Camden and Islington NHS
NHS Foundation Trust

# ASSESSMENT AND PREVENTION OF FALLS POLICY

## MARCH 2019

This policy supersedes all previous policies for the Assessment and Prevention of Falls

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| **Approved by (Group):** | Falls Steering Group<br>January 2019 |
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**Document history**

| Date | Version | Summary of amendments |
|---|---|---|
| June 2008 | 2 | Review of Version 1 |
| July 2011 | 3 | Review of Version 2 |
| Aug 2014 | 4 | Update to reflect NICE CG161 |
| Feb 2015 | 5 | Process for community teams revised |
| Dec 2015 | 6 | Risk assessment strategies and processes updated |
| Jan 2016 | 7 | Routine review |
| March 2019 | 8 | Comprehensive review – simplifying pathways, access to FALLSTOP on EPR Carenotes), change of timescales for screening and assessment for falls risks, flowcharts of actions to take to reduce falls risks and supporting information for staff. |

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|---|---|
| **Membership of the policy development/ review team** | Practice Development Occupational Therapist, Falls Steering Group |
| **Consultation** | Falls Steering Group, Falls Champions, Lead Occupational Therapists |

**DO NOT AMEND THIS DOCUMENT**

Further copies of this document can be found on the Foundation Trust intranet.

# Contents

## 1. INTRODUCTION

Falls can be devastating. Some falls can result in serious injury, such as hip fracture or serious head injuries, and these injuries can result in death. All falls, even those which do not result in injury, can be distressing and cause anxiety to patients, as well as to relatives, carers and staff. Falls can affect patients' physical function, confidence, independence and quality of life. Falls are also costly to the NHS: the annual total cost to the NHS alone from falls among older people is estimated by the National Institute for Health and Care Excellence (NICE) as £2.3 billion (NICE, 2015).

People aged 65 and older are considered to be at a higher risk of a falling: 30% of people older than 65 and 50% of people older than 80 fall at least once a year, (NICE, 2015). However, younger people are also at risk of falls and often have many of the risk factors noted below. In 2015/16 nearly a quarter of the 33,962 falls reported in mental health hospitals were under 65s (NHSI, 2017). Perhaps counterintuitively, hospital patients may be at a greater risk of falling than people in the community, as these patients have newly acquired risks and are exposed to unfamiliar surroundings (RCP, 2017).

The causes of falls are complex and multifactorial and there are many risk factors which are contributory to falls. A history of falls in the past year is the single most important risk factor for falls and is a predictor of further falls. (NICE, 2017). Other risk factors include reduced strength, balance and gait, side effects of medications, continence issues, postural hypotension, fear of falling, cognitive impairment, delirium, infection, impaired vision or hearing, poor footwear or foot care and environmental factors such as slippery floors and trip hazards. Likewise, there are no single or easily defined interventions which, when implemented on their own, have been shown to reduce falls. There is some uncertainty about exactly what is effective, especially in hospital settings (Cameron et al, 2018). However, multifactorial intervention and multiple interventions performed by the multidisciplinary team and tailored to the individual patient can reduce falls by 20-30% (NICE, 2015, RCP, 2015).

The policy promotes compliance with NICE Clinical Guideline 161: 'Falls in older people: assessing risk and prevention' (2013), National Patient Safety Agency Rapid Response Report: 'Essential care after an inpatient fall' (2011) and NICE Clinical Guideline 176: 'Head injury: assessment and early management' (2014).

This policy should be read in conjunction with the Trust's policies and guidance listed in the section 12 - Associated Documents.

### 1.1. Trust Policy Statement

- The Trust is committed to improving the mental and physical health of its patients while maintaining their safety at all times. The prevention of falls in any care setting is therefore essential to our duty of care. The purpose of this policy is to raise awareness of the risks of falls and to outline processes, duties and responsibilities to manage these risks.
- The Trust has an obligation to protect service users, staff and visitors who enter their premises and is committed to ensure that the regulations/guidance informing this policy are fully implemented.
- The Trust also expects staff members to uphold the Trust Values while carrying out their responsibilities to ensure compliance with the policy.

## 2. SCOPE OF THE POLICY

This policy is relevant to all who use all services within the Trust, both inpatient, day patients, and community. The policy applies to service users of all ages.

All healthcare professionals employed by the Trust who are responsible for planning or delivering direct care should understand falls prevention and management. This Policy should be used by medical, nursing, therapy and care staff within the Trust including occupational therapists, psychologists and social workers.

## 3. AIMS AND OBJECTIVES

The Trust aims to minimise the risk of falling for all of those who receive care from the Trust. This policy sets out the systems and processes which the Trust has put in place to achieve this. The Trust will work with patients, carers and family members to mitigate the risk and consequences of any falls.

The specific objectives of the policy are:

- All service users should be screened to identify whether they are at risk of falling.

- Those identified as being at risk should have a multifactorial falls assessment to identify individual risk factors. This assessment may be done in-house or, where appropriate, by referral on to a community falls team.
- A robust, clinically reasoned plan should be put in place for patients who are identified as at risk of falling. This may include intervention and advice to reduce the incidence and impact of falls and/or onward referral to appropriate community services.
- Each ward or team should have a nominated Falls Champion who will act as a point of expertise to other staff.
- The safety of services will be continuously improved by embracing a fair and open culture which promotes lessons learned and does not apportion blame.

## 4. DUTIES AND RESPONSIBILITIES

**4.1. The Director of Nursing** has responsibility at Board level for the programme of work around the management and prevention of falls.

**4.2. The Deputy Director of Nursing** has the responsibility at operational level for the programme of work around the management and prevention of falls. They are responsible for ensuring the policy is reviewed, updated and implemented across all clinical teams.

**4.3**. **Associate Divisional Directors and Divisional Clinical Directors** have the responsibility for the implementation and application of the policy within their respective divisions.

**4.4. Matrons, Operational Service Managers and Occupational Therapy Leads** are responsible for the implementation and monitoring of the policy within their clinical teams. They are also accountable for the education of Team/Ward managers in the management of the policy.

**4.5. The Falls Lead** is responsible for providing expertise about falls prevention and management. They are responsible for giving advice and guidance to senior management and to staff working directly with service users and they facilitate regular Falls Champions meetings. They ensure the policy is up to date and compliant with national guidance and monitor trends and patterns in falls across the Trust. They report to the Falls Steering Group.

**4.6. Team/Ward Managers** are responsible for ensuring that:

- All staff members in their team are aware of this policy and adhere to the guidance.
- All staff within their team are competent in the management of falls.
- All patients are screened for their risk of falls, assessed as appropriate, and prevention strategies are implemented.
- The appropriate actions are taken following a fall involving a patent, and the Trust's RM03 Incident Reporting Policy (2016) is followed.
- Their team has a Falls Champion and that adequate support is provided to enable them to fulfil their role.
- Their Falls Champion attends the Falls Champions' meetings and learning from this is cascaded to all staff within their team.
- The ward/team has the correct equipment and documentation to appropriately implement falls management strategies.
- Monitoring and audit arrangements as detailed section 9 are adhered to.
- As appropriate to their service, ensuring that they monitor the environment.
- Learning and feedback from falls incidents, including serious incidents, are shared amongst all staff within their team, and recommendations from serious incidents are implemented in a timely fashion.

**4.7. Falls Champions** are responsible for:

- Raising awareness of this policy in their clinical area, assisting with the implementation of the falls management agenda and encouraging their teams in consistently delivering falls risk management strategies.
- Attending Falls Champions' Workshops and cascading learning from these to staff within their team.
- Educating and supporting staff from their team who are required to perform FALLSTOP Screens and Assessments about the assessments and falls management strategies.
- Encouraging discussion of risk factors for falls at ward round, handover and at multidisciplinary team meetings.

- Educating all staff on appropriate actions following a fall, relevant to their service.
- Ensuring that information about falls prevention is readily available on the ward or in the team for staff to offer to patients, their families and carers.
- Completing or supporting with the falls audit.
- As appropriate to their service and in conjunction with the team manager, ensuring that they monitor the environment.

The Falls Champions are not responsible for completing all FALLSTOP Screens and Assessments for their team. All competent clinical staff are responsible for completing this assessment when indicated.

**4.8. All Clinical Staff** are responsible for:

- Complying with the recommendations in this policy.
- Supporting the multidisciplinary team to ensure that all patients' falls risks are reviewed and managed according to this policy.
- Ensuring that appropriate action is taken following a fall and the Trust's Incident Reporting Policy is followed.
- Working in collaboration with patients and their carers/relatives/families to promote effective falls risk management.
- Attending education sessions provided by the Falls Champions, and informing their Ward/Team Manager about any gaps in their knowledge in relation to falls risk management.
- Challenging unsafe practice that may increase the risk of falls.

Each staff member is accountable for his/her practice and must acknowledge limitations of professional competence and only undertake activities in which they are competent.

**4.9. The Trust Falls Steering Group** is responsible for monitoring and reviewing falls rates, injuries and trends in relation to falls, as well as supporting and advising the Falls Lead, reviewing management strategies and identifying the need to change or implement new strategies.

## 5. DEFINITIONS

**5.1. Fall:** A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level (NICE, 2017).

**5.2. Delirium**: Delirium is a common clinical syndrome characterised by disturbed consciousness, cognitive function or perception, which has an acute onset and fluctuating course (NICE, 2010).

**5.3**. **Moderate harm:** Where the fall resulted in harm that required hospital treatment or prolonged length of stay but from which a full recovery is expected (RCP, 2015).

**5.4. Severe Harm:** Where the fall resulted in harm causing permanent disability or the person is unlikely to regain their former level of independence (RCP, 2015).

