Sheffield Health and Social Care NHS Foundation Trust

Policy:

OPS 016A Falls (Inpatient) Policy

Executive Director Lead	Executive medical director
Policy Owner	Falls lead
Policy Author	Falls lead

Document Type	Policy
Document Version Number	2.0
Date of Approval By PGG	26/07/2021
Date of Ratification	11/08/2021
Ratified By	Quality Assurance Committee (QAC)
Date of Issue	August 2021
Date for Review	31/01/2023 (Extended from 31/07/2022 by PGG on 25/07/2022)

Summary of policy

This policy provides an overview on the assessment and management of falls risk factors for patients admitted to SHSC inpatient wards. The policy also covers the clinical assessment and management of a patient post-fall.

Target audience	All inpatient ward staff

Keywords	Falls, falls risk, multifactorial risk assessment

Storage & Version Control

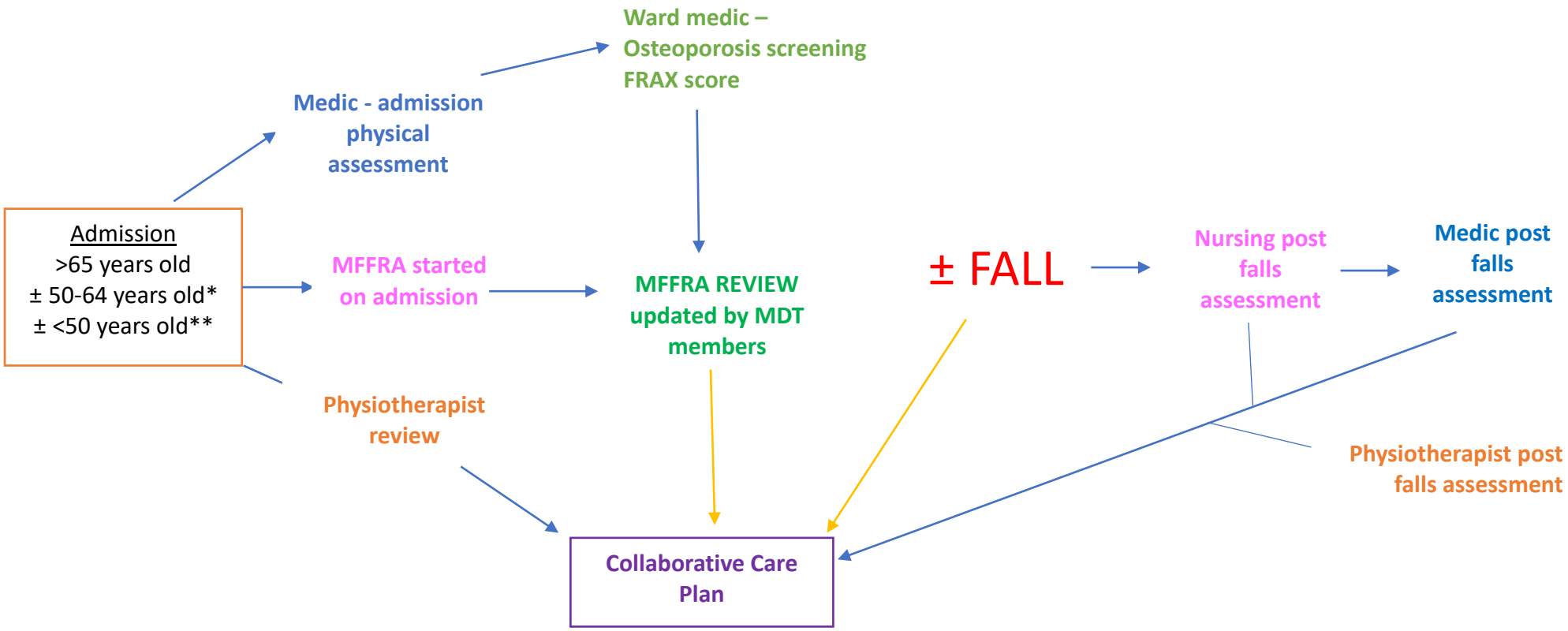
Version 1 of this policy is stored and available through the SHSC intranet/internet. Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
2.1	Replacement of existing policy		Previous falls policy covering inpatient wards and residential care homes
0.1	New draft policy created	07/01/20	New policy created in response to CQC findings
1.0	Approval and issue	08/03/21	Amendments made during consultation, prior to ratification.
2.0	Amendments		• Removal of nursing falls risk assessment on admission tool; this has now been combined within the MFFRA document. • MFFRA document simplified and re-formatted. • Removal of medical post falls assessment document.

Contents

Flowchart



* If judged to be at higher risk of falls due to an underlying condition
** If mobility problems, history of falls or conditions that predispose to falls

1 Introduction

A fall is defined as an event which causes a person to, unintentionally, rest on the ground or a lower level, and is not a result of a major intrinsic (such as a stoke). Falls account for almost two-fifths of patient safety incidents reported to the National Patient Safety Agency (NPSA) resulting in significant human and financial cost.

Falls are extremely common in older adults; approximately 1 in 3 adults over the age of 65 years fall at least once a year. A fall is the leading cause of mortality in those aged over 75 years. Falling in hospital is a common occurrence, with estimates of 600 falls occurring daily on acute hospital and mental health inpatient wards.

