and liaise with trust falls meeting.

5.6 **Health & Safety Advisor** will provide advice on managing and preventing falls as required.

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

- Risk assessments are carried out which cover their areas of responsibility and that appropriate actions are taken
- Duty of Candour should be considered and applied where applicable.
- Care plans are developed and implemented to manage identified risks.
- Where appropriate a Bed rails 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 **Community Falls Specialists:**

- To provide advice and support to staff in relation to the management of falls of service users.
- To provide service user information to support staff, service users and carers.

5.9 **Staff 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/shoes with a back)
- Receive falls awareness training where relevant.

6. Process

6.1 **Quality Governance**

6.2 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.

6.3 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.

6.4 **Environment**

6.5 Environmental factors that may impact on falls risk are listed in appendix C.

6.6 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.

6.7 **Relevant Legal, Statutory and Professional Requirements**

6.8 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, 2018).
- 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).

6.9 Reporting of Slips, Trips and Falls

6.10 All witnessed slips, trips and falls (including near misses) be reported by clinical staff **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, Ulysses 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
- Outcome of investigations
- Type of injury
- If a fall from bed, were there bedrails
- Floor wet/dry
- Footwear
- Walking aid in use
- Mental state
- Days since admission
- Medication affecting risk of falls

6.12 The drop down falls boxes on Datix should be completed as fully as possible.

6.13 The reporter, reviewer and DATIX administrator agree the level of severity as follows:

- No harm: Where no harm came to the service user.
- 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)

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

6.15 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, 2017).

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

6.17 **Risk Assessment**

6.18 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. Where possible this will be done via completion of the Workplace Inspection risk assessment quarterly in line with Trust Policy SA07 (Health Safety & Welfare Policy) and the appropriate action taken to reduce the risk so far as is reasonably practicable.

6.19 Community teams (including those working in care homes, nursing homes, Service users' own homes and clinics) will complete an environmental risk assessment that is appropriate and relevant for clinical area/discipline.

6.20 **Service User Falls**

6.21 It is important that falls management balances rehabilitating service users with their right to make their own decisions about what they are willing to do to manage their falls risk however if a service user is deemed not to have capacity in relation to their falls risk a management plan should be decided in their best interest with multi-disciplinary team and family. Healthcare professionals should follow the Trust and Department of Health guidelines on consent and should appropriately follow the Mental Capacity Act and deprivation of liberty safeguards (NICE, 2017).

6.22 NICE CG161 (2017) state that all inpatients aged 65 years or older should be regarded as at risk of falling.

6.23 A multifactorial falls assessments will be completed for service users based on their needs. For more information please see individual areas' SOPs.

6.24 **Complex care wards and ward 35**
On admission all service users will be assessed using appropriate falls assessment and management plan within 24 hours of admission or as soon as is reasonably practicable. This will be reviewed regularly during the service users ward stay and if they fall during their ward stay for audit purposes. This is in line with NICE QS86.

6.25 **All Other Service User Areas**
All inpatient wards will screen for an increased falls risk using an appropriate tool. Then complete a Multi factorial assessment with service users identified using the falls screening tool.

6.26 Clinical staff who have undertaken competency training will complete falls assessments with high risk service users when appropriate.

6.27 All service users assessed with increased risk of falling should have individualised interventions as recommended by NICE guidance (NICE, 2017).

6.28 Service users identified as being at risk of falls or their carers will be provided with a falls leaflet when appropriate. Falls leaflets provide 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 Foundation Trust do about falls and who can provide more information (NICE, 2017). Falls management information will also be provided for the service user, their family members and carers (if appropriate and the service user agrees) (NICE, 2017). Falls information provision will take into account the service user's ability to understand and retain the information (NICE, 2017). Ward staff should also explain about the nurse call system if appropriate (NICE, 2017).

6.29 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, 2017). Unfortunately there is less evidence regarding the effectiveness of falls management in mental health settings particularly with regard to people with dementia (NPSA, 2007).

6.30 Services users 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 service user deliberately put themselves on the floor.

6.31 All witnessed falls in the community will have a datix completed. Ongoing work to clarify exactly which community falls will be datixed.

6.32 All inpatients who have fallen are to be reviewed by the Multi disciplinary Team re Falls management.

6.33 For Inpatients only: Enhanced observation, over and above general observations, is a therapeutic intervention with the aim of reducing factors which contribute to increased risk and promote recovery. It may be indicated that an individual who is a risk of falls might need to be supported on an increased level of observation (level 2 and above). A care plan must support the use of enhanced observations, with the service user being actively encouraged to engage in this process. The use of enhanced supportive observations must be reviewed regularly as outlined in the Supportive Observation Policy, for more information see the Supportive Observation Policy SD04.

6.34 **Post-fall protocol (NICE GUIDANCE 2015 updated 2017)** https://www.nice.org.uk/guidance/qs86/chapter/Quality-statement-4-Checks-for-injury-after-an-inpatient-fall
For inpatients a copy of the post fall protocol will be available in ward offices. The post fall protocol is part of appendix B. A post-fall protocol should include:

- Checks by healthcare professionals for signs or symptoms of fracture and potential for spinal injury before the patient is moved.
- Safe manual handling methods for patients with signs or symptoms of fracture or potential for spinal injury (community hospitals and mental health units without the necessary equipment or staff expertise may be able to achieve this in collaboration with emergency services).
- Frequency and duration of neurological observations for all patients where head injury has occurred or cannot be excluded (for example, unwitnessed falls) based on the NICE guideline on head injury. See Appendix B.
- Timescales for medical examination after a fall (including fast-track assessment for patients who show signs of serious injury, are highly vulnerable to injury or have been immobilised); medical examination should be completed within a maximum of 12 hours, or 30 minutes if fast-tracked.

6.35 As part of discharge planning consider service user's ongoing falls risk and management.

6.36 All falls resulting in moderate harm will have a 72 hour review (Being Open 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.

6.37 Consider discussing multiple falls with colleagues to determine different management strategies.

6.38 Duty of Candour should be considered and applied where applicable according to Regulation 20 of the Health and Social Care Act. Examples may include death for inpatients; severe harm for inpatients e.g. hip fracture; inpatient or community service users who had a significant gap in our care which caused significant harm.

6.39 If someone is unsteady or falling. If a member of staff is next to that service user who is unsteady or falling. They can assist in controlling that person's descent, if they have received training in controlling a person's descent to the

floor and it is safe for them to do so. Staff should summon assistance and begin assessing that person for injuries, if it is within their role to do so.

6.40 Signs of Head Injury :

- Any loss of consciousness ('knocked out') as a result of the injury, from which the person has now recovered.
- Amnesia for events before or after the injury ('problems with memory')[4].
- Persistent headache since the injury.
- Any vomiting episodes since the injury.
- Any previous brain surgery.
- Any history of bleeding or clotting disorders.
- Current anticoagulant therapy (Referred to A&E immediately).
- Current drug or alcohol intoxication.
- There are any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected).
- Irritability or altered behaviour ('easily distracted', 'not themselves', 'no concentration', 'no interest in things around them').