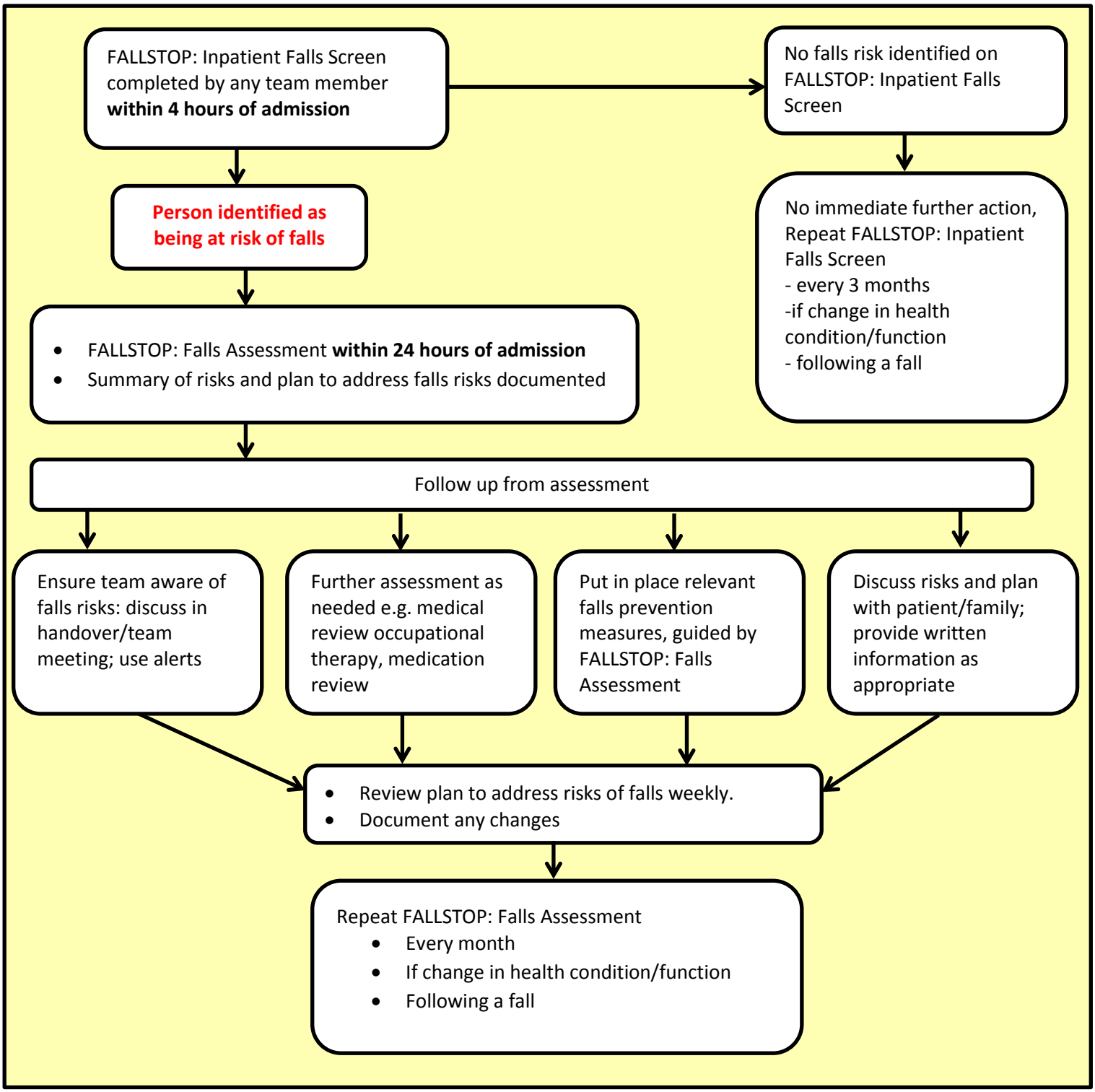
**5.5. Head injury:** Any trauma to the head other than superficial injuries to the face (NICE, 2014).

## 6. FALLS MANAGEMENT PROCEDURES

### 6.1. Inpatient and residential settings – including Stacey Street Nursing Home, Hanley Gardens, 154 Camden Road, Highview and Aberdeen Park

The FALLSTOP Screen and Assessment will be completed by a registered Mental Health Nurse, a Registered Nurse or a competent clinical team member. It can also be completed by a Clinical Support Worker who has achieved the competencies in section 7.

The falls pathway for inpatient and residential settings is outlined in the flowchart below.


FALLSTOP: Inpatient Falls Screen completed by any team member **within 4 hours of admission**
No falls risk identified on FALLSTOP: Inpatient Falls Screen
**Person identified as being at risk of falls**
No immediate further action, Repeat FALLSTOP: Inpatient Falls Screen
- every 3 months
-if change in health condition/function
- following a fall
FALLSTOP: Falls Assessment **within 24 hours of admission**
Summary of risks and plan to address falls risks documented
Follow up from assessment
Ensure team aware of falls risks: discuss in handover/team meeting; use alerts
Further assessment as needed e.g. medical review occupational therapy, medication review
Put in place relevant falls prevention measures, guided by FALLSTOP: Falls Assessment
Discuss risks and plan with patient/family; provide written information as appropriate
Review plan to address risks of falls weekly.
Document any changes
Repeat FALLSTOP: Falls Assessment
Every month
If change in health condition/function
Following a fall

### 6.1.1. Screening for Risk of Falls

A falls screen should be completed within four hours of admission using the FALLSTOP: Inpatient Falls Screen (Appendix 2), which is integrated into Carenotes and located within the Physical Healthcare section.

Patients who are identified as not being at risk of falling by the FALLSTOP: Inpatient Falls Screen will need a further screen if their clinical condition deteriorates, or else every three months.

The FALLSTOP: Inpatient Falls Screen also identifies if the patient requires a Bed Safety Rail Assessment (Appendix 6) as detailed in the Trust's 'Bed Rails: Management and Safe Use Policy' CL67 (2016).

### 6.1.2. Multifactorial Assessment of Falls Risks

Patients identified as being at risk of falling by the Inpatient FALLSTOP: Inpatient Falls Screen will require a FALLSTOP: Falls Assessment (Appendix 4) to be completed within 24 hours of admission. This is a multifactorial assessment designed to identify the patient's individual risk factors for falling.

The FALLSTOP: Falls Assessment is integrated into Carenotes and located within the Physical Healthcare section. The FALLSTOP: Falls Assessment provides direction as to interventions to address an individual's falls risk. See also Appendix 7. As part of the FALLSTOP: Falls Assessment, there should be a summary of the individual's falls risks and a plan of how those risks will be addressed.

All patients aged 65 or over are deemed to be at risk of falls and are required to have a full multifactorial falls assessment. Under 65s are required to have a full assessment where there is evidence of unsteadiness, alcohol or drug withdrawal, learning disabilities, confusion, agitation or sedation or any other observed falls risk.

Where there is a very high risk of falls, for example a frail elderly person or someone who is heavily sedated, the assessment should be completed as a matter of urgency and measures to address risk put in place. In all cases, staff are expected to use their clinical judgement to ensure robust management of falls risks.

The staff member completing the assessment is responsible for:

- Fully documenting the assessment, including updating progress notes, the Risk Assessment and the Care Plan on Carenotes.

- Alerting the team to the risk of falls.
- Ensuring interventions to minimise the risk of falls are implemented. Guidance on interventions is given in the FALLSTOP: Falls Assessment and suggestions are available in Appendix 7.
- Making appropriate referrals as indicated on the assessment.
- If appropriate, placing the at risk of falls 'F' magnet next to the patient's name on the ward whiteboard and, with the patient's consent, place the 'F' sign on the board in the patient's bedroom (alternatively this could be placed in the patients wardrobe).
- Discussing the outcome of the Screen/Assessment with the patient and with relative/carer, as appropriate, at the earliest opportunity and providing oral and written falls prevention information, including explaining individual risk factors for falling in hospital.
- If on assessment, the patient is identified as at risk of significant injury from a fall, i.e. they are at high risk of sustaining a fracture or subdural haemorrhage from a fall, the staff member completing the assessment has the responsibility to immediately
    - Communicate the risk at all handovers, ward rounds and MDT meetings
    - Add the 'At risk of falls AND significant injury i.e. fracture/subdural haemorrhage' alert to Carenotes
    - If used in that setting: place the 'high risk of injury' magnet next to the patient's name on the ward whiteboard and with the patient's consent, place the 'high risk of injury' sign on the board in the patient's bedroom.

**6.1.3. Reassessment of Falls Risks**

The falls management plan, as documented in the FALLSTOP: Falls Assessment, should be reviewed weekly by the team.

The FALLSTOP: Falls Assessment should be repeated:

- following a change in clinical condition (deterioration or an improvement)
- following a fall
- monthly if no fall

The Repeat Assessment section at the end of the FALLSTOP: Falls Assessment should be used to document the outcome of repeat assessments. The member of staff completing the repeat assessment should document any change against the corresponding letter, and the outcome of any referrals/requests. If there is no change in plan of care required 'no change' should be documented.

### 6.1.4. Transfer Between Wards

On transfer to another inpatient ward within the Trust, the FALLSTOP: Inpatient Falls Screen and Falls Assessment should be reviewed by the receiving team. Any gaps in the Screen or the Assessment should be completed by the receiving team and that team must ensure they are confident that a robust falls management plan is in place for those who are at risk of falls. The Screen and Assessment should then be repeated as required in section 6.1.3. When there is a move to setting with a significant change in the physical environment, the FALLSTOP: Inpatient Falls Screen must be repeated within 4 hours of transfer, with a full assessment of those at risk within 24 hours of transfer.

### 6.1.5. Delirium

Staff should be vigilant of patients who are at risk of developing delirium, as these patients are often at high risk of falling (RCP, 2017). A tailored multicomponent intervention package should be delivered by a multidisciplinary team to prevent or manage delirium (NICE, 2010). This should include:

- When possible, being cared for by staff who are familiar to them
- Avoiding moving patients within and between ward or rooms unless absolutely necessary
- Addressing cognitive impairment and/or disorientation by providing appropriate lighting, clear signage, a easily visible clock and calendar
- Talking to the patient to reorientate them, explaining where they are, who they are, and the roles of the members of the team
- Introducing cognitively stimulating activities (e.g. reminiscence)
- Facilitating regular visits form family and friends
- Addressing dehydration, constipation, poor nutrition, pain and sensory impairment
- Assessing for hypoxia
- Looking for and treating infection, and avoiding unnecessary catheterisation
- Encouraging mobility
- Promoting good sleep patterns and sleep hygiene

If a patient demonstrates signs of delirium then staff need to request a medical assessment where a formal assessment for delirium using the confusion assessment method (CAM), or other tool should be used (RCP, 2015; NICE, 2010).