Falling has significant and devastating impact on quality of life due detrimental changes to physical health and psychological needs (NICE 2013). Physical and psychological harm post fall are associated with increased rates of morbidity and mortality. Serious fall-related injuries include hip fracture, limb fracture, spinal injury and head injury. It is estimated that 14,000 people die annually in the UK because of an osteoporotic hip fracture (National Service Framework for Older People 2001).

Psychological harm includes a fear of falling and reduced confidence, which negatively impact upon mental state and lead to reduced mobility, increased isolation and increased dependence on others (NICE 2013).

Falls are associated with significant increased healthcare costs due to numerous factors, including increased hospital admission length, surgical interventions and increased care costs on discharge (NICE 2013).

Though falls are more common in older adults, people of any age can experience a fall. Those who have previously fallen are at greater risk of falling again, especially if admitted to hospital. Fall risk is not a static entity and often changes with time and hence the need to review fall assessment and management plans.

Fall management is an important and priority area of patient safety within the NHS. Fall management includes multiple activities from direct patient contact to organisational responsibility.

From an organisation level, appropriate staff training regarding falls management needs to be in place. Appropriate falls data governance is required to identify any gaps or trends in clinical practice in relation to the occurrence and outcomes following a fall. Such data could identify gaps in training needs. Falls management must be transparent and therefore this data must be presented to patients and/or their relatives. Falls governance supports lesson learning from serious incidents and should ensure that current policy is up to date.

All patients admitted to hospital at risk of falling must undergo a multifactorial risk assessment. A fall has a multifactorial aetiology with many risk factors being modifiable (NICE 2013). Assessment of falls risk must be multidisciplinary as no one healthcare professional has the knowledge, experience or competencies to assess a patient's falls risk and devise an appropriate management plan independently. This has led to the recommendation of a multifactorial falls risk assessment and management plan.

Not all falls will be preventable despite a multifactorial falls risk assessment and management plan being in place. The aim of such an assessment and management plan is to reduce the number of falls and severity of injury sustained if a fall does

occur. Any change in the risk factors associated with falling or a fall occurring must trigger a review of the patients falls risk assessment and management plan.

Appropriate management of a patient following a fall is essential to improve the chances of recovery and reduce further injury. A standardised approach to post falls management must be in place.

In summary, falls management involves the need for healthcare professionals to have knowledge and understanding to be falls aware, to have the skills to assess for and address fall risk factors, as well as having the competences to act when someone has fallen.

Strategic approach

The overall aim of the inpatient falls strategy is to

1) Improve falls assessment and management within inpatient wards
2) Reduce the incidence of falls within inpatient wards
3) Reduce the severity of injury sustained following a fall
4) Improve patient outcomes following a fall

These aims will be achieved by the following objectives:

a) Increasing understanding of an individual's fall risk at the point of admission so a provisional management plan can be implemented
b) Improving multifactorial falls risk assessment
c) Improving multifactorial falls risk management interventions
d) Reducing the risk of physical harm caused by falls
e) Improving clinical practice through effective governance of falls management

The strategy for falls management within the trust is divided into four domains, which are referred to as the '4As of Falls'. See Figure 1. The 4As approach provides a means for staff within the trust to:

- Be ***aware*** of falls – through mandatory training and governance
- ***Assess*** for falls – through provision of an individual assessment to identify falls risk factors
- ***Address*** risk factors for falls – through preventative measures taken to reduce the risk of falling (and sustaining injury)
- ***Act*** when someone has fallen – through management protocols to ensure correct procedures are followed.

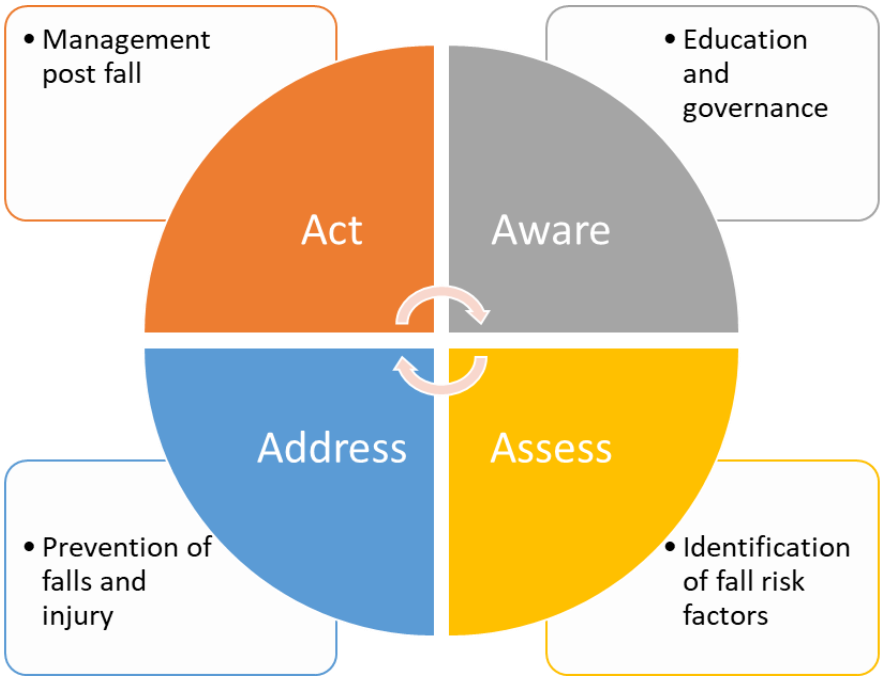


Figure 1: 'The 4As of Falls'

2 Scope

This policy addresses the assessment, prevention and management of falls within SHSC inpatient wards.