6.41 **Neurological Observations** : NICE Pathways Observations of a patient with a head injury. file:///C:/Users/Nlamont/Downloads/head-injury-observations-of-patients-with-head-injury-in-hospital.pdf last updated: 14 October 2019.

6.42 Neurological observations are important in unwitnessed falls because of the possibility of a unknown cranial injury or bleed.

6.43 In-hospital observation of patients with a head injury should only be conducted by professionals competent in the assessment of head injury.

6.44 For patients admitted for head injury observation the minimum acceptable documented neurological observations are:

- **GCS; pupil size and reactivity; limb movements; respiratory rate;**
- **heart rate; blood pressure; temperature; blood oxygen saturation. See recommendations on GCS.**
- **Perform and record observations on a half-hourly basis until GCS equal to 15 has been achieved.**

The minimum frequency of observations for patients with GCS equal to 15 should be as follows, starting after the initial assessment in the emergency department:

- Half-hourly for 2 hours.
- Then 1-hourly for 4 hours.
- Then 2-hourly thereafter.

- Should the patient with GCS equal to 15 deteriorate at any time after the initial 2-hour period, observations should revert to half-hourly and follow the original frequency schedule.

6.45 **Patient changes during observation that need review :**

- Development of agitation or abnormal behaviour.
- A sustained (that is, for at least 30 minutes) drop of 1 point in GCS score (greater weight
- should be given to a drop of 1 point in the motor response score of the GCS).
- Any drop of 3 or more points in the eye-opening or verbal response scores of the GCS, or 2
- or more points in the motor response score.
- Development of severe or increasing headache or persisting vomiting.
- New or evolving neurological symptoms or signs such as pupil inequality or asymmetry of
- limb or facial movement.

7. Consultation

7.1 This policy was reviewed and updated with consultation from the trust falls group, local services staff including complex care wards and older peoples Community Mental Health Teams, manual handling, community division staff, pharmacy.

8. Training and support

8.1 An online training programme has been developed in line with the Nice Falls guidance (2017) to raise awareness of falls assessment and management. It is proposed that all staff will be able to do this as part of their continuing professional development and it will be role specific mandated for appropriate clinical staff.

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.

8.4 Neurological observation trainng and GCS training will be delivered to staff.

9. Monitoring

9.1 All services will monitor the number of incidents within their area and review risk assessments, actions taken, interventions and care plans as appropriate.

9.2 The Trust wide Falls Prevention Group will examine best practice across disciplines and monitor compliance against NICE clinical guideline CG161 and NICE quality standard QS86.

9.3 An inpatient falls audit is completed yearly.

9.4 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 and location Managers) as necessary and provide a report to the Trust Health & Safety and Infection Control Committee on an annual basis.

9.5 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.

9.6 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.

9.7 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.

9.8 Falls information will be reported to the QAC via the safety report three times a year to look at trends and receive assurances on the actions being taken.

9.9 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.

9.10 In line with CCG7: Three high impact actions to prevent Hospital Falls there will be quarterly submission via National CQUIN collection of 80% of older inpatients receiving key falls prevention actions. The demoninator being admitted patients aged over 65 years, with length of stay at least 48 hours. Exclusions are patients who were bedfast and/or hoist dependent during their stay and patients who die during their hospital stay. The three specified falls prevention actions are:

- Lying and standing blood pressure recorded at least once.
- No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics or antipsychotics or anxiolytics).
- Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

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 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:	Three times a year.
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 report presented to the Trust Health & Safety Committee by the Health and Safety Advisor. Known breaches will be discussed at the Trust Health & 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' care plans and a reduction in falls.

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

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 2020	Trust Falls Meeting.

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? *Include outline of objectives and function aims* The aim of this procedure is to ensure efficient and effective management of slips, trips and falls. Developed in line with guidance from NICE (2017), Management of Health and Safety at Work Regulations (1999), Work at height Regulations (2005).
Who will be affected? *e.g. staff, service users, etc* All service users, staff, visitors and contractors

Evidence
What evidence have you considered? Policy only …This is a Policy review.
Disability (including learning disability) No significant issues.

Sex No significant issues. Gender differences in falls rates will be reviewed at Trust Falls Meetings
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.* No significant issues.
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.* Older people are more likely to fall. This Policy covers all adults (over 18+ years).
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.* No significant issues.
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.* No significant issues.
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.* No significant issues.
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.* No significant issues.
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.* Requirement to discuss falls issues with carers. Communication guidance available for how and when families wish to be contacted regarding ward falls in falls policy. Service user's care plans and notes may include further information on liaising with carers.
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.* No significant issues.
Cross Cutting *implications to more than 1 protected characteristic* People who have multiple falls risk factors e.g. increased age, frailty, cognitive impairment and physical disability are more likely to fall (NICE, 2017).

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	*Use not engaged if Not applicable* Supportive of HRBA.
Right of freedom from inhuman and degrading treatment (Article 3)	*Use supportive of a HRBA if applicable* 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 *detail any engagement and involvement that was completed inputting this together*

No engagement undertaken as this was a review of this Policy.

Summary of Analysis *This highlights specific areas which indicate whether the whole of the document supports the Trust to meet general duties of the Equality Act 2010*

Eliminate discrimination, harassment and victimisation
Policy is supportive.

Advance equality of opportunity
Not engaged.

Promote good relations between groups
Not engaged.

What is the overall impact?

Addressing the impact on equalities
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

Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- Plans already under way or in development to address the **challenges** and **priorities** identified.
- Arrangements for continued engagement of stakeholders.
- Arrangements for continued monitoring and evaluating the Policy for its impact on different groups as the Policy is implemented (or pilot activity progresses).
- Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies.
- Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results.
- Arrangements for making information accessible to staff, service users and the public
- Arrangements to make sure the assessment contributes to reviews of DoH Strategic Equality Objectives.

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
Band 7
Physiotherapist

Caroline Dawn
AHP Lead

Caroline Angell
OT Team Lead for North Liverpool

Date assessment completed:

10th December 2018

Name of responsible Director:

Executive Director of Nursing and Secure Services

Date assessment was signed:

10th December 2018

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.)

Service User……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 service user on four or more medications?		
3.	Does the service user have epilepsy, seizures or a neurological condition, i.e. Stroke or Parkinsonism?		
4.	Does the service user (or carer) report any problems with their balance?		
5.	Is the service user 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 the service user is at risk of a fall and must therefore receive a multifactorial falls assessment and management.

(Nandy et al, 2004).

