Name of Policy: Slips, Trips and Falls Policy (Patient)

Effective From: 24/11/2017

<table>
<thead>
<tr>
<th>Date Ratified</th>
<th>02/11/2017</th>
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<tbody>
<tr>
<td>Ratified</td>
<td>Falls Strategic Group</td>
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<tr>
<td>Review Date</td>
<td>01/11/2019</td>
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<tr>
<td>Sponsor</td>
<td>Director of Nursing, Midwifery and Quality</td>
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<td>Expiry Date</td>
<td>01/11/2020</td>
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This policy supersedes all previous issues
### Version Control

<table>
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<tr>
<th>Version</th>
<th>Release</th>
<th>Author/Reviewer</th>
<th>Ratified by/Authorised by</th>
<th>Date</th>
<th>Changes (Please identify page no.)</th>
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<tbody>
<tr>
<td>1.1</td>
<td>24/04/2013</td>
<td>R Webber</td>
<td>Director of Nursing, Midwifery and Quality</td>
<td>24/04/2013</td>
<td>Amended bed rails assessment tool</td>
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</table>
| 2.0     | 16/03/2015 | Robert Webber, Falls team nurse. | SafeCare Council | 11/02/2015 | • Amended bed rails assessment tool  
• Removed falls risk tool. Added falls assessment and intervention pathway.  
• Removed care standard, all actions now in falls assessment and intervention pathway.  
• Frequency of head injury or un-witnessed fall observations  
• Fractured NOF link  
• Time investigation has to be completed in.  
• Falls sensor monitoring chart |
| 3.0     | 24/11/2017 | Emma Tipping Deb Scott Falls Team Nurses | Falls Strategic Group | 02/11/2017 | • Head injury guidelines removed and replaced with inpatient post falls guidelines and ICAR post fall guidelines  
• Added use of falling star sticker  
• Added new DATIX sub-category for patients who are lowered to the floor or place themselves on the floor  
• Updated HCA training  
• Monitoring compliance updated to include CBA |
Gateshead Health NHS Foundation Trust Slips Trips and Falls Policy

1. Introduction.

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs. (NICE 2013)

“The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, cardiac, neurological or muscular-skeletal conditions, side effects from medication, or problems with their balance, strength or mobility.

Problems like poor eyesight or poor memory can create a greater risk of falls when someone is out of their normal environment on a hospital ward, as they are less able to spot and avoid any hazards.”(Patient Safety First, 2009)

Although the majority of falls result in no harm or minimal injury, the impact on the patient can still be significant, leading to loss of confidence, delayed discharges and loss of independence. The National Patient Safety Agency (NPSA 2005)

Legislation

The Health and Safety at Work Act 1974 requires employers to ensure the health and safety of their employees and others who may be affected by their work activity. In addition, employees must not endanger themselves or others and must use any safety equipment provided.

Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 requires organisations to take proper steps to ensure service users are protected against the risks of receiving care or treatment that is inappropriate or unsafe.

Guidance of this legislation from The Care Quality Commission (CQC) Essential standards of quality guidance states "People who use services have safe and appropriate care, treatment and support because their individual needs are established from when they are referred or begin to use the service. The assessment, planning and delivery of their care, treatment and support:

- Is centred on them as an individual and considers all aspects of their individual circumstances, and their immediate and longer-term needs.
- Is developed with them, and/or those acting on their behalf.
- Reflects their needs, preferences and diversity.
- Identifies risks, and says how these will be managed and reviewed.
- Ensures that risk assessments balance safety and effectiveness with the right of the person who uses the service to make choices, taking account of their capacity to
make those choices and their right to take informed risks.

The Management of Health and Safety at Work Regulations impose a duty on employers to assess the risk of slips, trips and falls to employees and others and to take action to control these risks.

The Workplace (Health, Safety and Welfare) Regulations require floors to be suitable for the purpose for which they are used and free from obstructions and slip hazards.

The Provision and Use of Work Equipment Regulations require work equipment to be well maintained, suitable equipment to be selected and for training in its use to be provided.

The Work at Height Regulations require that work at height is properly planned, appropriately supervised and carried out in a manner which is so far as reasonably practicable safe. Any person working at height must be competent to do so. Suitable and sufficient measures should be taken to prevent any person falling a distance liable to cause personal injury.

2. Policy scope

This is a trust wide policy and applies to:
- all members of staff employed/working within Gateshead Health NHS Foundation Trust;
- all in-patients and out patients attending Trust premises/services;
- all visitors including contractors to Trust properties; and
- all slips, trips and falls, including falls from a height

3. Aim of the policy

The Trust is committed to preventing or minimising the risk of slips, trips and falls to service users, staff, and other stakeholders who visit or use Trust premises. It aims to do this by:
- Ensuring that suitable and sufficient assessments are carried out on patients who are at risk from falls, and implementing any risk reduction measures required to minimise that risk.
- Providing a safe working environment which, so far as is reasonably practicable is free from hazards that contribute to falls.
- Ensuring any slip and trip hazards in the workplace are identified, reported and rectified.
- Ensuring where deficiencies are identified, appropriate risk assessments and risk reduction action plans are in place to reduce falls and ensure the best practice principles are applied.”

4. Duties – roles and responsibilities

The Trust Board

The Board is ultimately responsible for fulfilling all duties assigned to them in current UK Health and Safety legislation and will be responsible for the successful implementation of this policy.
Chief Executive
As accountable officer the Chief Executive is responsible for making sure that appropriate policies and systems are in place to reduce the risk of slips, trips and fall for patients, staff and visitors and that the policies are implemented and monitored.

Director of Nursing, Midwifery and Quality and Joint DIPC
Director of Nursing, Midwifery and Quality and Joint DIPC will lead on the management of patient falls. This will include implementation of this policy which includes the requirements of a patient falls strategy and embraces guidance from both NICE and the Older Persons National Service Framework. Any future guidance issued will be incorporated into the policy and local practice development.

Divisional Managers and Divisional Directors
Divisional Managers and Divisional Directors have a responsibility to make sure that the principles and practices outlined within this policy are implemented within their division.

Managers
Managers will be responsible for making sure that:
- slips and trips and falls risk assessments for their areas of work are available, current and used to populate their local risk register where appropriate;
- patient falls risk assessments (including falls from height) are undertaken and reviewed appropriately in accordance with this policy;
- appropriate action is taken and documented following patient risk assessments;
- local induction arrangements incorporate awareness of slips trips and falls and where indicated in the training needs analysis, suitable supplementary training is given;
- patients, visitors and staff are alerted to any slip or trip risks in the area;
- floor damage is reported via the call logging arrangements;
- staff are made aware of their own responsibility regarding wet surfaces and time required to clean and or maintain surfaces;
- room use and changes of use are risk assessed and or reassessed for slip and trip hazards;
- any incidents associated with a slip trip or fall should be categorised as per guidance on Datix fields, reported and where necessary investigated following the trust Incident Reporting Policy RM04.