This policy is relevant to all patients admitted to inpatient wards who are:

- Aged 65 years or older
- 50 to 64 years of age and judged to be a higher risk of falling because of an underlying condition (this may be a physical or mental health condition)

This policy may extend to patients less than 50 years of age who have mobility difficulties, a history of falling and conditions that predispose to falling, which include the side-effects of prescribed medications.

This policy applies to all healthcare professionals within the trust – substantive, bank and agency – who are responsible for planning and delivering direct patient care. The policy is applicable to all medical, nursing, therapy and care staff.

The policy is based upon the following guidelines, quality standards and literature:

- National Institute of Care Excellence (NICE) (2013, updated 2021). Falls in older people: assessing risk and prevention. Clinical guideline 161.
- National Institute of Care Excellence (NICE) (2015). Falls in older people. Quality standard 86 (QS86).
- National Institute of Care Excellence (NICE) (2015). Osteoporosis. Quality standard 149 (QS149).
- National Institute of Care Excellence (NICE) (2018). NICEimpact: falls and fragility fractures.
- National Institute of Care Excellent (NICE) (2014, updated 2017). Vitamin D: supplement use in specific population groups.

- National Institute of Care Excellent (NICE) (2020). Covid-19 rapid guideline: Vitamin D

3 Purpose

The purpose of this policy is to:

- Raise awareness amongst all staff members for the need for falls assessment, prevention and management.
- Provide patients, and/or their relatives, with information regarding falls management.
- Ensure a multidisciplinary approach to the care and management of patients who are at risk of falling or who have fallen.
- Reduce the risk of falling by means of multi-factorial falls risk assessment and implementation of appropriate interventions for falls prevention.
- Ensure a standardisation of assessment post fall to reduce the risk of injury.
- Ensure effective falls data governance is in place

4 Definitions

Fall – is an event which results in an individual coming to rest unintentionally on the ground or other lower surface, whether or not an injury is sustained.

Slip – is a slide accidentally causing the individual to lose their balance; this is either corrected or causes the individual to fall.

Trip – is to stumble accidentally, often over an obstacle, causing the individual to lose their balance; this is either corrected or causes the individual to fall.

Hazard – can be defined as any source of potential damage, harm or adverse health effects.

Risk – can be defined as the chance or possibility that an individual will be harmed or experience an adverse health effect if exposed to a hazard.

5 Duties

Trust Board – The Trust Board has ultimate responsibility for managing the implementation of health and safety within the trust.

Executive Directors Group – The Executive Directors Group is responsible for the ratification of this policy and ensuring it is implemented by all clinical corporate staff

6 Procedure

As described above, the inpatient falls strategy is divided into four domains; aware, assess, address and act.

6.1. *Fall Aware – Increasing trust, staff, patient and relative awareness of falls through education and governance*

Staff level awareness

All healthcare professionals who have contact with patients should develop and maintain basic professional competence in falls assessment and prevention. Such competence will be achieved by mandatory training completed on a three-yearly basis:

a. All inpatient nursing and support staff will complete the e-learning package 'Preventing falls in hospital'

b. All inpatient medical staff and on-call junior doctors will complete the e-learning package 'CareFall'.

These e-learning packages are accessible at https://www.e-lfh.org.uk/programmes/preventing-falls/

Inpatient nursing staff, junior doctors and physiotherapists should be competent in measuring lying and standing blood pressure. Such staff members should be familiar with the Royal College of Physicians guidance on measuring lying and standing blood pressure. Please see Measurement of lying and standing blood pressure: A brief guide for clinical staff | RCP London.

All inpatient staff should be aware to report all fall incidents using the trust incident report system Ulysses.

Trust level awareness

Root cause investigations will take place for all serious falls so that lessons can be learnt to prevent similar incidents.

Patient and/or carer level awareness

Individual patients who are at risk of falling, and their cares, should be offered information orally and in writing about falls. This will be achieved by:

1) Patients named nurse, and/or physiotherapist, to speak to patient, and/or carer, about falls risk and management and to document this conversation on their electronic patient record notes.

2) Patients individualised falls risk assessment and management plan being documented in their Collaborative Care Plan and a copy to be offered to the patient and/or carer. This action should be documented within the patients electronic patient record notes.

6.2 *Assess – Assessment of individual falls risk*

It is an accepted fact that all patients over the age of 65 years (and some patients under this age) are at risk of falling whilst in hospital.

Certain underlying medical conditions are known to particularly increase the risk of falling in those aged 50 to 65 years of age. Examples of such conditions include stroke, arthritis, Huntington's disease and Parkinson's disease.

Fall risk prediction (screening) tools are not recommended for use by NICE.

Required documentation
All patients over the age of 65 years, and those identified as 50-65 years who are at an increased risk of falling due to an underling medical condition, will require a specific 'Falls and Mobility' goal within their Collaborative Care Plan.

Falls risk must also be included in the DRAM.

Multifactorial falls risk assessment
All patients over the age of 65 years, and those identified at risk under 65 years of age, will undergo a MFFRA. A MFFRA aims to identify the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their inpatient stay. See Table 1 for areas covered by the MFFRA.