Post Fall Protocol

Appendix B

Service User falls

Witnessed or unwitnessed Ensure Nurse in charge and Doctor aware of fall and subsequent actions

Complete physical observations including NEWS2 Physical Obs and Early Warning Scores.

All service user falls should be reviewed by a Doctor as soon as possible. Check and remove obvious hazards.

If balance/mobility issues refer to physiotherapy for review

If problems with activities of daily living refer to OT.

No injury

No pain

No mobility changes

No change in sensation

No change in current presentation

No pain

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

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

Suspected injury or unwitnessed fall/patient found on ground

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

Head injury/Spinal Injury/Hip fracture

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

Check Airway, Breathing, Circulation (ABC)

DO NOT MOVE

Neuro obs

Contact ambulance or medical team and transfer to A&E. Inform responsible medics or senior nurse within 30 minutes

Other injury including soft tissue injuries, suspected fracture

Assist service user up using correct manual handling techniques

Nursing staff to monitor physical obs until medical review.

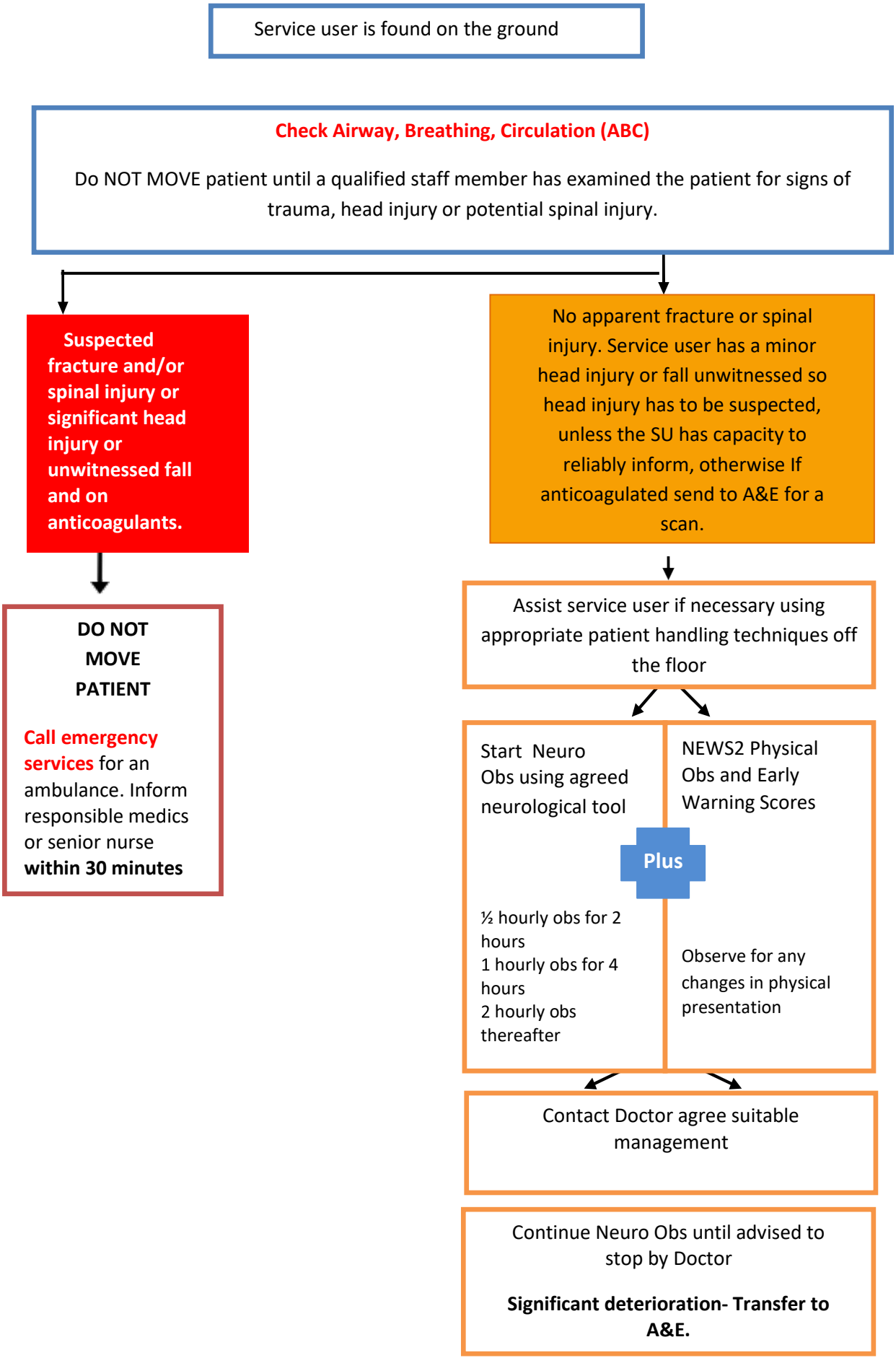
Medical staff to review and send to acute hospital if needed e.g. suspected fracture.

Offer pain relief if necessary

Clean and dress any wounds

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

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


Service user is found on the ground
Check Airway, Breathing, Circulation (ABC)
Do NOT MOVE patient until a qualified staff member has examined the patient for signs of trauma, head injury or potential spinal injury.
Suspected fracture and/or spinal injury or significant head injury or unwitnessed fall and on anticoagulants.
DO NOT MOVE PATIENT
Call emergency services for an ambulance. Inform responsible medics or senior nurse within 30 minutes
No apparent fracture or spinal injury. Service user has a minor head injury or fall unwitnessed so head injury has to be suspected, unless the SU has capacity to reliably inform, otherwise If anticoagulated send to A&E for a scan.
Assist service user if necessary using appropriate patient handling techniques off the floor
Start Neuro Obs using agreed neurological tool
½ hourly obs for 2 hours
1 hourly obs for 4 hours
2 hourly obs thereafter
NEWS2 Physical Obs and Early Warning Scores
Plus
Observe for any changes in physical presentation
Contact Doctor agree suitable management
Continue Neuro Obs until advised to stop by Doctor
Significant deterioration- Transfer to A&E.

Mersey Care NHS
NHS Foundation Trust

NAME:	
DOB :	
NHS NO:	Ward:

Inpatient Falls Screening Tool

If a **YES** answer is given to any **3** questions the patient may be at increased risk of falls. Therefore the corresponding management plan **MUST** be completed.
A patient may also provide other evidence during assessment not highlighted in the screening tool which may indicate the need for further assessment.

		Date/Time of Initial Assessment		Date of Re-Assessment		Date of Re-Assessment		Date of Re-Assessment	
		YES	NO	YES	NO	YES	NO	YES	NO
1	Has the patient fallen within the last 12 months?								
2	Is the patient expressing a fear of falling? (consider toileting needs, continence and level of anxiety)								
3	Does the patient appear disorientated, more confused than normal, restless?								
4	Is the patient >55yrs and prescribed 4 or more medications?								
5	Does the patient have difficulty independently standing from a chair of knee height?								
6	Does the patient have a current or previous neurological diagnosis or impairment?								
7	Does the patient require assistance to mobilize and or transfer?								
8	Does the patient have vision or hearing difficulties?								