The Falls Team
This Falls Team is a multidisciplinary partnership team, made up of nurses, occupational therapists and physiotherapists and is led by a Consultant geriatrician. The team also has input from a part-time orthogeriatrician who works across both medicine and orthopaedics. The team is responsible for:
- Implementing falls prevention strategies and raising awareness of falls prevention;
- The assessment and treatment of older people who have suffered physical and/or psychological harm as a result of a fall;
- Providing education and training in the prevention, assessment, management and treatment of falls;
- Sharing good practice and issues with their individual professional links. e.g. nursing
with the wider Modern Matron network, Nursing clinical leads, physiotherapy and occupational therapy with their own services;

- Providing investigating managers with advice and guidance when a fall has occurred; and
- Reviewing all patients falls via the Datix incident reporting system and providing an annual report to the Patient, Quality, Risk and Safety Committee (PQRS).
- Providing assessment, intervention and rehabilitation for those people who have fallen and who have been referred to the Falls Service.

**Estates Department**

The Estates team will:

- Develop (in conjunction with other trust specialists, e.g. domestic services, prevention and control of infection) policies which include measures to reduce the risk of slips and trips and any respective other legislation and code of practice;
- Develop a trust wide flooring policy in conjunction with other trust specialists;
- Make sure that contracts comply with the flooring policy and all appropriate trust policies and procedures, e.g. the infection prevention and control policies and arrangements for the management of road ways and path cleaning;
- Carry out periodic condition surveys and respond promptly to maintenance call logs in relation to Trust circulation and external road ways and footpaths;
- Develop an annual programme of work to manage any risks associated with the survey findings. This will contribute to the trust’s Estate Strategy; and
- Make sure that appropriate health and safety arrangements are in place for building and engineering contractors working on trust properties.

**Domestic Services**

The domestic services team will:

- Work with other Trust specialists e.g. capital projects team to manage risks associated with slips trips and falls;
- Develop procedures and work practices based on their risk assessments to prevent, reduce or manage the risks of slips trips and falls. e.g. alteration to cleaning programme as a result of inclement weather and provision of effective barriers in entrances;
- Identify risks via the patient environment monitoring programme (involving the Patient Environment Action Group and Patient Environment Action Team PEAG/PEAT) and develop a programme of measures that support the management of the risks. Inform the Director of Operational Services and members of the PEAG group thus supporting their respective strategies; and
- Ensure that domestic all staff are inducted and trained as per trust policy in department procedures, as well as the use of job work sheets e.g. all floors have risk assessments and a job work sheet which takes into account the risks of slips when wet and how to manage the short term risk from cleaning.

**All staff**

All staff must:

- Comply with the guidance in this policy;
- Work in such a manner to prevent or to minimise slip, trip and falling risks and in such a way as to alert others to slipping, tripping and falling risks;
- All healthcare professionals have a responsibility to develop and maintain basic
professional competence in falls assessment and prevention (NICE guidelines 2004);
• Follow the Trust policies and procedures including any locally developed processes;
• Clear up any spillages they see or make sure action is taken to do so. e.g. use a
  warning cone(s) and report to domestic services or estates department;
• call log any leaks or damage to floor coverings that may result in a slipping or
  tripping hazard; and
• Wear suitable foot wear for the environment and its risks which includes any
  personal protective equipment provided.

5. Definitions of terms

A fall
A fall is “unintentionally coming to the ground or some lower level other than as a
consequence of sustaining a violent blow, loss of consciousness, sudden onset of paralysis
as in stroke or in an epileptic seizure” (Kellogg International Working Group 1987).

A more simple definition of a fall is “an unexpected event in which the participant comes
to rest on the ground, floor or lower level” (Profane 2005)

A near fall/near miss
A near fall/near miss are “A sudden loss of balance that does not result in a fall.” This can
include a person who slips, stumbles or trips but is able to regain control prior to falling.

An un-witnessed fall
This occurs when a patient is found on the floor and neither the patient nor anyone else
knows how he/she got there.

Fall from a height
“A place is ‘at height’ if a person could be injured falling from it, even if it is at or below
ground level.” (HSE 2005) this includes patient equipment such as a bed or, trolley.

6. Prevention and management of slips, trips and falls

6.1 Falls Assessment and Intervention Pathway
• Excluding maternity (see maternity recovery policy) all in-patients are to
  have their falls risk assessed using the Falls Assessment & intervention
  pathway.
• (Directions and examples for completion of the tool can be found in
  Appendix 1).
• Assessment should be completed within 24 hours of admission and every
  subsequent 7 days thereafter
• Re-assessment is also to be carried out upon transfer to another ward,
  following a change in the patient’s condition, and also following a fall.
• Staff must ensure that each re-assessment is recorded in the evaluation
  section within the Falls Assessment and Intervention Pathway.
• Any documentation related to falls prevention should also be recorded
  within the evaluation section of the Falls Assessment and Intervention
  Pathway.
• The completed falls assessment will be held in the patient care plan.
6.2 Patients at risk of falling

- Falls can be an inevitable result of a patients’ acute condition and it is not possible to exclude the risk completely. However, patients admitted to hospital following a fall or patients having been assessed as being at increased risk of falling can have their falls risk reduced by implementing appropriate fall prevention measures, such as;
  - A falling star Sticker placed on the patients name board/ward board as a visual indication if being at risk of falling
  - Consider the level of observation required for each patient( see 6.2.1)
  - Anti slip socks are available from supplies for patients without any footwear. These should only be used until relatives/carers have been informed and can obtain alternative more appropriate footwear.
  - Provision of adequate lighting for safe mobilisation
  - Advice on provision of non-slip, supportive footwear
  - Making sure the call bell is within reach, visible and the patient is aware of its location and how to use it.
  - Advising the patient to call for help before getting up
  - Keeping personal care items within easy reach
  - Using a low bed, in the lowest position with wheels locked with bed table within reach
  - Providing a physically safe environment (eliminating spills, clutter, trailing wires, clothing and remove unnecessary equipment)
  - Checking sensory aids i.e. spectacles, hearing aids
  - Referring the patient to ward physiotherapist if mobility or transfers are a problem.
  - Supplying the patient, family and carers with falls prevention information and actively engaging them in all aspects of falls prevention
  - Referring to occupational therapist if problems with activities of daily living.
  - Offering regular use of toilet facilities as appropriate to the individual.
  - Where appropriate considering the use of a bed/chair sensor alarm to alert staff and prompt the patient. ( see 6.2.1)
  - Locate patient in a bed that is easily observed by all staff
  - Carrying out bed rails assessment (RM59 Safe Use of Bed Rails Policy) (see appendix 3)
  - Providing assistive equipment (i.e. raised toilet seat)
  - Assigning a bed so the patient can get up towards their stronger side if possible.
  - Providing diversional activities e.g. conversation, games.
  - Giving clear prompts to the patient prior to initiating activities.
  - Individualising equipment specific to patient need.
  - Checking ferrules on walking sticks, crutches and walking frames for excessive wear. Replacing if necessary.
  - Advising patient on use of grab rails.
  - Initiating a medication review.
  - Considering use of hip protectors.
  - Referring to falls team.
6.2.1 Levels of Observation