Assessment domains of MFFRA
Identification of falls history – this should include i. Have they fallen in the past year? ii. How often have they fallen? iii. Determination of the context and characteristics of the fall(s)
Assessment of gait, balance, mobility, strength and muscle weakness
Assessment of perceived functional ability and fear relating to falling
Osteoporosis and fracture risk
Assessment of visual impairment
Assessment of cognitive impairment and neurological examination
Assessment of urinary incontinence
Cardiovascular examination
Medication review

Table 1: Assessment domains of the MFFRA

On admission all patients over the age of 65 years, and those identified as 50-65 years of age who are at an increased risk of falling due to an underlying medical condition, will require a MFFRA to be started. The MFFRA is accessible through the document section on the electronic patient record system. See Appendix 3.

Commencing an MFFRA on admission will provide a provisional falls assessment and management plan until all members of the multidisciplinary team are able to complete their respective sections. An MFFRA is not the sole responsibility of one profession or individual. The MFFRA will be formally reviewed by the MDT at the first opportunity, this may be within the first MDT meeting.

The MFFRA will be completed by contributions from the following professionals; medical, nursing, physiotherapy, pharmacy, occupational therapy, psychology and dietitian.

A summary of findings of the MFFRA should be documented in a patients Collaborative Care Plan.

All patients, and/or their relative, will be offered a copy of their Collaborative Care Plan. Nursing staff should document if this has occurred.

Falls history
A falls history should also be elicited by nurse on admission and documented on the MFFRA.

Lying and standing blood pressure
All patients should have a lying and standing blood pressure recorded on admission. The need to continue to measure lying and standing blood pressure will be determined by the regular medical team or on-call junior doctor.

Medical assessment
Assessment of cognitive impairment, neurological examination, cardiovascular examination, assessment of urinary incontinence and medication review are performed by the junior doctor or physicians associate when the patient is admitted.

The medical team will assess patients for risk factors for osteoporosis. All women aged >65 years or older and all men aged 75 years or older should have a FRAX score calculated. The FRAX tool is available here: https://www.sheffield.ac.uk/FRAX/tool.aspx.

All patients admitted over 50 years of age who have had a previous fall should have a FRAX score calculated regardless of the presence of osteoporosis risk factors.

A FRAX score should be calculated for women less than 65 years and men less than 75 years of age with no history of previously falling if any risk factors for osteoporosis are present. See Table 2.

Risk factor
Steroid use
Low BMI
Cigarette smoking
Excess alcohol intake
Lack of physical activity
Vitamin D deficiency
Low calcium intake
Family history of hip fracture
Previous fracture in site characteristic of osteoporosis
Early menopause
Associated diseases (e.g. rheumatoid arthritis and diabetes)

Table 2: Osteoporosis risk factors

Medication reconciliation and review
Medical reconciliation occurs for all patients when admitted to an inpatient ward. For patients 65 years or older, and for select patients aged 50 to 64 years, the ward pharmacist will also undertake a medication review specifically for falls risks and document this on the ‘Pharmacy

medical review for falls' document. See Appendix 4. The pharmacy review will be discussed in MDT and the information will be populated into the MFFRA.

Nutritional assessment

Nutritional deficiencies should be identified as these can contribute to impaired balance and strength. All patients will be assessed using the Malnutrition Universal Screening Tool (MUST) on admission, which includes a measure of BMI and weight loss. All nursing staff will be fully training to complete MUST accurately, understand it's limitations and develop an appropriate nutrition action plan. Such action plan will be documented in the patients care plan.

All patients should be prescribed Cholecalciferol on admission if not already prescribed and regardless of whether they are deficit in Vitamin D or not.

All patients will have their need for a calcium supplement considered.

Physiotherapist assessment

All patients will be assessed by a physiotherapist as soon as possible following admission. Information gained will contribution towards the Multifactorial Falls Risk Assessment (MFFRA).

Environmental factors

Inpatient areas should be regularly checked for environmental risks for falls as per the trusts risk management strategy.

Any identified concerns relating to the environmental should be addressed and/or reported to estates immediately.

Identification of patients most at risk of falling

Patients who are most at risk of falling should be easily identifiable by all staff members on shift. Patients at most risk should be identified at handover and in safety huddles.

6.3. *Address – Prevention of falls through addressing identified risks*

The MFFRA will form the basis of an individualised multifactorial intervention. Where possible a patient should be encouraged to participate in their individualised falls prevention plan. This should be facilitated by open discussion, collaboration and information sharing with the patient.

All MDT members should bear in mind that a patient's level of risk in terms of falls may not remain static and therefore their falls management plan may change through the course of admission.

Walking aids

Nursing staff should label walking aids so that the patient does not use an aid that is not theirs.

If there is evidence of damage to the walking aid the ward physiotherapist should be informed. The physiotherapist should explore options for acquiring a replacement if damage is evident.

It is the responsibility of a physiotherapist to ensure that a patient's walking aid is appropriate for them (i.e. correct height, correct type of aid).

Footwear

If nursing staff have identified a patient as having inappropriate footwear on admission the need for a safer replacement must be addressed immediately. If appropriate footwear cannot be provided by a carer/relative, anti-slip socks should be provided to the patient.

Postural hypotension

Nursing staff should advice all patients who have been identified as having postural hypotension to slowly rise from sitting in a chair or getting out of bed.

Medical management

If any physical health problem is identified that may contribute to falls risk the patient should be referred to the necessary medical speciality, if indicated, by the ward medical team if they are unable to manage the issue independently. For example, cardiac pacing should be considered for patients with a cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls.

The medical team will devise a management plan for all patients identified as having postural hypotension, bradycardia or tachycardia.