### 6.1.6. Pharmacy Medication Assessment

The ward pharmacist will complete a FALLSTOP: Pharmacy Medication Assessment (Appendix 5) for all patients:

- Following a fall
- Admitted who are 65 years old and over
- Admitted who are under 65 years and identified by the FALLSTOP: Inpatient Falls Screen as being at risk of falls

For patients who have fallen whilst an inpatient, the pharmacist will assess their medications at the point of the fall.

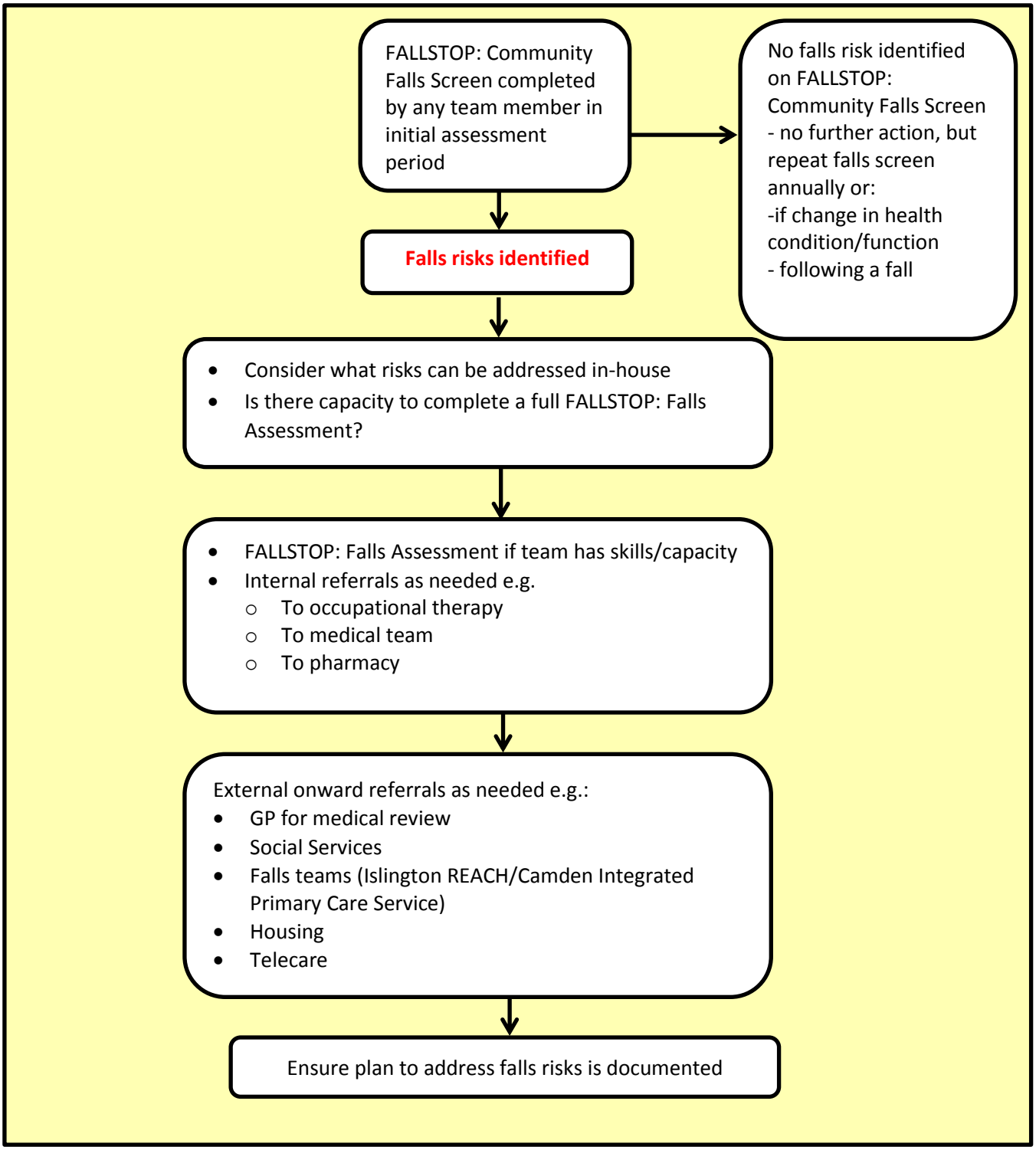
For patients who are 65 years old and over or who are under 65 years and have been identifies as being at risk of falls, the pharmacist will assess their pre-admission and current medicines.

### 6.2. Community Recovery Service for Older People

Service users at the Community Recovery Service for Older People are not required to have a FALLSTOP Screen, but all should have the more comprehensive FALLSTOP: Falls Assessment. This should be completed within their first two weeks of attendance.

### 6.3. Community Services, including Crisis Houses, Day Units and Supported Housing

The falls pathway for community settings is outlined in the flowchart below.



### 6.3.1. Screening for Risk of Falls

A falls screen should be completed within the initial assessment period. Ideally this will be the FALLSTOP: Community Falls Screen (Appendix 3), which is integrated into Carenotes and located within the Physical Healthcare section. Some Community Teams may incorporate the FALLSTOP screening questions into their screening forms or the Single Assessment Process, reflecting local protocol.

As appropriate, carers should also be consulted and information gathered from them.

Patients who are identified as not being at risk of falling by the FALLSTOP: Community Falls Screen will need a further Screen if their clinical condition deteriorates or else annually.

Patients identified as being at risk of falling by the FALLSTOP: Community Falls Screen require a multifactorial assessment to identify individual risk factors for falling.

If there are any immediate concerns about the falls risks of a patient in the community, (for example: signs of infection/delirium, problems with continence, dehydration, malnutrition, clutter, poor lightning, unsafe footwear, vision or hearing problems), staff should address these promptly.

If the FALLSTOP: Community Falls Screen identifies a patient has broken a bone since the age of 50 from a minor accident, e.g. a fall, and they are NOT receiving osteoporosis treatment, the patient should be referred to the medical team or GP for their osteoporosis/fracture risk to be assessed.

The Falls Screen should be repeated at each annual review or CPA, or if there is a deterioration in clinical condition.

The staff member completing the Falls Screen is responsible for:

- Addressing any immediate concerns.
- Discussing the outcome of the screen with the patient immediately and with relative/carer as appropriate at the earliest opportunity and offering falls prevention information.
- Updating the progress notes, Risk Assessment and Care Plan on Carenotes.
- Alerting the team to the risk of falls.
- Ensuring that onward referrals are completed.

### 6.3.2. Multifactorial Assessment of Falls Risks

Some community teams have the relevant skills and capacity to carry out a multifactorial falls assessment in-house. In this case, the FALLSTOP: Falls Assessment, located in the

Physical Healthcare section of Carenotes may be used. As part of the assessment, there should be a summary of the individual's falls risks and a plan of how those risks will be addressed.

If it is not possible to complete a full multifactorial falls assessment within the team, the person should be referred on to the appropriate community falls team.

If it is not appropriate to either complete a FALLSTOP: Falls Assessment or to refer on, e.g. if it is known that the person is already engaged with a falls team or other similar team, this should be documented in Carenotes.

If the patient is not identified as requiring a multifactorial assessment based on the Screen, but the assessing clinical team member is concerned about the patient's risk of falls, the team member may request a FALLSTOP: Falls Assessment in-house if there is capacity/ skills, or make an onward referral to the appropriate falls team.

### 6.4. Management of the Falling and Fallen Patient

The Trust is committed to patient and staff safety, and minimising the risk of injury to:

- Patients who fall
- Staff dealing with a falling patient or a patient who has already fallen.

#### 6.4.1. The Falling Patient

Staff should:

- Attempt to protect the patient's head; but this should not compromise the staff member's safety.
- Try to move any objects which may cause injury to the patient.
- Avoid intervention if they have any limitations e.g. pregnancy or musculoskeletal injuries.
- Not catch, support the full body weight or physically lower a falling patient, but instead consider the option of redirecting the patient e.g. guiding the patient away from harm, but not taking full body weight.

#### 6.4.2. Essential Care After a Fall

Following a fall there is still an opportunity to reduce the degree of harm to the patient by:

- Promptly detecting and effectively treating any injuries.
- Considering why the patient fell.
- Applying measures that will reduce the risk of further falls or injury.

When a serious injury occurs, safe manual handling and prompt assessment and treatment are critical to the patient's chances of making a full recovery.

### 6.4.3. Management of a Fall in Inpatient Services, Residential Settings, Crisis Houses and Day Units (including Stacey Street Nursing Home, Hanley Gardens, 154 Camden Road, Highview and Aberdeen Park and the Community Recovery Service for Older People)

Following a fall, the extent of any potential injuries must be established and the fall managed appropriately. This includes checking for signs and symptoms of fracture, potential for spinal injury, or serious head injury before the patient is moved. If there is any clinical uncertainty, staff must not move the patient or use any hoist.

In inpatient services and other settings where there is a qualified nurse on duty, this person should complete the checks.

In settings when a qualified nurse is not available, a competent clinical team member including a competent Clinical Assistant Practitioner or Clinical Support Worker may do this. The pathway to manage a fall is detailed below.

# INPATIENT POST FALLS PATHWAY

**DO NOT MOVE THE PATIENT UNTIL ACTION 1, 2, 3 & 4 COMPLETED**

## ACTION 1: IMMEDIATE RESPONSE

**Initial ABCDE Assessment:** A = Airway; B = Breathing; C = Circulation; D = Disability (**A**lert, response to **V**oice, response to **P**ain, **U**nresponsive); E = Exposure

→ **If medical emergency, call an ambulance immediately – CALL 999 – and summon emergency team**

**Exclude Injury:** Visually assess the patient, checking for evidence of:
- Bruising, laceration, swelling/redness, abrasions
- Any neck, back pain, or facial injury
- Shortening or deformity of lower limbs, restricted movement, pain, unable to weight bear.