The level of observation should be considered for each patient at risk of falls.

- **Intentional Rounding**: ensuring patients are offered toileting, drinks repositioning of patients ensuring buzzers are at hand and environment is clear of clutter
- **Bay Nursing**: patients are cohorted and the presence of a staff member continuously within that bay who does not leave the bay until someone else relieves them.
- **Zone nursing**: where patients are nursed in individual rooms staff are situated within the an allocated zone ensuring continuous observation of patients within that area
- **1-1 observation**: staff member sits with the patient engaging them in conversation activities etc. Again this person would not leave the patient until relieved by another member of staff.
- Should there be difficulty in carrying out the level of observation for patient (i.e. staffing, resources) the nurse responsible for the patient should escalate to the nurse in charge of the shift and also report this to the area matron or senior nurse out of normal working hours. A Datix should also be completed
- Levels of observation and frequency should be documented within Intentional Integrated Monitoring Chart (appendix 4)

6.2.2 Bed and Chair Sensors

- Bed and chair sensor alarms should not be used as a primary method of falls prevention but in conjunction with other falls prevention methods
- Bed and chair sensor boxes are obtained via the equipment library (bleep 2780) and via portertrack out of hours and should be returned once no longer in use as per medical devices policy
- Bed and chair sensor pads are for single patient use only and must be changed after 14 days
- Staff should indicate start date on pad and also within Integrated Intentional Rounding Chart
- Ensure that the sensor section within the Integrated Intentional Rounding Chart (appendix 4) is completed at least hourly ensuring sensor alarm is checked for connectivity and also that is on correct position
- Should falls sensor be disconnected for any reason staff to ensure that there is documented evidence within the Falls Assessment and Intervention Pathway giving a rationale for discontinuing of use and also what methods of falls prevention are in place / implemented thereafter. Consideration should also be given for regular reassessment of patients condition if a sensor has been removed/disconnected to enable staff to evaluate and action the most appropriate falls prevention methods to be used for each individual patient
- Should there be no sensor boxes within medical devices or after contacting other ward areas (as per obtaining equipment out of
hours guidelines) Staff should consider alternative falls prevention methods appropriate for the individual patients needs and inform nurse in charge. A Datix should also be completed

6.3 Post fall actions

Inform medical staff immediately if any injury apparent

When a patient falls or is found on the floor, the patient should be assessed for serious injury before they are moved. Where appropriate the patient should be returned to their bed or chair in a safe manner as per manual handling regulations and made comfortable. A medical staff member or Acute Response Team should review the patient as soon as possible.

Post fall assessment should be carried out using the post fall protocol in the in-patient falls assessment and intervention tool. The following where possible should be recorded:

- Date and time of fall
- Description of fall (if possible)
- Patient temperature, pulse, respirations, blood pressure (lying and standing if possible) and EWS score.
- Neurological observations (see 6.4)
- Ensuring any post fall investigations / procedures are carried out (i.e. x-ray)
- Reassess falls risk factors and record actions taken to reduce risk of further falls and/or level of harm caused by the fall.
- Inform family/carer.
- Reassess use of bedrails using bedrails risk assessment tool.
- Complete DATIX incident form.

6.4 Head injury/Un-witnessed fall

Neurological observations should be carried out on

- patients sustaining a head injury,
- Un-witnessed falls or if a head injury cannot be excluded.
- See appendix 2 for frequency of recording neurological observations.

6.5 Hip Fracture

Care pathway for inpatients with a suspected fractured neck of femur available at;


6.6 Bedrail Risk Assessments (Also See RM59 Policy for Use of Bed Rails)

Bedrails are designed to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed. They DO NOT prevent a patient getting out of bed and falling elsewhere as they are not designed for, and should not be used to limit the freedom of patients, nor should they be used to restrain patients with conditions likely to cause erratic or violent movements.

Qualified Clinical Staff are responsible for ensuring patients are appropriately
assessed for the use of bed rails using the bedrails risk assessment matrix (Appendix 5) found within the patient risk assessment booklet. This assessment should be carried out on and must be carried out within 24 hours of admission and re-evaluated following a change in the patient’s condition but with a minimum review of every 7 days.

7. Incident Reporting (DATIX)

A DATIX incident form must be completed following a patient fall.

Please note: if a patient has placed themselves on the floor or has been assisted to the floor then this should not be reported as patient accident (no fall) with correct sub category of self-lowered to floor or staff assisted lowered to floor

Perception on the severity of harm caused as a result of a fall varies between staff. For Gateshead Health NHS Foundation Trust, the definitions used by the NPSA for reporting to the NRLS are used; Examples and definitions on the level of harm are shown below.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition adapted to falls</th>
<th>Examples from reports to the NRLS</th>
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</thead>
<tbody>
<tr>
<td>No harm</td>
<td>Where no harm came to the patient.</td>
<td>“No apparent harm.” “No complaints of pain, no visible bruising.”</td>
</tr>
<tr>
<td>Low harm</td>
<td>Where the fall resulted in harm that required first aid, minor treatment, extra observation or medication.</td>
<td>“Patient says he has a sore bottom...” “Shaken and upset.” “...graze on right hand.” “Small cut on finger.”</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>Where the fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital.</td>
<td>“Sustained fracture to left wrist.” “...one inch laceration over left eye, taken to A&amp;E for suturing.” “Fractured pubic rami, put on 48 hours bedrest.”</td>
</tr>
<tr>
<td>Severe harm</td>
<td>Where permanent harm, such as brain damage or disability, was likely to result from the fall.</td>
<td>“...following an x-ray, a fractured neck of femur was confirmed.” Note: up to 90 per cent of older patients who fracture their neck of femur fail to recover their previous level of mobility or independence.</td>
</tr>
<tr>
<td>Death</td>
<td>Where death was the direct result of the fall.</td>
<td>“Patient heard to fall from commode hitting her head on the floor as she fell... bleeding from back of head... fully responsive but CT scan requested together with 15 minute neuro obs.” “Gradually Glasgow Coma Scale lowered ...patient intubated and sedated and transferred to intensive care unit (ICU). Patient died later the same day.”</td>
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</table>