The medical professional calculating the FRAX score should follow the guidance of the National Osteoporosis Guideline Group in terms of fracture risk management. The detailed guidance is available here:
https://www.sheffield.ac.uk/NOGG/NOGG%20Guideline%202017.pdf

A patient's medications will be reviewed upon admission by the medical team. The rationale for the prescribing of psychotropic medication, in terms of falls risk, will be documented in the 'Review' notes and on the MDT proforma by the prescriber and medical team respectively. The Collaborative Care Plan should be updated as necessary.

Management of visual impairment

If a patient has been identified as having a visual impairment they should be referred for an eye test if indicated and appropriate. Nursing staff should liaise with a relative/carer to arrange this. Opticians can attend inpatient wards to undertake an eye test at a cost to the patient.

Management of hearing impairment

If a patient has been identified as having a hearing impairment, they should be referred to audiology if indicated and appropriate. Patients can be referred to the audiology department at the Royal Hallamshire Hospital.

If a patient has a hearing aid the ward team should ensure that it is working appropriately e.g. batteries are working, does not need cleaning, etc.

Management of nutritional concerns

Patients who are at risk of falls that have a MUST score ≥ 2, are frail, who have muscle wastage, dysphagia &/or medical conditions that affect nutritional health e.g. gastroenterological, neurological etc. should be referred to the dietitian and the medical team informed.

The ward will be able to provide an appropriate diet (see nutrition strategy), including nourishing snacks & drinks, for those with a poor appetite.

The dietitian will provide nutritional advice and may recommend the prescribing of supplements. The dietitian should document the outcome of their review in the Collaborative Care Plan as well as in a 'Review' note.

Physiotherapy

A physiotherapist will undertake an initial assessment of the patient and devise a tailored physiotherapy plan for patients if required.

Group physiotherapy sessions will be held on older adult inpatient wards where appropriate, which all patients will be encouraged to attend.

Fear of falling

If a patient has a fear of falling occupational, physiotherapy and psychological interventions should be offered to address this. There is an evidence base for the cognitive behavioural therapy.

Medical devises to manage falls risk

Hip protectors should not be routinely offered to all patients. Hip protectors should be offered to patients who are considered at high risk of falling. Such patients will be identified by the MDT. It should be documented in the patients electronic patient record notes and on their care plan if they have been offered hip protectors and if they refuse to wear them.

If a patient is deemed at high risk of falling use of a bed and/or chair alarm should be considered by the nurse on admission. Use of a bed alarm should be reviewed within the MDT. The role of a bed alarm is to alert nursing staff when a patient is mobilising so that assistance can be provided. A bed/chair alarm does not prevent falling alone.

If a patient requires a bed and/or chair alarm nursing staff should bear in mind how far the patients bedroom is from the nursing hub; the further the distance, the longer the time it will take for nursing staff to respond and so the higher risk of a patient falling on mobilising from their bed and/or chair.

For patients who are at risk of falling out of bed the use of a bed safety rail should be considered. A bed rail is not appropriate for all patients and therefore a risk assessment must be completed; this can be found on the electronic patient record system. If a patient is unable to provide consent for use of a bed safety rail a capacity assessment is required and, if necessitated, a best interest decision should be made and documented.

Observational level

If a patient is at high risk of falling the nurse on admission should consider placing the patient on a 1:1 observational level. Observational level in terms of falls risk will be reviewed within the MDT.

Observational levels can be reviewed at any time point throughout admission.
If a patient is on a 1:1 observation level consideration should be made by the MDT regarding whether the observation level can be reduced when the patient is in bed asleep if a bed alarm is in-situ.

The purpose of a 1:1 observation level is to prevent a patient from falling in the first place; the purpose of 1:1 observation is not to stop a patient from falling when they have started to fall.

7.4 Act – Acting when a fall has occurred

A patient's chances of making a full recovery when a fall has occurred are dependent upon safe manual handling and prompt assessment and treatment.

If a patient is falling staff should not attempt to catch them as this can result in both injury to the patient and staff member. If safe to do so, the staff member should assist the patient downwards and safely to the floor.

Nursing assessment post-fall

If a patient falls the Post Falls Protocol should be followed if available. See Appendix 5. This protocol should be easily accessible to all staff members, e.g. laminated and placed in the nursing office.

Initial focus post fall is rapidly identifying and treating any resultant injury. Physical observations (use of NEWS2) and assessment for injury should be performed immediately post fall.

Assessment post fall should include enquiries for comfort and pain. All patients who have fallen should be checked for signs or symptoms of a hip fracture, spinal injury and head injury. See Table 3.

Moving a patient with a potential spinal injury or suspected fracture before an injury has been appropriately immobilised can cause severe harm.

Any obvious environmental hazards which appear to have contributed to the fall should be made safe if possible.

If the patient is unable to stand themselves appropriate manual handling techniques and/or equipment (e.g. a hoist) should be used if it is safe to move the patient.

Spinal injury	**Hip fracture**
Unnatural posture/position Pain in neck or back Step/twist in curve of spine Pale, cool, clammy skin Slow pulse Difficulty breathing Loss of bladder/ bowel control Loss of feeling &/or movement	Pain Limb shortening & rotation Difficulty mobilising Difficulty weight bearing
Head injury	
Unconsciousness/lack of full consciousness	
Problems understanding, speaking, reading or writing	
Loss of feeling in part of the body	
Problems balancing or walking	
General weakness	
Any changes in eyesight	
Any clear fluid running from ears or nose	
A black eye with no obvious damage around the eye	
Bleeding from one or both ears	

New deafness in one or both ears
Bruising behind one or both ears
Amy evidence of scalp or skull damage
Seizure

Table 3: Signs and symptoms suggestive of injury post fall

Medical review

A doctor/physician associate/advanced clinical practitioner should review the patient post fall as soon as possible even if no obvious injury has been sustained.