→ **If signs of hip fracture DO NOT MOVE patient**

## ACTION 2: BASELINE OBSERVATIONS

**Complete the following observations:** Temperature, BP, Pulse, Respiratory Rate, Oxygen Saturation, NEWS Score, Blood Sugar.
**Record results on NEWS2 Chart**

Are both pupils equal and reacting to light? **Record on NEWS2 Chart** → **If NO, CALL 999**

**Check for signs of head injury:** Loss of consciousness/Amnesia for events before or after incident/Persistent headache/Drowsiness/Episode of vomiting/Previous brain surgery/Any history of bleeding or clotting disorders/Current anticoagulant therapy such as warfarin/Current drug or alcohol intoxication/Irritability or altered behaviour/Other noted change in condition eg seizure → **If any of these present, CALL 999. If unsure treat as head injury**

**Neurological Assessment:** **Perform if patient hit head /head injury can't be ruled out/ unwitnessed fall/on anti-coagulant or anti-platelet therapy**
**Complete all sections of the neurological observations chart. Closely monitor pupil size and reaction.**
Neurological observations and physical observations (NEWS) need to be monitored as follows:
- Every 30 minutes for 2 hours…
- then hourly for 4 hours…
- then 2 hourly thereafter (NICE, CG176)

→ **If Coma Scale (GCS) score less than 15, CALL 999**

→ **If change in neuro obs, GCS deteriorates to less than 15, any change in clinical condition indicating serious head injury, CALL 999**

Is patient on anti-platelet therapy? e.g. include aspirin, clopidogrel, dipyridamole, prasugrel, ticagrelor. → **Urgent medical review required – call Duty Doctor**

**ACTION 3: RED FLAGS**

Is there:
Suspected spinal or hip fracture
Suspected serious head injury/GCS <15
Suspected stroke/TIA
Suspected other fracture
Chest pain reported by patient

→ **Call 999 immediately; call emergency team; continue to take 15 minute observations until ambulance arrives**

**ACTION 4: MOVING AND HANDLING**

Use the patient's clinical picture to safely retrieve from the floor
If patient is able to stand unaided or with minimal support, explain safest way to stand
If patient unable to stand unaided, assess most appropriate way to retrieve from floor and document how done

→ **If fracture/serious injury suspected - DO NOT MOVE PATIENT; CALL 999**

**ACTION 5: IMMEDIATE SUPPPORTIVE CARE GIVEN TO PATIENT**

Provide analgesia if appropriate

Arrange medical assessment

Consider infection or delirium

Consider pressure area risk assessment and interventions

→ **Medical assessment to be completed within 12 hours: discuss urgency with doctor**

**ACTION 6: INFORM NEXT OF KIN**

Ensure patient's next of kin informed promptly of the fall and of any contributory factors, any injury, plan of care

**ACTION 7: REASSESS PATIENT'S FALLS RISK AND REPORT INCIDENT**

When patient is stable, reassess FALLSTOP Assessment

Update Carenotes – add 'fall whilst an inpatient alert, update notes, update Care Plan and Risk Assessment

Ensure incident is discussed at handover and ward round

Complete DATIX incident form

When urgent A&E attendance is indicated, the member of staff assessing the patient should designate another member of staff to immediately contact the ambulance service on 999. In inpatient services, if indicated, the emergency team should also be summoned as per the Trust's Recognising and Responding to the Physically Deteriorating Patient (Inpatient) (2018).

All appropriate observations need to be recorded on the NEWS2. In some settings, equipment to assess these observations may not be available: this should be indicated on the Chart.

Neurological observations and physical observations need to be monitored by a qualified nurse or doctor following a fall if the patient hits their head, if a head injury cannot be ruled out, if the fall was unwitnessed or the patient is on anti-platelet therapy. If the fall occurs in a setting where there is no nurse or doctor, this should be recorded.

Pupil size and pupil reactions are assessed with neurological pen torches, and the team/ward manager is responsible for ensuring these torches are readily available and easily accessible in all inpatient areas.

The frequency and duration of neurological observations will be in line with NICE Clinical Guideline 176: Head Injury (NICE, 2014). Neurological observations are recorded on the Neurological Observation Chart, located on the NEWS2, and will be monitored as follows:

- Every 30 minutes for 2 hours…
- Then hourly for 4 hours…
- Then 2 hourly thereafter

Throughout neurological monitoring, if any of the following changes occur, urgent A&E attendance is required, and the ambulance service should be called immediately on 999 (as appropriate to the setting, the emergency team should also be summoned):

- Any change in neurological observations
- GCS deteriorates to less than 15
- A change in clinical condition which potentially indicates a serious head injury including (but not limited to):
- Any episodes of vomiting
- Clear fluid running from the ears or nose
- A persistent headache

- Black eyes with no associated damage around the eyes
- Bleeding from one or both ears
- Bruising behind one or both ears
- Altered behaviour/irritability
- Drowsiness
- Loss of consciousness
- Seizure
- Continuing concern by the professional

If the patients NEWS score increases, action needs to be taken as per NEWS2 Chart instructions. Staff are required to use clinical judgement and raise any concerns with the shift coordinator or Duty Doctor

For patients without serious injury, the service user must be retrieved from the floor in the most appropriate way:

- If the service user is able to transfer himself/herself unaided from the floor to a suitable position, and this is safe, allow the patient to do so, with verbal encouragement
- If the service user is unable to transfer himself/herself from the floor unaided, then the appropriate manual handling equipment must be used i.e. a hoist
- If appropriate manual handling equipment, i.e. a hoist, is not available then the ambulance service must be called and the service user's comfort should be maintained and awareness given to the service user's tissue viability

All patients who fall need to be reviewed by a doctor within 12 hours.

The patient's next of kin should be informed promptly of the falls incident,

A fall will automatically trigger a new FALLSTOP: Falls Assessment. This assessment should be completed as soon as possible following the falls incident.

Following an inpatient fall, the 'fall whilst an inpatient' alert should be added onto Carenotes, and the progress notes, Risk Assessment and Care Plan updated.

The falls incident should be communicated to the wider team, including the ward occupational therapist, and discussed at handover, at ward round and at multidisciplinary meetings

An online Datix incident form should be completed at the earliest opportunity following the falls incident, clearly documenting the time and circumstances of the fall including any

associated symptoms. All staff need to record as much information as possible regarding the events that have lead up to the fall if these are known.

If the fall causes moderate or severe harm, including death, this should be reported directly to the responsible Associate Director and to the Trust's Risk and Patient Safety Manager.

### 6.4.5. Management of a Patient Fall in the Community whilst a Member of Staff is Present

Following a fall, the member of staff present needs to check for signs and symptoms of fracture, potential for spinal injury, or serious head injury before the patient is moved. If there is any clinical uncertainty, staff must not move the patient.

The member of staff should immediately contact the ambulance service on 999 when urgent A&E attendance is indicated.

All appropriate observations need to be recorded on the NEWS2 Chart as detailed in the Trust's CLO7B  Recognising And Responding to the Physically Deteriorating Patient (Community Settings). Equipment to assess these observations may not be available to the service/team member: if equipment is not available this should be documented.

In the community it is unlikely nursing staff would have access to neurological pen torches, so it is unreasonable to expect pupil size and pupil reaction to be assessed.

In the community, it is not reasonable for staff to undertake prolonged monitoring of neurological or physical observations if the patient hits their head or a head injury cannot be ruled out. If the member of staff feels, based on clinical judgement, that the patient needs to be monitored they should recommend the patient attends A&E (especially if the patient lives alone).

If staff notice any of the following changes whilst with the patient, urgent A&E attendance is required and an urgent ambulance should be called, as they potentially indicates a serious head injury:

- Any episodes of vomiting
- Clear fluid running from the ears or nose
- A persistent headache
- Black eyes with no associated damage around the eyes
- Bleeding from one or both ears
- Bruising behind one or both ears

- Altered behaviour/irritability
- Drowsiness
- Loss of consciousness
- Seizure
- Concern by the professional

For patients without serious injury, the service user must be retrieved from the floor in the most appropriate way:

- If the service user is able to transfer himself/herself unaided from the floor to a suitable position, and this is safe, allow the patient to do so, with verbal encouragement.
- If the service user is unable to transfer himself/herself from the floor unaided, then the appropriate manual handling equipment must be used i.e. a hoist.
- If appropriate manual handling equipment, i.e. a hoist, is not available then the ambulance service must be called and the service user's comfort should be maintained and awareness given to the service user's tissue viability.

If the patient remains in the community and does not attend A&E, when the member of staff leaves the patient the staff member needs to advise the patient, and their relatives/carers if present, to call an ambulance if they experience any of the changes detailed above which potentially indicates a serious head injury.

If appropriate, the patient's next of kin should be informed of the falls incident.

A fall will automatically trigger a reassessment of the FALLSTOP: Community Falls Screen. The clinical notes, Risk Assessment and Care Plan on Carenotes need to also be updated.

An online Datix incident form should be completed at the earliest opportunity following the falls incident, clearly documenting the time and circumstances of the fall including any associated symptoms. All staff need to record as much information as possible regarding the events that have lead up to the fall if these are known

If the fall causes moderate or severe harm, including death, this should be reported directly to the responsible Associate Director and to the Trust's Risk and Patient Safety Manager.

**6.4.6. Actions to be Taken Following a Community Fall (staff not present at the time of fall)**

Staff should ensure that information about the fall is documented in Carenotes.

Staff should reassess the patient using the FALLSTOP: Community Falls Screen and carry out interventions as appropriate.

An online Datix incident form should be completed by the assessing staff member clearly documenting the time and circumstances of the fall including any associated symptoms. As much information as possible should be included in the report regarding the events that have led up to the fall.