Definitions of severity for patient safety incidents adapted to falls NPSA (2007)
7.1 Incident Investigation (See policy RM04 for full guidance)

<table>
<thead>
<tr>
<th>Actual severity</th>
<th>Investigator/final approver</th>
<th>Level of investigation</th>
<th>Timescales</th>
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<tr>
<td></td>
<td></td>
<td>See further guidance in 6.3 below</td>
<td>Opened within</td>
</tr>
<tr>
<td>No harm or low harm</td>
<td>Ward/ department manager</td>
<td>Brief review</td>
<td>48 hours</td>
</tr>
<tr>
<td>Moderate harm</td>
<td>At the discretion of the Associate Director dependant on the business unit structure. See Datix documentation</td>
<td>Concise investigation*</td>
<td>48 hours</td>
</tr>
<tr>
<td>Severe or death (SIs)</td>
<td>At the discretion of the Associate Director dependant on the business unit structure.</td>
<td>Comprehensive* investigation</td>
<td>24 hours</td>
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<td></td>
<td>See Datix documentation</td>
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8. Training

The details of mandatory training for falls, including eligibility and frequency, are described in the Trust’s Mandatory Training Needs Analysis (TNA).

Additional non mandatory training is also offered by the falls team for clinical staff.

- **Preceptor training.** The preceptorship programme is primarily a work based process. The programme is offered twice a year and is open to all qualified staff within the Trust. The training is a 1 hour session provided by the falls team aimed at providing newly qualified staff the skills and knowledge to manage patient falls in the ward environment, which includes;
  - Falls risk assessment.
  - Bedrail risk assessment.
  - Medications risks.
  - Environmental risks
  - Medical condition risks.
  - Post fall observations (including neurological observations).
  - Incident reporting.

- **Health Care Assistant (HCA) training.** The programme is offered on a monthly basis through the care certificate training. The training is a 1 hour session provided by the Practice Development Team aimed at giving HCA’s the skills and knowledge to
manage patient falls on the ward. This includes;

- Falls risk assessment.
- Bedrail risk assessment.
- Environmental risks
- Physiological risks.
- Post fall observations (including neuro observations).
- Incident reporting.

- **Medical staff.** Specific falls risk identification and management training is provided by the falls team consultants, the training is provided as a rolling programme to the following staff groups;
  - Medical students
  - Foundation trainees
  - Junior doctors
  - G.P.’s

- **All other staff.** There is a 90 minute session covering falls awareness and falls prevention held bimonthly on site at QEH. The training is open to all grades of staff and all disciplines, including students on clinical placements. Staff can book themselves on to the training by contacting OD & Training. A Certificate of attendance is given following completion of the half day training.

- Ad Hoc Sessions are available upon request. The falls team are able to provide bespoke training to individual clinical areas/departments. This is usually a 1-2 hour session.

- **Ward based Training.** In addition to training sessions, Clinical Practice Leads (CPL’s) and Practice Development Nurses (PDN’s) provide ward based falls training in the form of a competency booklet.

9. **Diversity and Inclusion**

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

10. **Process for monitoring compliance with this policy**

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
</tr>
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<tbody>
<tr>
<td>Falls risk assessment completed within 24hrs of admission</td>
<td>Audit of inpatient records Inclusive of back to basics audit Falls Team Annual</td>
</tr>
<tr>
<td>Bedrail risk assessment completed within 24 hours of admission</td>
<td>Audit of inpatient records Falls Team Annual</td>
</tr>
</tbody>
</table>
11. **Consultation and review of this policy**

This policy has been reviewed by the Health and Safety Risk and Assurance Manager and Falls strategic group.

12. **Implementation of this policy**

This policy will be implemented in accordance with policy OP27 Policy for the development, management and authorisation of policies and procedures.

13. **References**

National Health Service Litigation Authority (2012) Risk Management Standards 2012 - 2013 
The Workplace (Health, Safety and Welfare) Regulations

14. **Associated documentation**

Please also refer to:
- RM01 Risk Management Strategy.
- RM04 Incident Reporting and Investigation Policy.
• RM06 Manual Handling Policy.
• RM24 Inter and multi agency information exchange Policy.
• MH28 Mental Health Act 1983 (as amended in 2007) Policy
• OP27 Policy for the development, management and authorisation of policies.
• OP31 Operational Policy for Medical Device Engineering and Library
• OP57 Deprivation of Liberty Safeguards Policy
• RM49 Being Open Policy.
• RM50b Slips Trips and Falls Policy non-clinical.
• RM59 Policy for Use of Bed Rails.
• Risk Assessment Guidance
• Care Standard 28E Care Of Patient With Delirium
• Guidelines for Management of Osteoporosis
In-Patient Falls Assessment & Intervention Pathway
Guidelines for completion

Excluding maternity (see maternity recovery policy) all patients admitted to the acute trust, will be assessed for the risk of falls using the identified risk assessment tool. The falls risk assessment is split into three parts and must be carried out within 24 hours of admission.

Part 1
To be completed for all patients. If the patient is unconscious no further action is required. Re-assess falls risk following a change in the patient’s condition but with a minimum review of every 7 days.
Weekly falls risk assessment is required for patients who have been identified as being a falls risk and have a current full falls risk assessment (part 3) initiated for this admission.

Part 2
To be completed for all inpatients not meeting the criteria set out in part 1. If you answer NO to ALL of the questions in Part 2 no further actions are required. Re-assesse falls risk following a fall or a change in the patient’s condition but with a minimum review of every 7 days.

If you answer YES to ANY of the questions in part 2 complete a full falls risk assessment (Part 3)

Part 3
To be completed for all patients identified in part 2 as being a falls risk.

Assessment to be completed on admission. If unable to obtain information from patient/relative or carer, document this in the evaluation, observe patient and complete assessment within 24 hours of admission.

Complete each risk factor in Part 3 to identify patients falls risk. For each factor identified as a risk, describe the actions taken to mitigate the risks in the actions/comments section (See Policy RM50a for example).

Evaluate falls risk daily in patients care plan.

Re-assess risk factors weekly or following a fall or a change in the patient's condition. Please document this in the evaluation section of this document indicating the relevant Factor number in the column

Patient risk assessment will be held in the patient care plan.

