

Slips, Trips and Falls Management (Inpatient) Policy

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| Services  |  |
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| Mental Health and LD  |  |
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| 1.0 | June 2008 | Tracy Lindsay | Final | To be read in conjunctionwith Healthand Safety Policy |
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| 3.0 | September2011 | Michael McGheeTracy Lindsay |  | Minor amendments |
| 4.0 | July 2014 | Falls Group |  | Multifactorial RiskAssessment introduced in accordance with NICE (2013), FRAZE removed& Minor amendments. |
| 5.0 | June 2015 | Falls Group |  | Minor amendments toreflect NICE standards 86 (2015) andstaff feedback |
| 6:0 | May 2018 | Falls Group |  | Minor amendments to reflect NICE standard 176& feedback from staff & incidents included a |
| 7.0 | April 2023 | Fall group  |  | Updated external / internal policy.Included information for adults of working age.  |

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**INTRODUCTION**

1. Falls in hospitals are the most common patient safety incident reported for inpatient hospital beds in England. Each year around 282,000 patient falls are reported to NHS England Patient Safety division for hospitals and mental health units (NPSA, 2011, 2015). Although 96% of these incidents resulted in minor injuries or no harm, the impact on the patient’s recovery can be huge affecting confidence leading to delays in discharge and the loss of independent living. (NPSA, 2010).
2. Whilst falls are not exclusively seen in older adults, falls for this patients group are a common and serious problem, particularly those who have underlying pathologies or conditions. 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 (NICE, 2013). It is estimated that 34% of all falls lead to an injury, although 30% are likely to be minor injuries, 3% moderate injury and1% will result in major injury (NPSA, 2010).
3. Working age adults using mental health services have almost four times the incidence of hospitalised falls compared to general population (Romano et al 2021).
4. 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 health care costs. (NICE, 2015).
5. A systematic approach to the assessment and prevention of falls in all at risk groups is essential to highlight risk and risk manage care, not just older adults. Evidence shows people with a severe mental health condition are at higher risk for falls and hip fractures secondary to pharmacological intervention (Romano et al 2021). This policy and procedural documents describe the Trust’s approach to addressing this risk within ELFT inpatient hospital and community settings, whilst providing a duty of care to the patient, and a safe system of work for Trust employees.
6. This policy has been written with due consideration to: Health and Safety at Work Act (1974); the Manual Handling Operational Regulations (HSE, 1992); the Human Rights Act (1998); NICE clinical guideline CG161 (2013); NICE quality standard QS86 (2015), guidance from the National Patient Safety Agency (NPSA, 2007, 2010, 2011) and Fall Safe care bundles (Royal College of Physicians 2015).

#### PRINCIPAL LEGISLATION AND GUIDANCE

1. The Management of Health and Safety at Work Regulations (1992) in line with the Health and Safety at Work Act (1974), include duties for people in control of workplaces to assess risks (including slips, trips and falls). They require that appropriate arrangements be implemented for effective planning, organization, control, monitoring and review of any measures to safeguard health and safety identified by risk assessment.
2. The National Institute for Clinical Excellence (2013). Clinical Guideline CG161: “Falls: Assessment and Prevention of Falls in Older People” sets out guidelines and key priorities regarding the assessment and prevention of falls in older people and the NICE (2015) quality standards QS86: ’Falls in older people: assessment after a fall and preventing further falls, both guidelines have been adopted and have informed the development and review of this policy.
3. ***Despite being specific to older people the principles of the NICE Guidelines can & should be applied across all age groups*.**
4. **Special Considerations People Living with Dementia:**
	1. People with a dementia are four to five times more likely to experience falls than older people without cognitive impairment (CDC 2020). The consequences of a fall can cause considerable anxiety and distress to the person with dementia and their families as outcomes e.g., hip fracture & can cause significant change in a person’s functional capacity. Fractures and hip fractures are three times more common in people living with dementia than those without dementia.
	2. Though not everyone living with dementia will experience a fall, some factors including symptoms, current illness, the environment and certain medications can increase the risk of falling. It is therefore important that staff try to understand why people living with dementia fall and how recognising and reacting to these risks in a preventative way may help reduce falls.
5. Some of the reasons why people with dementia fall:
	1. Gait and balance problems
	2. Effects of certain medications
	3. Environments that can be difficult to interpret
	4. Delirium – unrecognised and unmanaged
	5. Reduced attention
	6. Multi factor assessments for falls risk will be undertaken for all inpatients and special consideration for risk modification for those with cognitive impairment and dementia. This will include medication reviews, adjustment of the environment (signage, lighting and wayfinding) and delirium screening for acute changes in agitation or drowsiness with onward escalation.

#### DEFINITIONS

1. **SLIP:** A slip is to slide accidently causing the person to lose their balance; this is either corrected or causes a patient to fall
2. **TRIP:** A trip is to stumble accidently often over an obstacle causing the person to lose their balance, this is either corrected or causes the person to fall
3. **FALL:** A fall is an unintentional or expected loss of balance resulting in coming to rest on the floor, the ground or on an object below knee level (NICE 2015).