### 6.5. Learning Lessons and Improving Practice

All staff should promote a culture of learning lessons from falls incidents to improve the safety of the services the Trust provides its service users, improve practice and to reduce the risk of further incidents. The fundamental purpose of reviewing incidents is to learn from them, and not to apportion blame.

The Trust facilitates learning by promoting a fair and open culture that abandons blame and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff member involved but rather the system in which the individuals were working.

#### 6.5.1. Falls After Action Review

A Falls After Action Review is a useful way for individuals involved in the incident to learn from what happened, why it happened, what went well, what needs improvement and what can be learned to reduce the likelihood of the incident happening again.

Refer to the Trust's Management of Serious Incidents Policy Policy (2018) for details of the review process.

#### 6.5.2. Serious Incident Investigation

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, or level 2 investigation if appropriate, instigated.

Serious Incidents relating to falls incidents are reported and investigated in line with the Trust's RM03 Incident Reporting Policy (2016) and RM05 Management of Serious Incidents Policy (2018).

All serious incidents must be reported to the Service Manager and Associate Divisional Director within the division as soon as possible after the incident. Out of office hours the senior manager on call and on-call director should be made aware of the incident. An online

Datix form must be completed and submitted, and should contain as much detail about the incident as is known at the time of reporting. Teams must not delay reporting an incident on Datix even if the details of the incident are not fully known. The Risk and Patient Safety Manager must also be notified of a serious incident as soon as possible after the incident and always within one working day of the incident occurring.

## 7. TRAINING

All Trust staff must develop and maintain basic professional competences in falls assessment and prevention.

Falls risk training *Preventing Falls in Hospitals*, developed by the Royal College of Physicians is available on the Electronic Staff Record (ESR). This can be undertaken by any staff, and is required to be completed by Falls Champions.

Ward and team managers are responsible for ensuring that all staff within their team are competent in the management of falls. Staff will be supported in these objectives by a designated Falls Champion for each ward/team.

Regular meetings are held for Falls Champions with the Falls Lead. These sessions support the Champions to lead their local teams in consistently delivering falls risk management strategies. The ward and team managers are responsible for ensuring that their team has a Falls Champion and that their Falls Champion attends the meetings.

The Falls Champions and the ward/team managers are both responsible for ensuring learning from the Falls Champions Workshops is cascaded to all staff within the team

Newly qualified nurses, clinical assistant practitioners and clinical support workers, need to be assessed and deemed competent to undertake the falls risk management assessments relevant to their team/service. The following competencies need to be achieved:

- Demonstrate knowledge of falls risk management, and be able to carry out a FALLSTOP Falls Screen.
- Demonstrate knowledge of the next steps if a falls risk is identified, when it is appropriate to carry out a FALLSTOP FALLS Assessment and able to perform the assessment.
- Demonstrate knowledge of what to do when a person falls. Qualified nurses need to be competent in performing a neurological assessment.

## 8. DISSEMINATION AND IMPLEMENTATION ARRANGEMENTS

- This policy will be placed on the Trust intranet.
- This policy will be disseminated through the Associate Divisional Director and Divisional Clinical Director for each service to the Ward /Team Managers who are responsible for the dissemination and implementation of this policy in their team.
- The Falls Lead should be contacted for clarification or support in the implementation of the policy.

## 9. MONITORING AND AUDIT ARRANGEMENTS

| Elements to be monitored | Lead | Method for monitoring compliance | Frequency | Reporting (Committee/Group responsible for overseeing implementation of actions) | Parent Committee(Board sub-committee that receives assurance) |
|---|---|---|---|---|---|
| Quality inpatient care relating to falls management | Ward Manager/Falls Lead | Meridian falls audit, monitoring adherence to falls risk management process | Monthly | Trust Falls Steering Group | Quality Committee |
| Quality care relating to falls management in the community services | Team Manager/Falls Lead | Falls audit monitoring adherence to falls risk management process | Ad hoc | Trust Falls Steering Group | Quality Committee |
| Safe environment in relation to falls risk management | Ward/Team manager | Monitoring environmental factors that may impact on falls risk via Environmental audit. | 6 monthly | Trust Falls Steering Group | |
| Staff training | L&D/Falls Lead | - Attendance at Falls Champion Workshops<br>- Completion of ESR training<br>- Attendance at training provided by the Falls Lead<br>- Attendance, training record and sign off of preceptorship competencies of newly qualified nurses | 6 monthly | Trust Falls Steering Group | Quality Committee |

## 10. REVIEW OF THE POLICY

This policy will be reviewed in March 2021 or following a serious incident recommendation, change in legislation or best practice advice.

## 11. REFERENCES

Cameron ID, Dyer SM, Panagoda CE, Murray GR, Hill KD, Cumming RG, Kerse N. (2018) *Interventions for preventing falls in older people in care facilities and hospitals.* Cochrane Database of Systematic Reviews 2018, Issue 9.

Hopewell S, Adedire O, Copsey BJ, Boniface GJ, Sherrington C, Clemson L, Close JCT, Lamb SE. (2018) *Multifactorial and multiple component interventions for preventing falls in older people living in the community*. Cochrane Database of Systematic Reviews, Issue 7.

NHS Improvement (NHSI) (2017) *The incidence and costs of inpatient falls in hospitals: report and annexes*

National Institute of Health and Clinical Excellence (NICE) (2014) *Head injury: assessment and early management*. Clinical Guideline 176. Updated 2017.

National Institute of Health and Care Excellence (NICE) (2015) *Falls in older people*. Quality Standard 86 (reviewed 2017)

National Institute for Health and Care Excellence (NICE) (2013) *Falls: assessment and prevention of falls in older people.* Clinical Guideline 161

National Institute for Health and Clinical Excellence (NICE) (2010) *Delirium: diagnosis, prevention and management.* Clinical Guideline 103

National Patient Safety Agency (NPSA) (2011) *Essential Care after an inpatient fall, Rapid Response Report*

Public Health England (2017) *Falls and fracture consensus statement: supporting commissioning for prevention*

Royal College of Occupational Therapists (COT) (2015) *Occupational therapy in the prevention and management of falls in adults.*

Royal College of Physicians (RCP) (2017) *National Audit of Inpatient Falls: Audit Report*

Royal College of Physicians (RCP) (2015) *National Audit of Inpatient Falls: Audit Report*

## 12. ASSOCIATED DOCUMENTS

CL67 Bed Rails: Management and Safe Use Policy (2016)

RM08 Being Open and Duty of Candour Policy (2015)

RM07 Clinical Risk Management Policy (2017)

CL29 Diabetes – Good Practice Guidelines (2013)

RM03 Incident Reporting Policy (2016)

RM05 Management of Serious Incidents Policy (2018)

MHA12 Mental Capacity Act 2005 (incorporating the Deprivation of Liberty Safeguards) Policy (2015)

CL04 Observation and Engagement Policy (2015)

CL21 Physical Health and Well Being Policy (2019)

CL46 Pressure Ulcer Prevention and Management Policy (2013)

CLO7 Recognising and Responding To the Physically Deteriorating Patient (Inpatient) (2018)

CL07B Recognising And Responding To The Physically Deteriorating Patient (Community Settings) (2016)

EF21 Slips Trips and Falls Management (Non Clinical) (2018)

## 13. APPENDICES

**Appendix 1**

## Equality Impact Assessment Tool

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the policy/guidance affect one group less or more favourably than another on the basis of:** | | |
| | Race | No | |
| | Ethnic origins (including gypsies and travellers) | No | |
| | Nationality | No | |
| | Gender | No | |
| | Culture | No | |
| | Religion or belief | No | |
| | Sexual orientation including lesbian, gay and bisexual people | No | |
| | Age | Yes | This policy aims to address in particular patients aged over 65, as well as those under 65 who are considered to be at risk of a fall due to an underlying condition |
| | Disability - learning disabilities, physical disability, sensory impairment and mental health problems | Yes | The policy addresses in particular those who have a disability or health problem which increases their risk of falls |
| **2.** | **Is there any evidence that some groups are affected differently?** | No | |
| **3.** | **If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?** | N/A | |
| **4.** | **Is the impact of the policy/guidance likely to be negative?** | No | |
| **5.** | **If so can the impact be avoided?** | N/A | |
| **6.** | **What alternatives are there to achieving the policy/guidance without the impact?** | N/A | |
| **7.** | **Can we reduce the impact by taking different action?** | N/A | |

Camden and Islington NHS
NHS Foundation Trust

## FALLSTOP: Inpatient Falls Screen

To be completed by any member of the clinical team within 4 hours of admission

Patients aged 65 and over are at increased risk of falls following admission to hospital. Patients under 65 with other risk factors may be at risk of falls, depending on clinical condition. (NICE CG161, 2013)

| | |
|---|---|
| Is your patient aged 65 or over?* | ○ Yes ○ No |

If YES, proceed to FALLSTOP Falls Assessment immediately. This must be completed within 24 hours of admission.

For patients under the age of 65 only - Do they have any of the following?

| | | |
|---|---|---|
| Unsteadiness | ☐ Yes | ☐ No |
| Alcohol/drug withdrawal | ☐ Yes | ☐ No |
| Learning disabilities | ☐ Yes | ☐ No |
| Confusion, agitation or sedation | ☐ Yes | ☐ No |
| Other falls risks (document) | ☐ Yes | ☐ No |

If YES to any of the above, there is a risk of falls so complete the full FALLSTOP Falls Assessment.