Is the patient assessed as at risk of falls? □Yes □No

Date Multifactorial Management Plan commenced …….

Comments:

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NHS Foundation Trust

<table>
<tr><td>NHS No.
Name:
DOB:</td><td colspan="4">Multifactorial Falls Management Plan
(to be completed for all patients identified as at higher risk of falling and reassessed weekly following a fall)</td></tr>
<tr><td>Hourly rounds commenced ☐ YES ☐ NO ☐NA
Increased level of observations ☐ YES ☐ NO ☐ NA
(If so what frequency?)</td><td colspan="4">Sensor Pads: ☐ YES ☐ NO Higher
visibility bed location: ☐ YES ☐ NO ☐ NA
1:1 Care required? ☐ YES ☐NO</td></tr>
<tr><td>RISK AREA:</td><td>Date of initial assessment
...../......../.......</td><td>Review date
...../......../.......</td><td>Review date
...../......../.......</td><td>Review date
...../......../.......</td></tr>
<tr><td>MEDICATIONS:
Is the patient unsteady as a symptom of a condition?
e.g. Parkinson's
Is the patient confused?
Does the patient have Polypharmacy?</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>MEDICAL STATUS:
Does the patient have a known infection?
Is the patient at risk of seizures?
Does the patient have unstable Diabetes?
Excessive pain symptoms?
Any known cardiac conditions?
e.g bradycardia / syncope
Osteoporotic risk factors?</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>CONTINENCE & TOILET:
Urinalysis required on admission?
Is the patients falls risk associated with toileting?
Toileting aids required?</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>GAIT & BALANCE:
Need assistance to transfer or mobilize?
Does the patient have an appropriate walking aid?</td><td>☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>EYESIGHT & HEARING:
Able to recognize a pen from the end of the bed?
If wearing glasses, are they available to hand / clean?
Can the patient hear conversational speech?
If using hearing aid is it to hand and working?</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>BED:
Is the patient at risk or likely to fall out of bed?
(consider use of a low rise bed and 1:1 care)
Is the bed at its lowest possible height?
(do not lower if lowering height reduces level of indep)
Is the patient confused or agitated?
(consider use of rails – complete bed rails risk assessment)
Patient / relative consented to rails?</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td><td>☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>WARD POSITION:
Is the patient being cared for in the most appropriate -ward location?</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Comments:</td><td colspan="4"></td></tr>
</table>

Mersey Care NHS
NHS Foundation Trust

Name: DOB: NHS No.	**Multifactorial Falls Management Plan** (to be completed for all patients identified as at higher risk of falling and reviewed weekly or following a fall)

MEDICAL STATUS *example actions; medical review, polypharmacy review, completion delirium screen, urinalysis, lying and standing BPs, pain management, ECG*	**Review Dates**	**Assessor Initials**
Actions taken ☐Lying & Standing BPs ☐Medications / Polypharmacy review ☐NEWS2		

CONTINENCE CARE / TOILETING CARE *example actions; urinary continence screen, constipation management, toileting equipment*	**Review Dates**	**Assessor Initials**
Actions taken		

GAIT / MOBILITY *example actions; Physiotherapy assessment, mobility status and assistance required, appropriate walking aid provided, positioned close to patient, appropriate footwear available.*	**Review Dates**	**Assessor Initials**
Actions taken ☐Mobility assessment completed (Date……..)		

EYESIGHT & HEARING *example actions; hearing aids working, well-fitting hearing aids / glasses. bedside vision test*	**Review Dates**	**Assessor Initials**
Actions taken		

BED & CHAIR *example actions; chair at appropriate height, bed rails, low rise bed, falls prevention alarm*	**Review Dates**	**Assessor Initials**
Actions taken		

WARD POSITION *example actions; higher visibility bed, close observations / care (1:1 or cohort / tagged bay observations) ward area/bed space free of clutter.*	**Review Dates**	**Assessor Initials**
Actions taken		

Universal falls precautions advice provided and falls prevention information sheet given?

YES / NO (if no why not?)

Completed by: (Print) **Signature:** **Date:**

Mersey Care NHS
NHS Foundation Trust

NHS No.
Name:
DOB:

Post Falls Checklist & Management Plan

	1st Fall	2nd Fall	3rd Fall
	Date: Time:	Date: Time:	Date: Time:
Observations			
NEWS2 Observations How often do they need to be repeated?			
Is there a suspected head injury? – or was the fall witnessed to suspect a head injury? If YES then neurological observations and frequency must be commenced using the GCS (Glasgow Coma Scale) proforma and frequency as per NICE Guidance.			
Is the patients airway, breathing and circulation compromised as a result of the fall?			
Initial Checks of the Patient for injuries			
Is the patient complaining of any pain? If so where? Is there any loss of consciousness? Is there any limb deformity? If yes, where? Is the patient complaining of feeling lightheaded or dizzy? Are there any obvious injuries e.g. bruising / lacerations. If yes, where?			
Making the patient safe			
Has any equipment been used to assist the patient up after a fall? Any pain relief required? If yes what was given?			

Mersey Care NHS
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NHS No.
Name:
DOB:

	1st Fall	2nd Fall	3rd Fall
Charge Nurse or Nurse in Charge			
Does the patient have any medication high risks or medical high risks e.g. Anticoagulants.			
Name of Dr or ANP / ACP informed? Who informed the carer / NOK?			
Has a DATIX form been completed? WEB No:			
Nurse in Charge or Therapist			
Nurse in Charge to review previous actions and consider: ☐Sensor pads ☐Low profile bed ☐1:1 care	☐Hourly intentional rounds ☐Sensor pads ☐Move patient to better location ☐1:1 care	☐ Hourly intentional rounds ☐Sensor pads ☐Move patient to better location ☐1:1 care	☐ Hourly intentional rounds ☐Sensor pads ☐Move patient to better location ☐1:1 care
Has hourly intentional care rounds commenced? How often?			
Senior Nurse reviewed for Being Open, if required?			
Matron / Clinical Lead			
Matron / Clinical Lead informed of Fall and DATIX reviewed.			
Actions			
MDT informed via SAFER board rounds Are there any changes to be made to the falls management plan?			
MDT / OT/Physiotherapy comments following post fall review.			
Person Completing Form			
Print / Signature:	Designation:	Date:	Time:

Appendix C

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 reobust 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

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Appendix D

Falls Prevention Tool for Intervention

FRAT Completed – Positive Responses

SCORES 3 OR MORE – IS SERVICE USER MANAGING RISK?