The reviewing professional should consider investigation for a medical cause of the fall (e.g. delirium, cardiovascular factors).

Falls management plan review

If the cause of the fall is known this should be clearly documented within the patients notes and on the incident report. Staff should not guess the cause of the fall.

Nursing staff should review the patient's observation level and need for chair or bed alarms.

Other actions required post fall

The patients relative should be informed by the nurse in charge as soon as possible of the fall and actions taken to treat injury and manage risk of further falls.

An Ulysses incident report should be completed as soon as possible by nursing staff following a fall and should provide sufficient details for analysis and review purposes.

The aim for Ulysses incident report to replace the need for a Falls log to be completed if all required information can be included.

The patients DRAM should be updated immediately following a fall.

Following a fall, the MFFRA will be reviewed and update; such review should take place as soon as possible. Dates of update should be documented within the MFFRA form as directed. The CCP should be updated in regard to changes made on the MFFRA.

Patients repeatedly falling

Some patients will repeatedly fall despite review of the MFFRA and management plan following a fall. For patients who frequently fall, use of 1:1 observations should be considered.

Referrals to a general physician or Care of the Elderly consultant should be considered to ensure no medical cause of the falls has been missed.

Patients who deliberate place themselves on the floor or fall

Deliberate placement on the floor or deliberate falling can result in significant injury and post fall assessment should not differ from patients who non-deliberately fall. It should be borne in mind that such patients can experience non-deliberate falls as well. However, if a person has been witnessed deliberately placing themselves on the floor in a controlled manner and no injury appears present a post fall assessment may not be necessary.

Exploration of reasons why patients deliberately place themselves on the floor or fall should occur. Such patients may benefit from psychological formulation.

7 Development, Consultation and Approval

This section should include details of:

This policy was developed by the falls lead. The policy is based on relevant NICE guidelines. Elements of the policy were discussed in the falls prevention group.

This policy was reviewed by Policy Governance Group.

The policy will be reviewed in July 2022.

8 Audit, Monitoring and Review

Falls data will be reviewed monthly in the Falls Prevention Group. Quarterly reports of data will be provided to the Patient Safety Group.

Compliance with NICE standards, as encapsulated by this policy, will be audited on an annual basis.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Provisional falls risk management plan will be in place on admission	Timely completion of nursing falls risk on admission assessment tool	Falls prevention group	Annual	Falls prevention group	Falls prevention group	Falls prevention group
Multifactorial risk assessment and management plan present for patients who require one	Timely and concise completion of MFFRA	Falls prevention group	Annual	Falls prevention group	Falls prevention group	Falls prevention group
Thorough nursing assessment of injury post fall	Review of electronic patient record/Completion of proforma	Falls prevention group	Annual	Falls prevention group	Falls prevention group	Falls prevention group

Medical assessment post fall completed	Review of electronic patient record/Completion of proforma	Falls prevention group				

As this policy involves significant changes from the previous policy a review by the Falls Prevention Group will occur in July 2021. Routinely, however, this policy will be reviewed on a three-yearly basis or sooner in accordance with changes to NICE guidelines.

9 Implementation Plan

This policy was developed as part of the 'Back to Good' Programme and included as part of the Physical Health Project. More details of implementation are awaited from the Physical Health Project.

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Identified e-learning modules to be linked to mandatory training on ESR	Jennie Wilson	*01/08/2021*	
All current falls related electronic patient record documents to no longer be used in inpatient areas with exception of 'Falls log'. New falls documentation to be added to electronic patient record; order of priority identified as MFFRA, admission risk assessment and pharmacy proforma.	Chris Woods/Abhi Johnson	*01/08/2021*	
Slip socks or slippers to be available on the wards to be provided to patient if they have unsuitable footwear	Ward managers		
Adequate supply of bed/chair alarms available for use	SOM		
Physiotherapy presence in MDT			
Mechanism of generating required falls data for falls governance			

10 Dissemination, Storage and Archiving (Control)

This policy will be available to all staff via the trust intranet.

This policy replaces the policy titled ‘MD 007 Falls (inpatient and residential areas)’.

A communication email will be distributed notifying staff of the new inpatient falls policy and the main changes that this involves.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	08/03/2021			
2.0	August 2021	August 2021	August 2021	
3.2				
4.0				

11 Training and Other Resource Implications

All healthcare professionals who have contact with patients should develop and maintain basic professional competence in falls assessment and prevention. Such competence will be mandatory and will be provided at induction and three-yearly thereafter.

Mandatory training will be delivering by e-learning, which is accessible by ESR. All inpatient nursing and support staff will complete the e-learning package ‘Preventing falls in hospital’ All inpatient medical staff and on-call junior doctors will complete the e-learning package ‘CareFall’.

Inpatient nursing staff, junior doctors and physiotherapists should be competent in measuring lying and standing blood pressure. Such staff members should be familiar with the Royal College of Physicians guidance on measuring lying and standing blood pressure.

All inpatient staff should be aware to report all fall incidents using the trust incident report system Ulysses.