If NO, reassess the patient every 3 months or if there is a change in clinical condition.

| | |
|---|---|
| Discuss the outcome of this falls screen with the patient and their relatives/carer as appropriate. Tick box when done. | ☐ |

Bed Safety Rail Trigger for Assessment

| | | |
|---|---|---|
| Are there bed safety rails on the patient's bed?* | ○ Yes ○ No | If YES complete the Bed Safety Rail Risk Assessment |
| Would the patient potentially benefit from using bed safety rails?* | ○ Yes ○ No | If YES complete the Bed Safety Rail Risk Assessment |

| Name of clinician completing assessment* | Designation* | Date | Time |
|---|---|---|---|
| | | 14/03/2019 | 14:37 |

Your partner in care & improvement

## Appendix 3

# FALLSTOP: Community Falls Screen

Patients aged 65 and over are at increased risk of falls. Patients under 65 with other risk factors may be at risk of falls, depending on clinical condition. (NICE CG161, 2013)

| Is your patient 65 years or over?* | ○ Yes ○ No |
|---|---|

**Section 1 - For all patients 65 and over complete the following questions:**

| 1) Has your patient fallen in the last year? | ☐ Yes | ☐ No |
|---|---|---|

If yes, record details below, including when, where, how often, cause if known, any injuries or hospital admission:

| 2) Does your patient have a fear of falling? | ☐ Yes | ☐ No |
|---|---|---|

If yes, document discussion here:

| 3) Does your patient have any problems with their balance or gait? | ☐ Yes | ☐ No |
|---|---|---|
| 4) Since the age of 50, has your patient broken a bone following a minor accident e.g. a fall? | ☐ Yes | ☐ No |

If yes to either 1, 2 or 3:

a) Address any immediate concerns e.g. signs of delirium, problems with continence, dehydration, malnutrition, clutter, poor lighting, unsafe footwear, vision or hearing problems..

b) Provide falls prevention information; discuss the outcomes of this FALLSTOP: Community Falls Screen with the patient and their relatives/carer as appropriate.

c) Consider referring to community team as detailed below. If the person is already known to a falls team and re-referral not appropriate, please document this in Carenotes:

• Camden - Camden Integrated Primary Care Team via Central Access Team, 020 3317 3400. Referral form available on intranet.

Date referral made

• Islington – Islington REACH via Central Booking Service, 020 3316 1111. Referral form available on intranet.

Date referral made

If yes to 4, and the patient is NOT receiving treatment for osteoporosis, refer patient to their GP for their osteoporosis/fracture risk to be assessed.

(Common osteoporosis medications include: alendronate/alendronic acid, risedronate, ibandronate, zoledronic acid, strontium ranelate, raloxifene, denosumab, teriparatide)

If no to all questions, repeat the FALLSTOP: Community Falls Screen at each annual review or CPA or if there is a deterioration in clinical condition. If concerned about falls risks, make onward referral to above teams.

**Section 2 - For all patients under the age of 65 - Do they have any of the following?**

| | | |
|---|---|---|
| Unsteadiness | ☐ Yes | ☐ No |
| Alcohol/drug withdrawal | ☐ Yes | ☐ No |
| Learning disabilities | ☐ Yes | ☐ No |
| Confusion, agitation or sedation | ☐ Yes | ☐ No |
| Other falls risks (document these below) | ☐ Yes | ☐ No |

If no to all questions, repeat FALLSTOP: Community Falls Screen at each annual review or CPA or if there is a deterioration in clinical condition.

Answer the following if YES to any of the above questions:

| | | |
|---|---|---|
| 1) Has your patient fallen in the last year? | ☐ Yes | ☐ No |

If yes, record details below including when, where, how often, cause if known, any injuries or hospital admissions:

| | | |
|---|---|---|
| 2) Does your patient have a fear of falling? | ☐ Yes | ☐ No |

If yes, document discussion here:

| | | |
|---|---|---|
| 3) Does your patient have any problems with their balance or gait? | ☐ Yes | ☐ No |
| 4) Since the age of 50, has your patient broken a bone following a minor accident e.g. a fall? | ☐ Yes | ☐ No |

If yes to either 1, 2 or 3 address any immediate actions and refer patient to:

a) Address any immediate concerns e.g. signs of delirium, problems with continence, dehydration, malnutrition, clutter, poor lighting, unsafe footwear, vision or hearing problems.

b) Provide falls prevention information; discuss the outcome of this FALLSTOP: Community Falls Screen with the patient and their relatives/carer as appropriate.

c) Consider referring to community team as detailed below. If the person is already known to a falls team and re-referral not appropriate, please document this in Carenotes:

• Camden - Camden Integrated Primary Care Team via Central Access Team, 020 3317 3400. Referral form available on intranet.

Date referral made:

• Islington – Islington REACH via Central Booking Service, 020 3316 1111. Referral form available on intranet.

Date referral made:

If yes to 4, and the patient is NOT receiving treatment for osteoporosis, refer patient to their GP for their osteoporosis/fracture risk to be assessed.

(Common osteoporosis medications include: alendronate/alendronic acid, risedronate, ibandronate, zoledronic acid, strontium ranelate, raloxifene, denosumab, teriparatide)

If no to all questions, repeat the FALLSTOP: Community Falls Screen at each annual review or CPA or if there is a deterioration in clinical condition. If concerned about falls risks, make onward referral to above teams.

**Completed By**

| Name of clinician completing screen* | Designation* | Date | Time |
|---|---|---|---|
| | | 14/03/2019 | 14:38 |

## Appendix 4

# FALLSTOP: Falls Assessment

| ASSESSMENT DETAILS | |
|---|---|
| Date Of Assessment:* | |
| Time Of Assessment:* | |
| Designation:* | |
| Clinician* | |

| FALLS HISTORY | | |
|---|---|---|
| Does the patient have a history of falls? | ☐ Yes | ☐ No |
| **If yes, record details below including when, where, how often, cause if known, any injuries or hospital admissions:** | | |
| | | |
| **If cause of fall unknown, for example loss of consciousness, fainting, dizziness or other concerns, request medical review.** | | |
| Date medical review requested: | | |

| FEAR OF FALLING | | |
|---|---|---|
| Does the patient (or their carers) express any fears or anxieties around falling? | ☐ Yes | ☐ No |
| **If yes, document discussion here:** | | |
| | | |
| Date given: | | |
| **Refer to occupational therapist (OT).** | | |
| Date of OT referral: | | |

| ASSESS COGNITION | | |
|---|---|---|
| Does the patient have a diagnosis of dementia? | ☐ Yes | ☐ No |
| **If yes, complete the 'My Life Story Summary' booklet with the patient / their carer.** | | |
| Date 'My Life Story' booklet started: | | |
| Are there any signs of delirium i.e. recent changes or fluctuations in behaviour/level of confusion? | ☐ Yes | ☐ No |
| **If yes, request medical review.** | | |
| Date medical review requested: | | |
| Does the patient have other cognitive impairment eg. memory loss, reduced understanding of risk? | ☐ Yes | ☐ No |
| **If yes, discuss with MDT and consider referral to psychology or OT.** | | |
| Date of Referral: | | |

| ASSESS CONTINENCE | | |
|---|---|---|
| Does the patient have urinary/faecal incontinence/frequency/urgency/constipation? | ☐ Yes | ☐ No |
| **If yes, refer to Bladder and Bowel service or request medical review.** | | |
| Date of referral: | | |
| **Consider implementing regular toileting i.e. 2 hourly, and add to care plan on Carenotes.** | | |
| Does the patient need assistance with their toileting needs? | ☐ Yes | ☐ No |
| Does the patient use or need continence aids? | ☐ Yes | ☐ No |
| **If yes to either, consider use of continence aids, update care plan on Carenotes and inform MDT.** | | |

## LOWER SAFETY RAILS - Inpatients Only

| | | |
|---|---|---|
| Are there bed safety rails on the patients bed? | ☐ Yes | ☐ No |
| Is the patient at risk of falling out of bed? | ☐ Yes | ☐ No |
| Would the patient potentially benefit from using bed safety rails? | ☐ Yes | ☐ No |
| **If yes to any of these questions, complete the 'Bed Safety Rail Assessment' immediately.** | | |
| Date Completed: | | |

## LEVEL OF HYDRATION & OTHER MEDICAL RISK FACTORS

| | | |
|---|---|---|
| Are there any signs of dehydration or malnutrition? | ☐ Yes | ☐ No |
| **Ensure the MUST tool and the Food & Fluid Chart is completed and any problems identified are actioned. Consider referral to dietician.** | | |
| Does the patient have a complex medical condition which may increase risk of falls? | ☐ Yes | ☐ No |
| **If yes, tick which are applicable:** | | |
| ☐ Stroke | ☐ Parkinson's Disease | ☐ Other Neurological Conditions |
| ☐ Depression | ☐ Diabetes | ☐ Cardiac Disease |
| ☐ Bone / Joint Disorders | | |
| **Ensure these conditions are being appropriately managed throughout admission. If yes to diabetes, ensure diabetic management plan and monitoring regime in place.** | | |
| Is the patient receiving ECT treatment? | ☐ Yes | ☐ No |

## LIST OF MEDICATIONS

| | | |
|---|---|---|
| Has the patient been prescribed 4 or more medications, or any medications that may contribute to falls? | ☐ Yes | ☐ No |
| **If yes, request medical review with pharmacist and medical team.** | | |
| Date Requested: | | |
| **If possible, avoid prescribing or the administration of new night sedation.** | | |
| **If this assessment has been triggered due to an inpatient fall, request a priority medication review with the pharmacist.** | ☐ (tick when completed) | |

## LYING & STANDING BP

| | | | |
|---|---|---|---|
| Check lying and standing blood pressure (BP) and manual pulse. Select 'Click Here' to view the guidance. | Click Here | | |
| **Lying (at least 15 minutes)** | **Standing - Immediately** | **Standing - 1 min** | **Standing - 3 min** |
| | | | |
| Is there evidence of any abnormalities in lying and standing BP or an arrhythmia? | ☐ Yes | ☐ No | |
| Does the patient complain of any dizziness / light-headedness especially on standing? | ☐ Yes | ☐ No | |
| **If yes to any of the above questions request medical review.** | | | |
| Date requested: | | | |