YES	**No**
No further interventions documented in Service Users notes, with appropriate evidence	Assess the following risk factors
Service User in Nursing Home? Signpost to Community Matron for Falls Assessment	Contact Community Physiotherapy Tel: 0151-295 3988 and/or COTART (Community Occupational Therapy) on 0151-295 3693 for advice South Sefton 0151 247 6119/6118
NEUROLOGICAL CONDITION Is this affecting the Service Users gait or balance?	Yes
MEDICATION Is Service User on 4+ medications? Are there any side effects or issues with compliance?	Yes → Discuss with Medicine Management for Medication Review Tel: 0151-295 3633
OSTEOPOROSIS RISK Has the Service User a diagnosis of Osteoporosis – are adequate amounts of calcium take?	Yes → Discuss with PD/DN/Medicines Management for advice Tel: 0151-295 3633
URINARY INCONTINENCE Is there an issue with urgency? Is there difficulty in getting to the toilet on time?	Yes → Contact Continence Promotion Service for review-also self- referral Tel: 0151-295 3993 South Sefton Virtual ward referral form.
BP Does the Service User have postural hypertension? Check lying/standing up BP. Has medication been prescribed?	Yes → Discuss with Medicines Management or contact GP/Community Matron for review
VISION Has the Services User got a visual problem affecting reading or recognising objects? Are glasses worn?	Yes → Advise visit to Optician to have a retest. Ensure glasses are clean
HEARING Has the Services User got difficulties in hearing conversational speech? Are hearing aids worn?	Yes → Signpost to GP for Audiology Assessment. Check hearing aids are in good working order
NUTRITION Has the Services User lost weight or has poor fluid intake?	Yes → MUST to be completed and if required discuss with Dietician Tel: 0151-295 3868 South Sefton Virtual ward referral form.
MEMORY/COMPHRENSION/DEPRESSION Are there any signs of memory loss, comprehension, language loss or judgement? (Conduct (AMT) 4)	Yes → Refer to GP for Assessment by Pyschogeriatrician/ contact Mersey Care

PROBLEMS WITH FEET OR FOOTWEAR	Yes	Discuss with Community Falls Team Podiatrist Tel: 0151-296 7767 South Sefton Virtual ward referral form.
WALKING AND GAIT Has the Service User problems/lack of confidence with mobility & balance indoors/outdoors or difficulties with transfers?	Yes	Seek advice from Community Falls Team Tel: 0151-296 7767 South Sefton 0151 247 6119/6118
ACTIVITIES OF DAILY LIVING Does the Service User have difficulties with daily living tasks as a result of poor balance or a fear of falling?	Yes	Consider discussing with Community Falls Team Tel: 0151-296 7767 South Sefton 0151 247 6119/6118
GETTING UP FROM THE FLOOR Has the Service User the ability to get up from the floor?	Yes	Consider discussing with Community Falls Team Tel: 0151-296 7767 South Sefton 0151 247 6119/6118
ENVIRONMENTAL HAZARDS Are there home hazards which will increase the risk of falls e.g: Spillages, uneven flooring, work carpets, poos lighting?	Yes	Consider discussing with Community Falls Team Tel: 0151-296 7767 South Sefton 0151 247 6119/6118

If the Service User does not wish to consent to further intervention, provide a Falls Preventions Leaflet.

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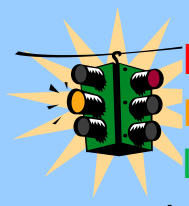
Appendix E

Medication and the Risk of Falls in the Older Person

Some drugs are more likely to be associated with falls. This chart will help you identify those drugs that may cause problems in the elderly- Adapted from RCP- Fall Safe resources(hyperlink)

Relevant drugs have been graded using a traffic light system according to their potential to cause a fall



High risk-commonly cause falls
Moderate risk-especially combinations
Low Risk – polypharmacy is a risk

Patients on four or more medications are at greater risk of having a fall and should be considered for referral for a review. Some drugs are more likely to be associated with falls and this chart helps to identify those drugs. Medication review can play an important part in falls prevention. Your local Falls Service recommends the following guidelines on medication review for all patients with falls: -

Patients with a newly recognised falls risk who are taking four or more medications, of which at least one is graded as moderate or high risk (Amber and Red sections below) should be referred for medication review as soon as possible. That medication review should give consideration to falls risk alongside the patient's other medical history.

Patients with a newly recognised falls risk taking four or more medications, where none of those medications have been graded as moderate or high risk (Amber and Red sections below), should have their medications reviewed as normal.

Drug Class	Drugs
Antidepressants Used to lift mood	**Tricyclic (TCAs) & related antidepressants**: Sedative affect :amitriptyline, clomipramine, dosulepin, lofepramine, imipramine **SSRIs**: *fluoxetine, paroxetine, citalopram, sertraline* **Others**: *venlafaxine,* duloxetine, mirtazepine **TCAs may cause drowsiness & blurred vision. SSRIs slightly less sedating. May blur vision. Risk of Hyponatraemia**
Antipsychotics including atypical Mental Health help control symptoms of schizophrenia, manic depression, paranoia.	**'Typicals'**: *haloperidol, trifluoperazine, sulpiride, chlorpromazine* **long term use is the most frequently implicated drug in causing drug induced Parkinson's disease.** **Atypicals**: *amisulpiride, aripiprazole, clozapine, olanzapine, risperidone, quetiapine-* ***sedation and slow reflexes***
Antiepileptics	**Phenytoin, Carbamazepine, Phenobarbital –** cerebellar damage, ataxia Valproate, Gabapentin, Pregabalin- anecdotal evidence of causing falls
Benzodiazepines & hypnotics (anxiety or sleeping tablets)	**Benzodiazepines:** *Diazepam,* lorazepam, nitrazepam, *temazepam, chlordiazepoxide* **Others**: zaleplon, *zolpidem, zopiclone,* **May cause hangover effects next morning. May cause unsteadiness if getting up in the night.**
Dopaminergic drugs Used in Parkinson's disease to slow the progression of the disease.	**Dopamine-boosting drugs:** *Amantadine, bromocriptine, levodopa, pergolide, rasagiline, ropinirole, rotigotine, selegline* **Sudden excessive daytime sleepiness can occur with levodopa-containing medicines (eg co-beneldopa, co-careldopa, Sinemet, Madopar & Stalevo) s. L-dopa often cause hypotension/ syncope**
Muscle Relaxants	**Baclofen, Dantrolene –** can cause drowsiness and reduced muscle tone