12 Links to Other Policies, Standards (Associated Documents)

Health and Safety Policy
Incident Reporting Policy
Risk Management Strategy
Back Care and Manual Handling Policy
Head injury management

13 Contact Details

Title	***Name***	***Phone***	***Email***
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Fall physiotherapist	Sapna Tulshan	0114 27150676	Sapna.Tulshan@shsc.nhs.uk
Pharmacist	Faith Kauseni	0114 2718474	Faith.Kauseni@shsc.nhs.uk
Dietitian	Libby Johnson	0114 27164293	Libby.Johnson@shsc.nhs.uk dietetic-referral@shsc.nhs.uk

Appendix 1

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: C Pocklington 4/6/21	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age			
Disability			
Gender Reassignment			
Pregnancy and Maternity			

Race			
Religion or Belief			
Sex			
Sexual Orientation			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date

Appendix 2

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	?
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	N
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y

Appendix 3: Multifactorial falls risk assessment and management (MFFRA) document

Multifactorial Falls Risk Assessment and Management Plan				
Name: **Hospital no.:**		**Ward:** **Date of admission:**		**Date commenced:** **Review dates:**
Falls history (within past 2 years):				
Previously fallen?	Y/N	Date(s): How many times:		
Cause identified?	Y/N	Cause:		
Circumstances of last fall	Activity at time: Where: Pattern: Other information:			
Any blackouts/LOC before falling?	Y/N	Review ECG Y/N/NA	Refer to cardiology Y/N/NA	
Any dizziness before falling?	Y/N	Assess for postural hypotension – see cardiovascular section below		
FALLS PREVENTION ASSESSMENT				
Past psychiatric and PMH:		**Reasons for admission and current physical health issues:**		
	On admission	**Assessment review**		**Further detail/Action**
Balance and gait	Concerns about balance and gait? Y/N	Unsteady on feet	Y/N	Physiotherapist review
		Problems with balance	Y/N	
		Problems with muscle strength	Y/N	
		Problems with joint ROM	Y/N	
		Abnormal gait	Y/N	
		Difficulty standing	Y/N	
		Slower reaction times	Y/N	
		Fear of falling	Y/N	

		Walking aid	Y/N	
		Mobility impaired by pain	Y/N	Medic review analgesia
Footwear	Appropriate footwear? Y/N	Safe alternative provided	Y/N	N – provide slip socks
Cardiovascular	Lying BP: Standing BP: Heart rate:	Feel dizzy/lightheaded on standing	Y/N	Medics to review Advise patient to stand slowly
		Legs 'give way' on standing	Y/N	
		>20mgHg difference in lying and standing BP	Y/N	
		Pulse <60 or >90	Y/N	Medics perform ECG
Cognitive impairment	Cognitive impairment evident? Y/N Known dementia? Y/N	Able to summon help post fall	Y/N	Consider observational level and use of assistive technology
		Able to use nurse call bell	Y/N	
Bone health	Known osteoporosis? Y/N	Diagnosis of osteoporosis	Y/N	Medics to review management
		FRAX score major fracture:	Medics to follow management advice	
		FRAX score hip fracture:		
		Calcium deficiency	Y/N	Colecalciferol to be prescribed as per policy
		Vitamin D deficiency	Y/N	
Vision	Visual impairment? Y/N Has glasses? Y/N	Will wear glasses	Y/N	
		Glasses broken:	Y/N	Ask family to replace
Toileting	Incontinent? Y/N Urine dip abnormal? Y/N	Urinary symptoms	Y/N	Medics to review cause
		Bowel symptoms	Y/N	
		Incontinent	Y/N	Type:
		Can locate toilet independently	Y/N	To care plan
		Can use toilet independently	Y/N	
Nutrition	BMI <22 Y/N Nutritional concerns Y/N	BMI <22	Y/N	Refer to dietitian
		Nutritional concerns	Y/N	
		Special dietary needs	Y/N	
		Recent weight loss	Y/N	Medics to review
		Difficulty eating	Y/N	Refer to SALT
Medication	Polypharmacy (>4) Y/N	Polypharmacy (≥4	Y/N	Medics to review

	Prescribed a sedative Y/N Prescribed an anticoagulant Y/N	medications)		ongoing need
		Prescribed antihypertensive	Y/N	
		Prescribed anticoagulant	Y/N	
		Prescribed anticholinergic	Y/N	
		Prescribed medication that affects pulse	Y/N	
		Prescribed sedative	Y/N	
		Prescribed other psychotropic medication	Y/N	
		Rationale for ongoing prescribing of sedative or other psychotropic medication:		

Additional information:

SUMMARY OF FALLS SINCE ADMISSION

Date:	Details (circumstances of falls, cause, injury, etc.)

FALLS RISK MANAGEMENT PLAN

Summary of main risks:

Goals of falls risk management plan:	
Aim to maintain or improve current mobility. Prevent falls from happening. Reduce number of falls that do occur. Reduce severity of injury sustained if fall does occur.	
Actions taken to address risks:	
State specific response to identified risks above.	
Individual physiotherapy plan in place:	Y/N
1:1 observation level required to manage falls risk:	Y/N
Bed alarm in place to manage falls risk	Y/N
Other equipment in place to manage falls risk	*State*

Appendix 4 – Pharmacy medication review for falls proforma

Medication currently prescribed	Indication	Effective in treatment Y/N	High fall risk (see over leaf) Y/N	Is there an alternative Y/N (use STOPP/START) Name alternative options	Can drug be reduced(r), stopped(s) or continued(c)

Hypertensive review

Patient is on how many hypertensives? ____
BP Lying _____
BP Standing _____
BP medications appropriate? Y / N
Any changes:

Anticoagulation Review

Is patient on an anticoagulant? Y/N
What is the indication and duration?