## SURROUNDINGS

| | | |
|---|---|---|
| Is a bedroom with a wheelchair accessible toilet/shower required? | ☐ Yes | ☐ No |
| To improve observation, is a bedroom close to the nurses' station required? | ☐ Yes | ☐ No |
| Are the surroundings clear of clutter and other trip hazards with enough space for movement? | ☐ Yes | ☐ No |
| Is the bed and chair too high or low for a safe transfer, or are there other seating issues? | ☐ Yes | ☐ No |
| **If yes, consider an alternative bed (e.g. high/low bed) / alternative size chair.** | | |
| Does the patient need additional lighting at night e.g. night light in toilet? | ☐ Yes | ☐ No |
| Does the patient have difficulty opening doors? | ☐ Yes | ☐ No |
| **Discuss with MDT including OT; ensure room and facilities are appropriate; document in Care Plan/Risk Assessment** | | |
| Does the patient have difficulty using or accessing the call bell? | ☐ Yes | ☐ No |
| **Are any of the following appropriate:** | | |
| Intermittent Observation? | ☐ Yes | ☐ No |
| Within Eyesight Observation? | ☐ Yes | ☐ No |
| Within Arm's Length Observation? | ☐ Yes | ☐ No |
| **Ensure appropriate level of observation in place and documented.** | | |
| **Ensure, as appropriate, the following are within easy reach: Call Bell; Mobility Aid; Bedside Table; Food and Drink.** | | |
| **Ensure the patient is orientated to the ward.** | ☐ (tick when completed) | |

| SHOES & SLIPPERS | | |
|---|---|---|
| Does the patient have unsafe footwear or bare feet? E.g. ill-fitting, poor grip, backless, high heeled shoes/slippers or only socks? | ☐ Yes | ☐ No |
| **If yes, encourage to wear suitable footwear. If necessary, ask relative to provide safe footwear.** | ☐ Yes | ☐ No |
| Date requested: | | |
| If no safe footwear is obtainable, does the patient need falls slipper socks? | ☐ Yes | ☐ No |
| **Arrange for these to be ordered.** | ☐ (tick when completed) | |

| TEST FOR INFECTION | | |
|---|---|---|
| **Perform a urinalysis.** | | |
| Date Urinalysis completed: | | |
| Is the urinalysis positive for blood, nitrates or protein? | ☐ Yes | ☐ No |
| **If yes, send MSU.** | | |
| Date MSU sent: | | |
| **Report abnormal results to medical team. Monitor TPR, BP, oxygen saturation and NEWS weekly.** | | |
| **If patient is at risk of infection, monitor TPR, BP, oxygen saturation and NEWS daily.** | | |

| TEST VISION & HEARING | | |
|---|---|---|
| Does the patient have impaired vision or hearing? | ☐ Yes | ☐ No |
| Does the patient wear glasses or a hearing aid? | ☐ Yes | ☐ No |
| **If yes, check they being worn, clean and working (label with name if at risk of misplacing).** | ☐ (tick when completed) | |
| Does the patient express concerns about their vision or hearing? | ☐ Yes | ☐ No |
| **Request medical review if concerns with vision or hearing.** | | |
| Date Requested: | | |

| OSTEOPOROSIS & BLEEDING RISK | | |
|---|---|---|
| Has the patient broken a bone since age of 50 or do they have osteoporosis? | ☐ Yes | ☐ No |
| Is the patient being prescribed any anti-coagulant or anti-platelet medications? | ☐ Yes | ☐ No |
| **If yes to either of the above, there is a risk of significant injury from a fall, so:** | | |
| **• Request medical review** | | |
| Date requested: | | |
| **• Consider placing 'High risk of injury' magnet on ward whiteboard and sign in patient's bedroom.** | ☐ (tick when completed) | |
| **• Add 'At risk or falls AND significant injury i.e. fracture/sub dural haemorrage' to Carenotes.** | ☐ (tick when completed) | |
| **• Discuss risk at handovers/ward rounds/MDT meetings.** | ☐ (tick when completed) | |
| Does the patient need a high/low bed with crash mats? | ☐ Yes | ☐ No |
| Does the patient require increased nursing observations? | ☐ Yes | ☐ No |
| **Ensure these are in place** | | |

## OCCUPATIONAL THERAPY

| | | |
|---|---|---|
| Has the patient fallen in the last year, been admitted to hospital recently following a fall, got a severe visual impairment or had a recent functional decline? | ☐ Yes | ☐ No |
| **If yes refer to OT.** | | |
| Date referred: | | |
| Is any equipment needed to help improve transfers? | ☐ Yes | ☐ No |
| Is support required to improve engagement in falls prevention interventions? | ☐ Yes | ☐ No |
| **If yes, to either, refer to OT.** | | |
| Date referred: | | |

## PROBLEMS WITH MOBILITY

| | | |
|---|---|---|
| Does the patient show any signs of being unsteady when transferring, standing or walking? | ☐ Yes | ☐ No |
| Are there any abnormalities of gait? | ☐ Yes | ☐ No |
| **If yes, to any of the above refer to physiotherapy.** | | |
| Date of physiotherapy referral: | | |
| Does the patient require a walking aid and/or assistance to transfer/mobilise? | ☐ Yes | ☐ No |
| **If yes, detail what walking aid and assistance is required:** | | |
| | | |
| **If patient uses a walking aid, check it is in good working order and ensure it is within easy reach at all times. If assistance is required, encourage patient to call staff before mobilising.** | | |

## PODIATRY

| | | |
|---|---|---|
| Does the patient have any problems with their feet i.e. long toenails, bunions, corns, oedema of feet/ankles, hard skin, redness, pain or discomfort? | ☐ Yes | ☐ No |
| **If yes document problems here and update care plan on Carenotes:** | | |
| | | |
| Refer to Podiatry: | | |

## Summary

| | |
|---|---|
| **Please briefly summarise falls risks and plan to address these in boxes below:** | |
| **Risk** | |
| **Plan** | |

## Outcome

| | **Signature: (Print name and designation)** |
|---|---|
| **Outcome of assessment discussed with patient and relatives / carers as appropriate.** | |
| **Place the at risk of falls 'F' magnet next to patient's name on ward whiteboard and place 'F' sign in their bedroom.** | |
| **Ensure this assessment is summarised in notes and that risks are documented in care plan and risk assessment on Carenotes.** | |

## FALLSTOP Repeat Assessment

Six repeat assessments can be recorded here. After that, please start a new form. Document any change from the initial assessment against each letter. If there is no change, document 'No Change'. Refer to policy for frequency of re-assessments

| Repeat Assessment 1 | |
|---|---|
| Date: | |
| Time: | |
| F | |
| A | |
| L | |
| L | |
| S | |
| T | |
| O | |
| P | |
| Staff Member: | |
| Designation: | |

## Appendix 5

# FALLSTOP: Pharmacist Medication Assessment

## For pharmacist to complete for all patients:

- Following a fall (assessing medications at point of fall), or
- Admitted who are over 65 (assessing pre-admission and current medications)
- Admitted who are under 65 years and identified by the FALLSTOP: Inpatient Falls Screen as being at risk of falls (assessing pre-admission and current medications)

Document all falls risk medicines (as per table below) and any recommendations below:

**Pharmacist Details:**

| Name of pharmacist completing assessment* | Designation* | Date | Time |
|---|---|---|---|
| | | | |

**High Risk Medicines:**

| Drug | Recommendations | Result of Recommendations (e.g. stopped, dose adjustment, continued) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Medium Risk Medicines:**

| Drug | Recommendations | Result of Recommendations (e.g. stopped, dose adjustment continued) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Lower Risk Medicines:**

| Drug | Recommendations | Result of Recommendations (e.g. stopped, dose adjustment continued) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Inform medical team of nature of risks and any remedial advice as necessary and document this in medical notes

| | |
|---|---|
| Total no. medicines prescribed | |
| No. falls risk medicines prescribed | |

**Medications that may contribute to Falls:**

| High Risk Drug | Conditions used for | Common drug names |
|---|---|---|
| **Anti Depressants** | Used for depression described as low mood, unable to cope, anxiety. Sometimes used for pain relief | Amitriptyline, Dothiepin, Lofepramine, Trazadone, Citalopram, Fluoxetine (Prozac), Paroxetine (Seroxat), Sertraline |
| **Antipsychotics** | Mental illness of many types including disturbed patients, schizophrenia, dementia aggression | Chlorpromazine (Largactil), Haloperidol (Seranace), Promazine, Amisulpride, Olanzapine, Quetiapine, Risperidone, Clozapine |
| **Anti-muscarinic** | Shaking as in Parkinson's disease, side effects of other drugs, urinary frequency, incontinence | Orphenadrine, Procyclidine, Benzhexol, Oxybutynin, Tolteradine |
| **Benzodiazepines and Hypnotics** | Anxiety, calming and to help with sleep | Diazepam (Valium), Chlordiazepoxide (Librium), Lorazepam, Oxazepam, Nitrazepam (Mogadon), Lorprazolam, Lormetazepam, Temazepam, Zaleplon, Zolpidem, Zopiclone, Chloral Betaine (Welldorm), Chloral Hydrate |
| **Drugs for Parkinson's Disease** | Slow movement, rigidity, shaking | Co-beneldopa, Co-careldopa, Selegiline |
| **Moderate Risk** | **Conditions used for** | **Common drug names** |
| **ACE inhibitors** | High blood pressure, heart failure | Captopril, Enalopril, Lisinopril, Perindopril, Ramipril, Trandolapril |
| **Angiotensin II antagonists** | High blood pressure | Losartan, Valsartan |
| **Alpha-blockers** | High blood pressure, prostate disease | Doxazosin, Prazosin, Terazosin |
| **Anti-arrhythmics** | Irregular heart beat, usually faster | Digoxin, Amiodarone, Disopyramide, Flecanide |
| **Anti-epileptics** | Epilepsy (seizures or fits), pain, mood stabiliser | Carbamazepine, Gabapentin, Lamotrigine, Phenytoin, Phenobarbitone, Epilim (Sodium Valproate), Clonazepam |
| **Anti-histamines** | Allergies, hayfever, rashes, help with sleep | Cetrizine (Zirtek), Desloratidine, Chlorpheniramine (Piriton), Diphenhydramine, Promethazine |
| **Beta-blockers** | High blood pressure, angina (chest pain) | Propranolol, Atentolol, Bisoprolol, Sotaolol |
| **Diuretics** | Fluid retention (swollen ankles, breathing problems) | Bendrofluazide, Indapamide, Frusemide, Bumetanide, Amiloride, Spironolactone |
| **Muscle Relaxants** | Relief of spasticity of voluntary muscle | Baclofen, dantrolene |
| **Low Risk Drug** | **Conditions used for** | **Common drug names** |
| **Calcium channel blockers** | High blood pressure, angina (chest pain) | Amlodipine, Diltiazem, Felodipine, Nifedipine, Verapamil |
| **Nitrates** | Angina (chest pain) | Glyceryl trinitrate, Isosorbide mononitrate |
| **Opiate analgesics** | Pain, especially terminal pain, Codeine used with Paracetamol in small doses for pain | Morphine (MST, Oramorph, Sevredol, Zomorph), Codeine, Dihydrocodeine, Tramadol |
| **Oral anti-diabetics** | Type 2 diabetes – elderly onset | Glibenclamide, Glicazide, Metformin |
| **Proton pump inhibitors PPIs and H2 antagonists** | Stomach ulcers, heartburn | Omeprazole, Lansoprazole, Pantoprazole, Cimetidine, Famotidine, Ranitidine |