Antidiabetic drugs Sulphonylureas-; Insulins; DDP-4 Inhibitors (Not Metformin)	**Sulphonylureas:** Gliclazide, Glibenclamide **DPP-4 inhibitors**- alogliptin, linagliptin, saxagliptin, sitagliptin, vidagliptin **Insulins** – multiple preps **All have risk of hypoglycaemia – especially those with dietary changes**
Opiate analgesics Used to relieve moderate to severe pain.	*Buprenorphine or fentanyl (patches multiple brands), codeine, co-codamol, co-dydramol, diamorphine, dihydrocodeine, morphine, tramadol.* **Drowsiness and sedation common when starting treatment.** **Confusion reported with tramadol.**
Anticoagulants Oral and injectable	**Vit K antagonists – Warfarin, Acencoumarol, Phenindione** **DOACs- Apixaban, Dabigatran, Edoxaban, Rivaroxaban** **LMWH- Dalteparin, Enoxaparin** **These do not cause falls but are a significant risk to falls patients**

Drug Class	Drugs
ACE Inhibitors (higher risk) /angiotensin II antagonists Used to treat hypertension, heart failure and post MI.	*captopril enalapril, lisinopril, ramipril, perindopril, quinapril, fosinopril, trandolapril, losartan, valsartan. irbesartan, candesartan, eprosartan, telmisartan* **Greater risk of hypotension if taking in combination with a diuretic, incidence of dizziness varies**
Alpha-blockers Used in men to treat enlarged prostate gland, may be used to treat hypertension.	*Alfuzosin, doxazosin, indoramin, prazosin, tamulosin, terazosin* **Doses used for treatment prostate problems are generally lower dose but still likely to contribute to postural hypotension and dizziness.** ***particularly in combination with beta-blockers***
Antiarrhythmics Drugs used to control how the heart beats and keep its rhythm.	*digoxin, amiodarone, flecainide,* **Dizziness and drowsiness are possible signs of digoxin toxicity** **Flecainide has a high risk for drug interactions and can also cause dizziness**
Beta-blockers - Used to treat hypertension, angina, heart irregularities & after heart attack.	*atenolol, bisoprolol, metoprolol, nebivolol, acebutolol oxprenolol, propranolol, carvedilol, sotalol* **Reports of dizziness may be due to postural hypotension, bradycardia**
Diuretics Used to treat hypertension, heart failure and fluid retention.	***Furosemide; bumetanide*** *, bendroflumethiazide, chlortalidone, cyclopenthiazide, indapamide, metolazone. amiloride, spironolactone.* **Can cause dehydration, dizziness, confusion and postural hypotension**
Antidementia drugs For dementia	Anticholinesterases-Donepezil, Rivastigmine, Galantamine Can cause symptomatic bradycardia and syncope NMDA-Memantine– drowsiness,balance & gate problems
Antihistamines Used in hay-fever, itching and to control nausea, vomiting, and vertigo (and adds to ACB Risk)	**Those most likely to cause drowsiness include:** *Sedating - chlorpheniramine, diphenhydramine & promethazine,* ***Others include:*** *loratidine, desloratidine, cetirizine, cinnarizine, levocetirazine* **Risk of hypotension with cinnarizine is a dose related, short term use where possible and is often issued for dizziness.**
Calcium channel blockers Used in hypertension &	*diltiazem, verapamil, amlodipine, felodipine, lacidipine, nifedipine,*

angina.	**May cause dizziness or fatigue, Risk of postural hypotension**
Nitrates other antianginal drugs Used to ease angina.	*glyceryl trinitrate- especially fast acting spray, Isosorbide preps (multiple brands inc Chemydur, Monomil, Imdur etc), nicorandil.* **Syncope/dizziness due to sudden drop in BP & paroxysmal hypotension.**
Anticholinergics burden risk Used in treatment of incontinence, antispasmodics and in Parkinson's disease. **(ACB Risk)**	*Oxybutynin, solifenacin, tolterodine, trospium, orphenadrine, procyclidine, benzhexol,* **Oxybutynin may cause acute confusion in the elderly, especially those with pre-existing cognitive impairment.**
Anti-Sickness / Vestibular Treatments Medications given to treat nausea, dizziness symptoms	*Prochlorperazine- dopamine agonist long term movement disorder with antihistamine and alpha receptor blocker properties* *Cyclizine/Metoclopramide* - hypotension, sedation, slow reflexes, loss of balance *Cinnarizine, Betahistine – Sedating antihistamines no long-term benefits and can cause falls*

Using this Medication Chart in Conjunction with Falls Risk Assessment

For the purposes of carrying out a holistic falls risk assessment: -

- Where a patient is taking four or more medications, but none of those medications is graded as moderate or high risk (Amber and Red sections above) the patient should be given a negative rating for the risk factor.
- Where a patient is taking four or more medications and one or more of the patient's medications is graded as moderate or high risk (Amber and Red sections above) the patient should be given a positive rating for the risk factor.

NB: If you have any doubt as to whether or not any medications being taken by a patient belong to any of the drug families graded as moderate or high risk (Amber and Red sections above), and that patient is taking four or more medications you should give that patient a positive rating.

Appendix F

In The Event of a Fall/Post Fall Management in Care Homes

Not all falls can be prevented. Some older people will fall, regardless of preventive measures. For these residents, it is imperative to:

- Minimise the risk of injury by ensuring the environment is as safe as possible.
- Implement measures to reduce the risk of a fracture.
- Investigate the underlying causes of the incident.
- Review care plans and risk assessments.

Guidance Flowcharts have been developed to signpost care homes as to the appropriate protocol.

- Flowchart A for New Patients Admitted to Care Home
- Flowchart B for Patient Falls in Care Home

The Community Matron will act as the gatekeeper

Effective management will help analyse problems, decide what to do, put decisions into practice and check that actions have been effective.

Once a falls assessment has been carried out for person specific risk factors, a care plan must be drawn up or evaluated. This care plan will include falls management interventions which meet the individual needs of the resident to reduce their risk of falling.