Is the anticoagulant still appropriate?

Outcome:

This list is not meant to be a fully comprehensive but intended to raise awareness of the types of drugs that can contribute to falls. Drugs have been graded as either high, moderate or low risk in terms of their 'potential to cause falls''.

HIGH RISK DRUGS

- **Antidepressants**: Avoid tricyclic antidepressans eg. Amitriptyline. Consider switch to SSRIs.
- **Antipsychotics**: Attempt withdrawal must be gradual to avoid precipitation of withdrawal symptoms. Avoid prescribing Prochloperazine (stemetil) for dizziness.
- **Antimuscarinics /anticholinergics**: Can cause acute confusion in elderly. Eg. Oxybutynin
- **Benzodiazepines & hypnotics**: Stop or reduce to the minimum effective dose. Avoid long acting benzodiazepines eg. Nitrazepam.
- **Dopaminergic drugs used in parkinsons**: Levodopa can cause sudden daytime sleepiness. As patient ages, maintenance doses may need to be reduced.

MODERATE RISK DRUGS

- **ACE Inhibitors/angiotensin II antagonists** eg. Enalopril
- **Alpha blockers** eg. Tamulosin, doxazosin
- **Antiarrythmics** eg. Digoxin, flecainide
- **Antiepileptics** eg. Carbamazepine, phenytoin
- **Antihistamine** eg. Chlorphenamine, cinnarizine
- **Beta-blockers** eg. Bisoprolol
- **Diurectics** eg. Furosemide
- **Opioid** eg. Codeine

LOW RISK DRUGS

- **Calcium channel blockers** eg. Felodipine
- **Nitrates** eg. Isosorbide mononitrate
- **Oral anti-diabetic**. Avoid long acting sulphonylureas eg. Glibenclamide
- **PPI & H2 Antagonists** eg. Cimetidine.

Use the STOPP/START tool kit to help review medication alternatives.

Appendix 5 – Nursing post fall assessment form

Nursing Assessment Post Fall

Call for help
Check ABCDE
Ensure staff safety
Establish if in pain
Establish what happened
Look for injury/deformity
Calculate NEWS2 score

Call for ambulance (Tel: 2222) and start ILS if:
Unresponsive
Cardiorespiratory arrest
Periarrest

DO NOT MOVE PATIENT UNTIL FULLY ASSESSED BY THE APPROPRIATE PERSON

SUSPECTED HIP FRACTURE

Features:		Actions if Yes to any features:
Limb shortening & rotation	Y/N	Call ambulance (Tel:2222)
Difficulty mobilising/weight bearing	Y/N	Keep patient still
Pain around hip	Y/N	No food or drink to be given

SUSPECTED LIMB FRACTURE

Features:		Actions if Yes to any features:
Pain/tenderness at site	Y/N	Call ambulance (Tel:2222)
Deformity	Y/N	Keep patient still, stabilise limb
Difficulty mobilising/weight bearing	Y/N	Do not move unnecessarily
Deep wound/bone visible	Y/N	No food or drink to be given
Swelling/bruising	Y/N	

SUSPECTED SPINAL INJURY

Features:		Actions if Yes to any features:
Pain in neck/back	Y/N	Call ambulance (Tel:2222)
Unnatural posture/position	Y/N	Do not move patients position
Step/twist in curve of spine	Y/N	Keep patient still
Pale/cool/clammy skin	Y/N	No food or drink to be given
Slow pulse	Y/N	Hold their head still
Difficulty breathing	Y/N	Keep head in neck in line with upper body
Loss of bladder/bowel control	Y/N	
Loss feeling and/or movement	Y/N	

All patients should have a medical review following a fall at the earliest opportunity.

Nursing Assessment of Suspected Head Injury Post Fall

Patient has fallen – witnessed head injury, unwitnessed or not sure if head injury

↓

Nursing staff to start neurological observations and ask for a medical review

↓

Medic: obtain history, examine patient, assess for fracture, neurological examination and mental state assessment
Medications: must be inspected for anticoagulants, antiplatelets, etc.
Try to ascertain the cause of the fall: e.g. syncope, clip, postural hypotension, etc.
Further immediate investigation as indicated: ECG
Avoid use of sedative medication if possible

↓ ↓

If GCS 15/15 and other observations normal, neuro obs should be done:

- Half hourly for 2 hours then;
- Hourly for 4 hours then;
- 2 hourly until medical review and 12 hours have passed since fall

It should be handed over at shift changes that a head injury has occurred and medical advice sought if worrying signs develop.

If GCS <15/15 **or** subsequently drops **or** worrying signs are present, neuro obs should be continued half hourly and a CT brain considered:

Worrying signs include:

- Development of agitation, confusion or abnormal behaviour
- A sustained (at least 30 minutes) drop of one point in GCS – especially motor
- Any drop of two or more points in the GCS motor, or three in any other
- Development of headache or persisting vomiting
- New or evolving neurological symptoms or signs
- If there is concern from a carer/family

Patients who are at an increased risk of bleeding (e.g. anticoagulated, liver disease) should be considered for a CT brain in the absence of worrying signs.