## Appendix 6

# FALLSTOP: Bed Safety Rail Assessment

**Complete when indicated on the FALLSTOP Screen, FALLSTOP Assessment or if bed rails are requested by the patient, relative or carer**

- Bed safety rails should ONLY be used when their benefit outweighs the risk to the service user
- The service user should decide whether or not to have bedrails if they have capacity
- Relatives or carers cannot make decisions for adult patients (except in certain circumstances where they hold a Lasting Power of Attorney extending to healthcare decisions under the Mental Capacity Act 2005)
- **If a service user lacks capacity, staff have a duty of care and must decide if bedrails are in the patients best interests**

### SECTION A: Bed Safety Rail Trigger

Identify which physical risk and mental state factor describes your patient. Use the grid below to identify the risk of bed rail use, then date the box indicated and follow the instructions to complete assessment.

| | PHYSICAL RISK FACTORS | | |
|---|---|---|---|
| **MENTAL STATE** | **INDEPENDENT PATIENT (Manages own needs independently)** | **REQUIRES ASSISTANCE (needs aids to mobilise and / or transfer)** | **PATIENT IS FULLY DEPENDENT (requires assistance with all activities of daily living)** |
| CONFUSED AND DISORIENTATED | DO NOT USE bedrails | DO NOT USE bedrails | Use bedrails WITH CARE |
| DROWSY | DO NOT USE bedrails | Use bedrails WITH CARE | bedrails CAN BE USED |
| ALERT AND ORIENTATED | DO NOT USE bedrails | bedrails CAN BE USED | bedrails CAN BE USED |
| UNCONSCIOUS | Not applicable | | bedrails CAN BE USED |

| Bed safety rail trigger category | DO NOT USE | USE WITH CARE | CAN BE USED |
|---|---|---|---|

| Directions for further assessment | |
|---|---|
| • RED CATEGORY | DO NOT USE bed safety rails and complete section E ONLY |
| • RED CATEGORY | and the patient, relative or carer request Bed Safety Rails - continue from section B |
| • AMBER CATEGORY | and rails are to be raised - continue from section B |
| • AMBER CATEGORY | and bed rails are not used - complete section E ONLY |
| • GREEN CATEGORY | and bed rails are to be raised - continue from section B |

### SECTION B: Benefits versus risk analysis

**Ensure the benefits of safety rails outweigh the risk and complete the following risk assessment**

| The risk of NOT using Bed Safety Rails | | The risk of NOT using Bed Safety Rails | |
|---|---|---|---|
| **Is the patient likely to fall out of bed?** | - Please Select - | **Will bedrails affect the patient's independence?** | - Please Select - |
| Patients may be more likely to slip, roll, slide or fall out of bed if they have mobility or eyesight problems or are confused or drowsy. | | Bedrails can be a barrier to independence for patients who otherwise could leave their bed safely without help. | |
| **Is the patient likely to be injured in a fall from the bed?** | - Please Select - | **Is it possible the patient may climb over the bed safety rails?** | - Please Select - |
| This may be more likely and more serious for older patients, or those who are very ill, or have osteoporosis or take anti-coagulant drugs. | | The severity of injury is increased if the patient climbs over a bedrail and falls from a greater height. | |
| **Will the patient become anxious if bed safety rails are not used?** | - Please Select - | **Could the patient injure, trap or suffocate if the bed safety rails are raised?** | - Please Select - |
| Some patients may be afraid of falling out of bed even though their actual risk is low. | | Bedrails can cause injury if the patient knocks themselves on them or trap their legs or arms between them. There is also a very rare risk of suffocation. | |
| | | **Could the bed safety rails cause the patient distress?** | - Please Select - |
| | | Rails may distress some patients who feel trapped by them. | |
| **BED SAFETY RAIL USE IS RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON THE RIGHT** | | **BED SAFETY RAIL USE IS NOT RECOMMENDED IF THE RISKS ABOVE ARE GREATER THAN THE RISKS ON LEFT** | |

**SECTION C: Is it safe to raise the bed safety rails?**

| Is it Safe? | | Is there an Entrapment Risk? | |
|---|---|---|---|
| Do you consider the patient to be a typical sized adult? | - Please Select - | When the mattress is compressed is the gap between the lower bed rail and the mattress large enough to trap a limb? (the gap should not exceed 120 mm) | - Please Select - |
| If a pressure relieving mattress is required, are the bed rails high enough to prevent the patient from rolling out of bed? | - Please Select - | Is the gap between the bed safety rail and side of the mattress large enough to possibly trap the patients head? (the gap should not exceed 120 mm) | - Please Select - |
| Has the bed rail been inspected and maintained in the past year and is a sticker present to indicate this? | - Please Select - | Is the gap between the bars of the bed safety rail large enough to possibly trap the patients head? (gaps between bars should not exceed 120 mm) | - Please Select - |
| Is the service users' weight below the maximum weight capacity of the bed and mattress supplied? Typically 140-150kg | - Please Select - | Is the gap between the headboard and the bed safety rail large enough to possibly trap the patients head? (the gap should not exceed 60 mm) | - Please Select - |
| Are the bed, bed rails and mattress in good working order? | - Please Select - | If a pressure relieving mattress is required, do the bed rails cause an increased entrapment risk when extra compression is applied to the mattress edge? | - Please Select - |
| Is the bed rail suitable for the intended bed, according to the supplier's instructions? | - Please Select - | Rail bumpers reduce the risk of entrapment, BUT if they move the risk is increased. Can the bed safety rail bumpers move easily once fitted? | - Please Select - |
| Do the fittings or mattress allow the bed rail to be fitted to the bed securely, so that there is no excessive movement? | - Please Select - | | |
| YES to ALL (from above) = Bed Safety Rails can be raised | | One YES or more (from above) = DO NOT USE BED SAFETY RAILS, consider alternative strategies | |
| One NO or more (from above) = DO NOT USE BED SAFETY RAILS | | NO to ALL (from above) = Bed Safety Rails can be raised | |
| If bed rails are not in good working order or have not been serviced in the last year, alert team manager | | If gaps are present that are larger than specified, please contact the Medical Devices Lead | |

**SECTION D: Consent & Capacity**

| | |
|---|---|
| Does the patient have the ability to understand and weigh up the risks and benefits of bedrails once these have been explained to them | - Please Select - |
| If a service user lacks capacity, staff have a duty of care and must decide if bedrails are in the patients best interests and need to consider completing a Deprivation of Liberty Order | |
| Discuss the use of bed safety rails with the patient, relative or carer | ☐ tick when completed |
| Informed consent gained from the patient for the use of bed safety rails | - Please Select - |

**SECTION E: Assessment Outcome**

| | |
|---|---|
| Decision | - Please Select - |
| Assessment Completed By:* | Ian Kane |
| Designation* | |
| Assessment Date:* | 14/03/2019 |
| Assessment Time:* | 14:32 |
| Date of next review: | |

| | |
|---|---|
| Provide the patient with the 'Falls Prevention in an inpatient environment' leaflet which includes 'The correct use of bed safety rails' | ☐ tick when completed |
| Complete a Bed Safety Rail Care Plan on Carenotes | ☐ tick when completed |
| Reassess monthly or if clinical condition changes, complete a new FallStop Bed Safety Rail Assessment | |

## Appendix 7

**Falls Risk Management Strategies**

Falls management requires a multifactorial and multidisciplinary approach, and should include the following elements (COT, 2015, NICE, 2015, NICE, 2014, RCP, 2015)

- Assessment of a history of falls
- Assessment of a history of blackouts or syncope
- Assessment for fear of falling
- Assessment of cognition
- Assessment for the presence or absence of delirium
- A formal assessment for delirium
- Assessment of home hazards as appropriate
- Assessment of osteoporosis/fracture risk
- Assessment of continence and toileting
- Assessment of footwear
- Assessment of gait, balance and mobility
- An evaluation of vision and hearing
- An assessment of and provision for enhanced observation
- A measurement of lying and standing blood pressure
- Manual pulse to be taken which may detect an arrhythmia
- A review of room/bed space most appropriate for the patient
- A care plan to support the patient with cognitive impairment e.g. 'This is me' or ' My Life Story' (tailored to the patient, not generic)
- Access to safe footwear
- Review of all medication for medications that increase falls risk particularly psychotropic medication
- Modification of medications that increase falls risk
- Avoidance of unnecessary sleeping tablets/sedative medication
- Appropriate mobility aid in reach of the patient
- Provision of appropriate walking aids 7-days a week
- Strength and balance training for people with balance and gait problems
- Ensuring that patients have access to their own glasses/hearing aids
- Call bell in sight and in reach of the patient as appropriate
- Provision of oral and written information on falls for the patient
- Provision of oral and written information on falls for family/informal carers