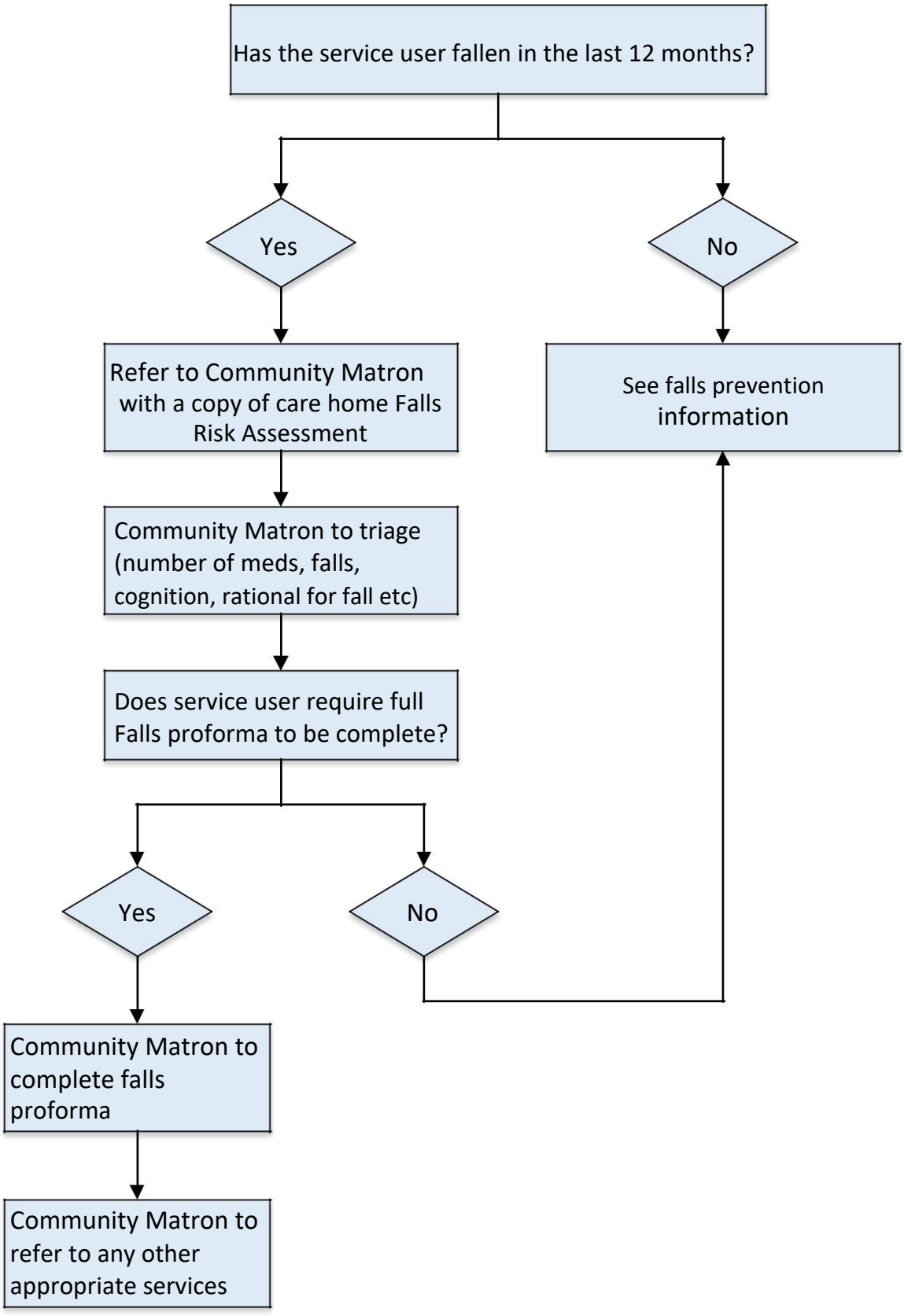
This will provide options for onward referral and management.

Key points

- Not all falls can be prevented. Some older people will fall, regardless of preventive measures.
- By ensuring that residents who fall are monitored and appropriately referred, further falls may be avoided.
- It is important to investigate incidents thoroughly. Effective accident investigation should look beyond the immediate cause of the incident.
- All accidents, including falls, should be recorded in the appropriate accident book and reported if RIDDOR criteria are met.

Flowchart A

Flowchart for New Service Users Admitted to Care Home



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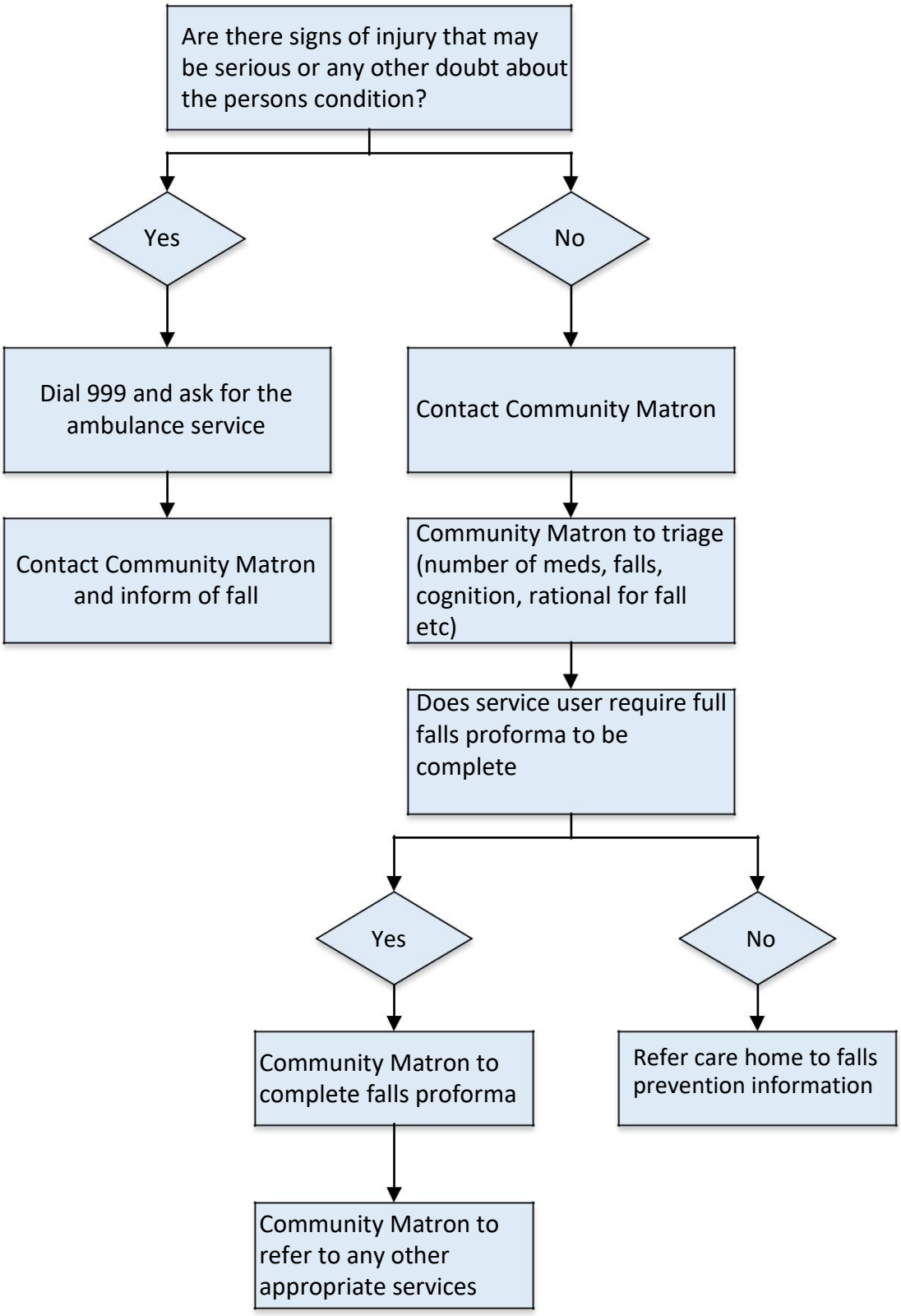
Flowchart for Service User Falls in Care Home



Residents Name:

D.O.B:

Appendix G

CARE HOME FALLS ASSESSMENT DOCUMENT

To be completed by a suitably trained clinician for persons who have fallen or are frequent fallers.