Once the assessment has been completed, the named nurse will plan the care with the patient and the carer if appropriate.

For any assistance with this document please contact the Falls Team on 4453817 References:

National Patient Safety Agency (2007) Slips, Trips and Falls in Hospital,

Gateshead Health NHS Foundation Trust Patient Observation Policy (2009),


Care Standard : ‘Falls’

Care Standard : ‘Use of Bed Rail’
### PATIENT FALLS ASSESSMENT & INTERVENTION PATHWAY (Parts 1 & 2)

#### Part – 1

(Answer YES or NO to the following)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Is the patient unconscious?</td>
<td></td>
</tr>
<tr>
<td>Has Part 3 full falls risk assessment been instigated for this admission?</td>
<td></td>
</tr>
</tbody>
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If YES no further action required, complete part 2 when patient regains consciousness. If NO complete part 2.

If NO complete Part 2.

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#### Part – 2

(Answer YES or NO to the following)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Has patient fallen or collapsed in the last year?</td>
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<tr>
<td>Is the patient taking cardiac or psychotropic medications?</td>
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<tr>
<td>Does the patient have any mobility problems?</td>
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<tr>
<td>Is the patient confused?</td>
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<tr>
<td>Does the patient feel dizzy/light-headed when standing?</td>
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<tr>
<td>Does the patient have any visual or hearing problems which affect their daily function?</td>
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If YES to any of the questions in part 2 complete full falls risk assessment (Part 3)

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## PATIENT FALLS ASSESSMENT & INTERVENTION PATHWAY (Part 3)

### Factor 1 - Ward environment

**All patients should have the following measures in place** *(Tick and sign the following actions when completed)*

<table>
<thead>
<tr>
<th>Action</th>
<th>Signature</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure ward orientation/induction completed</td>
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<tr>
<td>Ensure nurse call is accessible to patient and patient knows how to use it.</td>
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<tr>
<td>Ensure patients belongings are within easy reach</td>
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<tr>
<td>Ensure environment is clear of clutter and obstacles</td>
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<tr>
<td>Bed rails risk assessment completed.</td>
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</tbody>
</table>

### Factor 2 - Falls History

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take history from patient and/or the patient’s carer</td>
<td>Give brief description of falls/collapses include comment on frequency/location/circumstances and any injury</td>
</tr>
<tr>
<td><strong>Has the patient fallen or collapsed in the last 12 months?</strong> Yes ☐/No ☐</td>
<td>If fallen 2 or more times in the last year or had a single injurious fall or have gait and balance problems increasing their risk of falls then consider referral to the falls and syncope service for further evaluation post discharge from hospital. Issue patient/carer with falls prevention leaflet</td>
</tr>
<tr>
<td>Take history from patient and/or the patient’s carer</td>
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</tbody>
</table>

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**NAME:**

**DOB:**

**UNIT No:**

**NHS No:**
### Factor 3 – Medication

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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<tbody>
<tr>
<td>Is the patient on 4 or more medications?</td>
<td>Yes □ / No □</td>
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<tr>
<td>Do any of these include: Yes □ / No □</td>
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<tr>
<td>- Psychotropics (eg. night sedation or benzodiazepines)</td>
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<tr>
<td>- Cardiac medications</td>
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<tr>
<td>Refer to doctor or pharmacist for review of medications which increase falls risk.</td>
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### Factor 4 – Vision

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<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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</thead>
<tbody>
<tr>
<td>Can the patient see to the end of the bed (with or without glasses)?</td>
<td>Yes □ / No □</td>
</tr>
<tr>
<td>Check glasses (if worn) are in good state of repair and easily accessible</td>
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<tr>
<td>If problems with bedside visual assessment advise up to date eye test to patient or carer.</td>
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</tbody>
</table>

### Factor 5 – Hearing

<table>
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<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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</thead>
<tbody>
<tr>
<td>Does patient have difficulty hearing people speak or have known hearing impairment?</td>
<td>Yes □ / No □</td>
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<tr>
<td>Check hearing aids (if worn) are working correctly - if not initiate getting the batteries replaced or aid sent for repair.</td>
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<tr>
<td>If patient does not have known hearing impairment but has difficulty hearing advise up to date hearing test to patient or carer.</td>
<td></td>
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</tbody>
</table>

### Factor 6 - Footwear / Foot care

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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</thead>
<tbody>
<tr>
<td>Does the patient have ill-fitting shoes/slippers or soles in poor repair?</td>
<td>Yes □ / No □</td>
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<tr>
<td>Give advice about wearing safe footwear to reduce falls risk.</td>
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<tr>
<td>Offer anti-slip socks whilst in hospital if patient does not have their own appropriate foot wear.</td>
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<tr>
<td>Consider referral to podiatry department.</td>
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<tr>
<td>Risk factor 7 - Alcohol Intake</td>
<td>Suggested Action(s)</td>
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<tr>
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<tr>
<td>Does the patient drink &gt; 3 units of alcohol a day or have they fallen whilst intoxicated? Yes ☐ / No ☐</td>
<td>Advise re safe levels of alcohol consumption</td>
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<tr>
<td></td>
<td>Alert doctor to excess alcohol consumption for further review</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Factor 8 - Mobility /Balance</th>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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</thead>
<tbody>
<tr>
<td>Does the patient have any of the following?</td>
<td>If patient uses a mobility aid:</td>
<td></td>
</tr>
<tr>
<td>• difficulty rising from chair/bed Yes ☐ / No ☐</td>
<td>Check patient has correct mobility aid in close proximity</td>
<td></td>
</tr>
<tr>
<td>• unsteady gait/ poor balance Yes ☐ / No ☐</td>
<td>Check walking aid is in good state of repair, is set to the correct height and that patient appears to use it safely</td>
<td></td>
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<tr>
<td>• abnormal gait pattern (eg shuffling) Yes ☐ / No ☐</td>
<td>Discuss the use of patient call bell</td>
<td></td>
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<tr>
<td>• a mobility aid Yes ☐ / No ☐</td>
<td>If concerned about gait/balance/use of mobility aid:</td>
<td></td>
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<tr>
<td>• a tendency to furniture walk Yes ☐ / No ☐</td>
<td>Consider referral to physiotherapy and /or OT.</td>
<td></td>
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<thead>
<tr>
<th>Factor 9 – Continence</th>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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<tbody>
<tr>
<td>Does the patient have issues with:</td>
<td>• Consider infection – complete urinalysis</td>
<td></td>
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<tr>
<td>• Urinary frequency / urgency Yes ☐ / No ☐</td>
<td>• Complete fluid balance chart.</td>
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<tr>
<td>• Incontinence Yes ☐ / No ☐</td>
<td>• Consider moving to bed nearer to toilet facilities.</td>
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<td>• Consider referral to continence advisor</td>
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</tbody>
</table>
### Factor 10 - Medical History

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
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</tr>
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</table>
| Has the patient fallen/ collapsed or does the patient get dizzy on standing? Yes ☐ / No ☐                                           | Check lying & standing BP done  
  - 5 minute lying BP  
  - Immediate stand BP  
  - 3 minute standing BP  
  Provide patient with postural hypotension leaflet if evidence of drop in BP and encourage patient to drink at least 2L of fluid in 24hours (unless medically contra-indicated) |
|                                                                                                                                                                                                 | Ensure 12 lead ECG been performed.                                                                                                                                 |

### Factor 11 - Altered Mental State

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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</table>
| Does the patient appear confused? Yes ☐ / No ☐                                                                                     | Check AMTS or MMSE been completed  
  Perform infection screen  
  Urine culture and sensitivity  
  Consider use of bed/chair sensors  
  Move bed to an area of ward which increases observation.  
  Consider 1-1 nursing care                                                                                                              |
| Is there a known history of dementia/cognitive impairment? Yes ☐ / No ☐                                                            |                                                                                                                                                       |

### Factor 12 - Home environment

<table>
<thead>
<tr>
<th>Suggested Action(s)</th>
<th>Actions taken/Comments</th>
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<tbody>
<tr>
<td>Does the patient live in their own home? If so have they fallen at home? Yes ☐ / No ☐</td>
<td>Consider referral to OT</td>
</tr>
<tr>
<td>Does the patient have stairs at home? Yes ☐ / No ☐</td>
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<tr>
<td>Has the patient lost confidence as result of falling? Yes ☐ / No ☐</td>
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</table>

Assessment completed by:

Name (print)  
Signature  
Band  
Date
<table>
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<tr>
<th>Date/Time</th>
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</table>
**Post Fall Protocol**
To be completed in the event of a patient fall – additional copies can be downloaded from DATIX

DATIX No: Date & Time of Fall:

**Details of fall** (Give brief description of fall)

**Immediate Response**
Patient was alert and conscious □  Patient was unresponsive to any stimulus □

**Observations** – record haemodynamic observations on appropriate charts.
- Lying & Standing BP
  - 10 min lying / sitting
  - 2 min standing
  - Immediate standing
  - 5 min standing

Did the patient have any of the following prior to falling *(Tick all that apply)*
- Agitation □
- Delirium □
- Drowsiness □
- Nausea □
- Confusion □

Document action taken in evaluation section of falls assessment booklet/nursing records.

**Skin Condition** *(Document any lacerations / bruising in evaluation section of falls assessment booklet/nursing records)*
If laceration sustained send swab of wound for C&S.
Swab sent Yes □ NO □

If YES to any of the following refer for URGENT medical assessment.
- Shortening of limbs □
- Restricted limb movement □
- External rotation □
- Pain on applying pressure □
- Inability to bear weight □
- Deformity □
- Signs of head injury □
- Signs of facial injury □

No evidence of injury □

**Completion Of Post Fall Protocol**
Job Title: Date: Time: 
Signature: Print Name:
# Post Fall Protocol

To be completed in the event of a patient fall – additional copies can be downloaded from DATIX

<table>
<thead>
<tr>
<th>DATIX No:</th>
<th>Date &amp; Time of Fall:</th>
</tr>
</thead>
</table>

## Details of fall (Give brief description of fall)

## Immediate Response

- Patient was alert and conscious □
- Patient was unresponsive to any stimulus □

## Observations – record haemodynamic observations on appropriate charts.

<table>
<thead>
<tr>
<th>Lying &amp; Standing BP</th>
<th>Immediate standing</th>
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<tbody>
<tr>
<td>10 min lying / sitting</td>
<td></td>
</tr>
<tr>
<td>2 min standing</td>
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<tr>
<td>5 min standing</td>
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Did the patient have any of the following prior to falling *(Tick all that apply)*

- Agitation □
- Delirium □
- Drowsiness □
- Nausea □
- Confusion □

*Document action taken in evaluation section of falls assessment booklet/nursing records.*

## Skin Condition *(Document any lacerations / bruising in evaluation section of falls assessment booklet/nursing records)*

If laceration sustained send swab of wound for C&S.

<table>
<thead>
<tr>
<th>Swab sent □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes □</td>
</tr>
<tr>
<td>No □</td>
</tr>
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If **YES** to any of the following refer for **URGENT** medical assessment.

- Shortening of limbs □
- Restricted limb movement □
- External rotation □
- Pain on applying pressure □
- Inability to bear weight □
- Deformity □
- Signs of head injury □
- Signs of facial injury □

*No evidence of injury □*

## Completion Of Post Fall Protocol

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

**Signature:**

**Print Name:**
Inpatient Guidelines

**CT head- Risk factors**
- GCS less than 13 on initial assessment.
- GCS less than 15 at 2 hours after the injury (or 14 if patient confused prior to fall)
- Suspected open or depressed skull fracture
- Any sign of basal skull fracture
- Post-traumatic seizure
- Focal neurological deficit
- More than 1 episode of vomiting

**YES-** request FAST TRACK CT head to be completed within 1 hour

- Is patient on therapeutic anticoagulation, clotting disorder, platelets<20?
- 
- **YES-** CT head within 8 hours
- Is there a new loss of consciousness or new amnesia since fall?

**YES - CT head within 8 hours following risk factors:**
- Age 65 years
- History of bleeding or clotting disorder
- Fall from height (> 1 metre)
- FASTTRACKCTHEAD request should be reviewed by SpR grade or above
- After request BLEEP duty radiographer

---

### Required assessment on all patients

**Nursing team**
- Complete DATIX/post fall care bundle
- Next of kin to be informed
- Consider Duty of Candour
- Evaluate Falls Risk Assessment Documentation
- Lying and Standing BP
- Consider referral to falls team

**Medical Team**
- Review mechanism of fall
- LOC
- Screen for infection/delirium
- 12 Lead ECG
- Medication review
- Consider osteoporosis risk

**ASSESS ABCDE + EWS + GCSE**
- Assess mechanism of fall
- Check for signs of injury
- Assess manual handling needs
- Transfer to safe position

**Minor Injury**
- Deliver basic first aid
- Simple analgesia
- Repeat observations-return to normal frequency if no change
- Inform duty doctor/ART-to be reviewed within 4 hours