Risk Factor	Further Assessment	Y/N	Action

Name:	**NHS number:**
Telephone Number:	**Next of Kin:**
DOB:	**Care Home:**
Date of last fall:	**Number of falls in the last 6 months:**
Brief description of last fall:	

1. Medical	**What were the circumstances of the fall?** 1) Loss of consciousness? 2) Dizziness or palpitations? 3) Related to posture change? - standing - neck movement		Check for postural hypotension (see 3) and pulse – if slow review medication, reduce anti-arrhythmics ECG if HR**<60/>100/new irreg** IF ambulant **AND** no significant dementia **AND** recurrent LOC refer to Community Geriatrician Check lying/standing BP Medical review by GP
2. Medication	**Are any of the following present:** 1) 4 or more medications 2) Sedatives or antipsychotics 3) Antihypertensives/diuretics 4) Antidepressants 5) Warfarin 6) Calcichew D3 forte 1 BD		See medication in falls list: **Medication and the risk of falls in the older person (Traffic Light List)** Contact Medicines Management Team for review if on medications which can contribute to falls or if on ≥ 7 meds If **no** prosthetic valve/recent PE (6/12)/ DVT (3/12) and **recurrent** falls review warfarin **ALL** care home residents should be taking UNLESS h/o myeloma, hyperparathyroid/ hypercalcaemia Reduce dose to once daily if GFR below45

Risk Factor	Further Assessment	Y/N	Action
3. Postural Hypotension or Low BP	**Lying** BP (5mins supine) ___ /___ mmHg HR ___ bpm Standing BP ___ / ___ 1 min ___ / ___ 5 min **>20mmHg** SBP or SBP **< 90**?		Medication review : reduce/stop anti- anginals and hypertensives Adequate hydration Advice re care when standing Consider TEDs If on medication and drop of 20mmHg refer to MMT GP review if no improvement
4. Confusion	**Confirm whether old or new** If **new**, need to investigate as acute confusional state (delirium) Known dementia – under Psychogeriatrician or CPN? If known please add details for CPN or psychiatric team		History, examination, bloods for infection/metabolic upset, urine dipstick, review of medication (any new/sedatives/opiates) Chronic confusion - **environment** likely to be most important area of focus
5. Gait and Balance	**'Get up and go test'** – stand unaided and walk with usual aid Please specify type of walking aid and ability. …… …… …… …… Is mobility equipment being used? **Mobility equipment** – physio **Lifting equipment** – manual handling **Seating/pressure** – Equipment nurse specialist Review **footwear** – check fit, presence of back support,		If unsteady, **NO** recent physio input or significant deterioration since last fall **+ NO** significant cognitive impairment, refer for physio assessment. Consider review of equipment and physiotherapy List mobility equipment in use or may be needed. …… …… …… Advise re. sensible footwear Refer **surgical appliances** if foot

Risk Factor	Further Assessment	Y/N	Action
5. Gait and Balance (continued)	slippery heel/sole, height of heel Check **feet** - Long toe nails, corns, ulcers - Painful Reduced sensation		deformity or significant leg length discrepancy +/- **Podiatry referral** GP review if peripheral neuropathy suspected
6. Vision/ Hearing	Date of last eye test: (2 yearly recommended) Difficulty reading/recognising objects across room? Wears bifocals/varifocals? Cannot hear conversational speech?		If already under St Pauls, no action If **new** problems, refer optician Cataracts – GP to consider referral to St Pauls Otoscopy +/- wax removal Consider hearing test Check hearing aid in good repair
7. Environment	**Ask staff to look out for:** Slippery or uneven surfaces Loose rugs or carpets Obstructed walk ways Poor and uneven lighting Does the resident have dementia? Is the Specialist Equipment Team involved? Seating/bed /other equipment		**Advise CH staff re:** Non slip floor surfaces Avoid clutter/hazards – remove rugs and obstructing furniture, repair carpet edges Ensure adequate lighting – even, high and non-glare, and night lights Consider pressure alarm systems Care staff to supervise when mobilising Contact Specialist Equipment Team as appropriate
8. Continence	Assess for symptoms of urinary incontinence, urgency, frequency and nocturia		Urine dipstick and blood glucose - exclude diabetes Medication review- NB **diuretics** Consider referral to community continence team
9. Fracture risk	Recent fragility fracture ie standing height or less Corticosteroid more than 3 months		Over 75 - bisphosphonate (unless contraindicated –oesophagitis or advanced CKD) Under 75 – DEXA scan Concurrent prescription of bisphosphonate unless contraindicated. Review need for GI protection if on long term oral corticosteroid.

Risk Factor	Further Assessment	Y/N	Action
10. Nutrition	Has the service user lost weight in the last 6 months? Details of weight loss Eating/Drinkin/Swallowing difficulties What is their BMI (weight/Height^2)?		Start food chart Add detail of weight loss and time frame …… Please specify problem…… …… …… If BMI is less than 20, start food chart, refer to MUST tool and consider referral to dietician
11. Acute infection or Behavioural	Signs and symptoms- Behavioural changes-		

Suitability criteria for referral for Specialist Community Geriatrician input?

1. **Falls** where there is LOC or near LOC
2. Service users who have **postural symptoms** without postural hypotension
3. Difficult **medicine** regimes (**AFTER** GP review)
4. Service users with multiple problems – still repeatedly falling after intervention

LIST OF IDENTIFED RISK FACTORS
ACTION PLAN

You can use this assessment as the referral form to the following Services:

Service user needs referral to:

Medicines Management Team	0151-295 3633	
Physiotherapy	0151-295 3988	
Dietetics Team	0151-295 3868	

Onward referrals using Service specific referral form *(tick if referred to)*

Mental Health - Mossley Hill Community Team	0151-250 6124	
Specialist Equipment Services	0151-296 7736	
Podiatry	0151-295 9457	
SALT – Liverpool	0151-296 7403	
SALT - Sefton	0151-247 6110	
Continence Team	0151-734 5227	

References:

1. NICE guidelines - Management of falls DOH 2013
2. NICE guidelines -Osteoporosis DOH 2012
3. Oliver et al. BMJ 2007; 334: 82
4. Bouwen et al. Age and Ageing 2008; 37: 306
5. North Derbyshire falls service

Name of Assessor:	
Designation:	
Date of Assessment:	