**Major Injury**
- Consider any of the following features:
  - Abnormal limb position
  - Rotational Deformity of limb
  - Cervical spine tenderness
  - Pelvic tenderness
  - Rapid swelling/haematoma
  - New onset pain
  - New onset immobility

**Head Injury/Suspected Head Injury**
(Caution: suspect head injury in all unwitnessed falls)
- Offsite units must contact 999 within 15 minutes

**Commence neuro observations:**
- 30 minute neuro obs till GCS is 15 (14 if confused prior to fall) Then
  - Continue 30 minutes neuro obs for 2 hours
  - 1 hour neuro obs for 4 hours
  - 2 hour neuro obs until further medical review

**CAUTION:** Return/continue 30 min neuro obs if GCS continues to drop.

**if GCS >15 inform duty doctor/ART-the patient should be assessed within 15 mins to establish any evidence of brain injury OR**
- If GCS =14 OR Less (13 or less in previously confused)- the duty doctor should be bleeped for urgent assessment for any evidence of brain injury
- Duty doctor should consider FAST TRACK CT HEAD if any risk factors present

**Compliance with NICE head injury guidance - Updated 2014**
ICAR Post Fall Guidelines

**ASSESS**

ABCDE + EWS + GCS + BM (if diabetic)
- Assess mechanism of fall
- Check for signs of injury
- Assess manual handling needs
- Transfer to safe position

**Minor Injury**
- Deliver basic first aid
- Simple analgesia
- Repeat observations—return to normal frequency if no change
- Consider requesting medical review if appropriate

**Major Injury**
- Consider any of the following features:
  - Abnormal limb position
  - Rotational deformity of limb
  - Cervical spine tenderness
  - Pelvic tenderness
  - Rapid swelling/haematoma
  - New onset pain
  - New onset immobility
  - Call 999 ambulance immediately
  - Consider safe manual handling techniques
  - Do not move patient with suspected spinal or pelvic injury (unless resuscitation situation or felt not to be safe to leave patient in that position)
  - Increase frequency of EWS observation
  - Give simple analgesia

**Head Injury/Suspected Head Injury**
- (Caution: suspect head injury in all unwitnessed falls)
- Commence 30 minute neuro obs till GCS is 15 (14 if confused prior to fall)
- Then continue 30 minute neuro obs for 2 hours
- 1 hour neuro obs for 4 hours
- 2 hour neuro obs until further medical review or felt safe by nursing staff to discontinue

**Required assessment on all patients who have fallen**
- Complete DATIX/post fall care bundle
- Next of kinto be informed
- Evaluate Falls Risk Assessment Documentation
- Lying and Standing BP
- Screen for infection/delirium
- Medication review
- Consider referral to local falls team

**CT head—Risk factors**
- GCS less than 13 on initial assessment.
- GCS less than 15 at 2 hours after the injury (or 14 if patient confused prior to fall)
- Suspected open or depressed skull fracture
- Any sign of basal skull fracture
- Post-traumatic seizure
- Focal neurological deficit
- More than 1 episode of vomiting
- YES—FAST TRACK CT head to be completed within 1 hour
- Is patient on therapeutic anticoagulation, clotting disorder, platelets<20?
- YES—CT head within 8 hours
- Is there a new loss of consciousness or new amnesia since fall?
- YES—CT head within 8 hours if following risk factors:
  - Age >65 years
  - History of bleeding or clotting disorder
- Fall from height (>1 metre)

*Based on NICE head injury CG 178:2014*
### Appendix 3

#### Part 1

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Score/Ref No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are unconscious or completely immobile</td>
<td>Bedrails to be used 1</td>
</tr>
<tr>
<td>Patients who request bedrails or use bedrails at home</td>
<td>Bedrails to be used 2</td>
</tr>
<tr>
<td>Patients who are recovering from anaesthetic</td>
<td>Bedrails to be used 3</td>
</tr>
<tr>
<td>Patients who have disruption to their spatial or visual awareness</td>
<td>Use bedrails with caution 4</td>
</tr>
<tr>
<td>Patients who are not likely to attempt to get out of bed alone</td>
<td>Use bedrails with caution 5</td>
</tr>
<tr>
<td>Patients who are likely to attempt to get out of bed alone</td>
<td>Bedrails not recommended 6</td>
</tr>
<tr>
<td>Patients who are independently mobile</td>
<td>Bedrails not recommended 7</td>
</tr>
</tbody>
</table>

Initial risk grading score = Score

1. **Bedrails to be used**

2. **Score 4 - 5**

3. **Score 6 - 7**

---

#### Part 2

**Patient at risk of falling from bed or climbing over bed rail**

- Yes
  - Patient understands purpose of rails
    - Yes
      - Patient consent to bedrail use
        - Bedrails could be used
    - No
      - Bedrails inappropriate
        - See boxes 1+3 (Below)

- No
  - Physical/Cognitive condition
    - Consider actions in patients best interest.
      - See boxes 1+2+3 (Below)
    - Patient requests bedrails
      - Bedrails could be used with caution.
        - See boxes 1+3 (Below)
    - Patient not requesting bedrails
      - Bedrails inappropriate
        - See box 3 (Below)

**Communication difficulties**

- Consider:
  - Referral to appropriate specialist i.e. audiology / interpreter.
  - Use written or pictorial information.

---

**1. If bed rails are used consider:**
- a) Risk of entrapment and harm to limbs.
- b) Bedrail Bumpers
- c) Risk of patient climbing over top.
- d) Psychological effect to patient.

**2. Alternatives to bedrails:**
- a) Move patient to observable area.
- b) Use of bed alarm.
- c) Return bed to lowest height.
- d) Anticipate patient needs i.e. drinks, buzzer.
- e) Low profile bed.

**3. Document in daily care record:**
- a) Date & time assessment made.
- b) Rationale for decision made.
- c) Where bedrails are considered appropriate/inappropriate and patient has declined/requested their use.

---

Bedrail assessment should be made on admission and every 7 days or immediately post patient fall or a change in the patient’s clinical condition.
### Intentional Rounding

Intentional rounding is a structured process where nurses on the wards carry out regular checks with individual patients at set intervals. During these checks, nursing staff carrying out scheduled tasks or observations with patients; addressing patients’ pain, positioning and toilet needs; assessing and attending to the patient’s comfort; and checking the environment for any risks to the patient’s comfort or safety.

This form has been devised to incorporate the SSKIN bundle: a five step model to prevent pressure ulcers:

- **S** = Support surface
- **S** = Skin inspection
- **K** = Keep moving
- **I** = Incontinence
- **N** = Nutrition

and also incorporates measures staff can take as part of our falls prevention strategy:

- **F** = Footwear
- **O** = Observation level
- **C** = Call bell
- **U** = Understanding
- **S** = Sensors

#### SSKIN

- **Save our Skin (SOS) Stickers**
- **Action to be Taken**
- **Falls**

<table>
<thead>
<tr>
<th>Save our Skin (SOS) Stickers</th>
<th>Action to be Taken</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please place a SOS sticker on the patients’ white name board at the bedside for those patients who require assistance to change their position.</td>
<td>Please refer to Care Standard 15 for appropriate action to be taken for the prevention and treatment of pressure ulcers.</td>
<td>If patient is identified as at risk of falls please place a falling star on the patients white board as a visual prompt for staff.</td>
</tr>
</tbody>
</table>

#### FOCUS

- **Visible prompt to staff**
- **“Remember react to red skin”**

#### Equipment in Place: (Please tick)

<table>
<thead>
<tr>
<th>Mattress</th>
<th>NP 150 / Thermocontour Protecta Primo Clinactiv Duo 2 Dolphin Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed and chair sensor (please refer to Bed and chair sensor guidelines prior to use)</td>
<td>Please remember disposable pads are for single patient use to be changed after 14 days of first use</td>
</tr>
</tbody>
</table>

| Date bed and chair sensor in use |
| Date: |

<table>
<thead>
<tr>
<th>Support Surface</th>
<th>Preventative Products Gel products: Other:</th>
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</thead>
<tbody>
<tr>
<td>Prima 3 Foam Primagel Reflex</td>
<td></td>
</tr>
</tbody>
</table>

| Date for change of disposable pads |
| Date: |

<table>
<thead>
<tr>
<th>Chair Cushion:</th>
<th>Heel Floor Cushion (not to be used in bed) Invacare Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prima 3 Foam Primagel Reflex</td>
<td></td>
</tr>
</tbody>
</table>

| Date: |

#### References:

- Gateshead Health NHS Foundation Trust (2015) Slips, Trips and Falls Policy (RM 50)
- Gateshead Health NHS Foundation Trust (2014) In-Patient Falls Assessment and Intervention Pathway
- European Pressure Ulcer Advisory Panel (2009)
- National Pressure Ulcer Advisory Panel (2009)
- National Pressure Ulcer Advisory Panel (2011)
- www.healthcareimprovementscotland.org
- Gateshead Health NHS Foundation Trust (2014) Pressure Ulcer Prevention and Management Policy

File in Section 3 medical notes
<table>
<thead>
<tr>
<th>Date:</th>
<th>Record time of intervention</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Skin Inspection**
- Y – Yes
- N – No

**Please record any changes in daily care record and report to the nurse in charge**

**Keep Moving**
- L – Left side
- C – Chair
- R – Right side
- W – Walked
- B – Back
- P – Physio
- S – Stood
- O – Other please state

**Incontinence**
- I – Incontinence/skin cleaned barrier product used
- T – Toilet / Commode / Bed pan
- NA – Not applicable
- C – Catheter checked
- S – Stoma checked

**Nutrition**
- D – Drink
- F – Food
- N – Nil by mouth
- M – Mouth care given

**Footwear**
- Y – Yes
- N – No
- R – Patient removing footwear
- N/A – Please expand in Falls Assessment and Intervention Pathway reason

**Observation Level**
- I – Intentional rounding
- C – Cohort / Bay / Zone Nursing
- O – One to One observation

**Call Bell**
- Y – Yes
- N – No
- N/A – Please expand within Falls Assessment and Intervention Pathway

**Understanding patient needs**
- Y – Yes needs met
- N – No needs not met please expand in Falls Assessment and Intervention Pathway

**Sensor:**
- Y – Yes
- N – No
- N/A – No sensor required

**Non compliance (Please specify which aspect of care / number)**
- Patient not on Ward
- Please State

**Patient Repositioning Chart**

**Slips, Trips, and Falls Policy version**
- 3 (Patient)
- October 2017

**Falls Team**

---

**Signature:**

**Print name:**

**Date:**

---

**Signature:**

**Print name:**
### Integrated Fluid Chart

<table>
<thead>
<tr>
<th>Offer Oral intake or Mouth care &amp; record</th>
<th>IV</th>
<th>Other Peg / NG</th>
<th>Running Total In</th>
<th>Offer toileting and Record Urine</th>
<th>Record Bowel Activity</th>
<th>NG</th>
<th>Other (drains etc)</th>
<th>Running Total out</th>
<th>Initial</th>
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**Patients with midday totals of** Intake of less than **300mls** and/or Output less than **300mls**

**Must have:**
- Accurate fluid balance recorded
- Red drinking glasses Red jug lids
- Identified on Handovers that patient requiring encouragement/assistance to drink
- If safe to do so, relatives should be encouraged to give patient drinks.

**Tick and initial when in place**
- Daily target of fluid intake set
- Information about importance of hydration

**If urine output drops to below 30 mls per hour for more than four hours then the patient should be escalated as though they are at medium risk as per NEWS**
- if catheterised, please check urinary catheter is patent,
- if not catheterised already, consider if pt is in urinary retention and/ or need for catheter

<table>
<thead>
<tr>
<th>Offer Oral intake or Mouth care &amp; record</th>
<th>IV</th>
<th>Other Peg / NG</th>
<th>Running Total In</th>
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</tbody>
</table>

**24 Hrs Balance =**
Any patient NBM must have a plan including reason and review date in medical notes.

<table>
<thead>
<tr>
<th>Food Chart</th>
<th>All</th>
<th>¾</th>
<th>½</th>
<th>¼</th>
<th>0</th>
<th>record all dietary intake after every meal</th>
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</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
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<td>Record what has been refused by patient</td>
</tr>
<tr>
<td>Lunch</td>
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<td></td>
<td>Record what has been refused by patient</td>
</tr>
<tr>
<td>Supper</td>
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<td></td>
<td>Record what has been refused by patient</td>
</tr>
<tr>
<td>Snacks offered</td>
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</tbody>
</table>

**Food Chart Guidance**

Tick and initial when in place.

- **Any patient in the red**
  - Must be offered alternative meal/Build Ups at every meal that is missed
  - Must have a red placemat
  - Ensure likes and dislikes form is completed
  - Re calculate NRS

- **Any patient in the yellow**
  - Offer alternative meals
  - Ensure likes and dislikes form is completed
  - If in yellow for 3 days consider fortifying food and giving ward snacks / Build Ups

**WHAT assistance/support IS required to eat or drink?**

Remember

Nutrition & Hydration is as important as medication.