#### SCOPE

1. This policy applies to all staff employed by the Trust who have responsibility for patient care and any patient for whom the Trust has responsibility. This is a clinical policy which is supported by and must be read in conjunction with the following Trust policies:
	1. Clinical Risk Assessment and Management Policy (2020)
	2. Incident Policy (2018)
	3. Incident policy (2022)
	4. Manual and Handling Policy (2018).
	5. Policy and guidance for using bed rails safely and effectively for inpatient settings and NHS continuing care wards & Community health service settings (2019)
	6. Staff and visitor falls to be managed in accordance with the Health and Safety at Work Policy (ELFT, March 2018)
	7. Trust Health and Safety Policy (2021)
	8. This policy is written with consideration of the key NICE and NPSA guidelines and standards, it is linked to key ELFT policy as indicated and as recommended by the Royal College of Physicians (2015).

#### AIMS

1. The aims of this policy and the procedure are:
2. To reduce the risk of falls and harm to patients, through implementation of falls prevention management and quality standards.
3. Providing adequate falls risk identification and multifactorial assessment, recognising factors leading to falls and implementing appropriate actions and interventions for prevention and mitigation of injury when a likelihood of falling is present or a fall has occurred.
4. Highlight that falls are not excusive to older adults & affect adults of working age.
5. Pharmacological intervention can affect bone density resulting in broken bones, increased hospital care, associated cost and worse patient outcomes for all groups.
6. To provide staff training in falls risk assessment, management and prevention and to raise patient awareness of the potential for falls.
7. To ensure all staff maintain a safe environment which reduces the risk of falling by any patient on Trust premises.

#### RESPONSIBILITIES AND DUTIES

1. **Trust Responsibilities & Duties**
	1. The Trust recognises its responsibilities to implement in full its duties in respect of the prevention of slips, trips and falls by safe and proper means.
	2. The Trust delegates to the Chief Executive overall responsibility for the implementation of this policy and procedure, in turn this responsibility is delegated to the Directors and Senior Managers of the Trust.

#### Senior/General Managers Responsibilities & Duties

* 1. Senior Managers will produce risk assessments in their areas as required under the Management of Health and Safety at Work Regulations 1999, where falls are identified as a problem and ensure that appropriate actions are taken to reduce the risks as far as is reasonably practicable. The risk assessment should include environmental factors as well as individual capability assessments. Significant risks will be included on the directorate risk register and reviewed quarterly by the Directorate Management Team (DMT).
	2. Where training is identified as a suitable measure the Directors/ Senior Manager will consult with Trust Training and Development Department about the availability of suitable programmes.

#### Assurance Departments Responsibilities and Duties

* 1. The Trust incident reporting database (InPhase) will generate data on slips, trips and falls. The Trust Falls Group will produce periodic statistical reports on the nature and severity of such incidents and indicate trends.
	2. Incidents resulting in serious injury or patient death are reported to the Health & Safety Executive via RIDOR external agencies

#### Modern Matrons / Clinical Leads

* 1. Ensure that Falls Multi-Factorial Risk Assessment (Appendix 1) and the Advanced Falls Multi-Factorial Risk Assessment (Appendix 2) are used appropriately and staff are supported in the implementation of this process.
	2. Ensure that all slips, trips and falls, including near misses are reported and incident forms completed as per Trust wide Incident policy (2022).

#### Employees Responsibilities and Duties

* 1. All employees must be cognisant of patient groups who have an increased risk of falls and ensure through due diligence that environmental hazards are identified and reported urgently.
	2. Employees must understand the process for reporting all incidents/near misses, involving staff, patients and others via InPhase.
	3. All employees must maintain a safe environment in line with the Health and Safety at Work Act 1974. Employees adhere to the procedures as set out with this policy Employees must adhere to the Trust Training requirements

#### Immediately following a patient fall, the Nurse in Charge must:

* 1. Ensure patient safety and undertake a clinical assessment, NEWS2 score including neurological assessment: Alert, (new) Confusion, Voice, Pain, Unresponsive (ACVPU) following NEWS2 algorithm. This should also include a check for injury as part of the ‘Best Practice Guidelines for the Management of the Fallen Patient (Post- Fall Protocol) and in accordance with NICE Guidance QS 86 (2015) (Appendix 3) Carry out the check before the patient is moved. Where no injury is suspected, a lying and standing blood pressure should be taken.
	2. Ensure an InPhase incident form is completed for any incident resulting in a fall or a near miss.
	3. Carry out an Environmental Risk Assessment on the clinical environment and take any action necessary to make the environment safe and record findings and actions taken.
	4. Identify the reason for the patients fall, where possible, record details in patients records and review their falls management and prevention care plan and assessment
	5. The Multifactorial Falls Risk Assessment must be discussed and reviewed with MDT within 1 week post the fall and details recorded in the patient’s records.

#### PREVENTION PROCEDURE

1. **In-Patient area across the Trust: Falls Risk Assessment**
	1. All patients over the age of 65, those with a history of falls, have been clinically identified i.e., low bone density / pre-existing conditions, at risk from falls i.e., high dose anti-psychotic medications / medication which has not yet reached therapeutic levels etc., (appendix four) must have a Falls Risk Assessment (appendix 1) completed and documented on admission. It is the responsibility of the nurse coordinating the patients care to ensure that this is completed. Where a risk is identified a falls prevention care plan must be completed.
	2. Patients with an identified risk must have an individualised falls prevention care plan and the assessments reviewed monthly or as risk is identified to change.
	3. All older people or those with a history of falls, have been clinically identified i.e., low bone density / pre-existing conditions, at risk from falls i.e., high dose anti-psychotic medications / medication which has not yet reached therapeutic levels must have a Multi Factorial Falls Risk Assessment (Appendix 1) completed by the multi-disciplinary team (MDT). The assessment should be completed at the first MDT review following admission or within the first week of admission.
	4. The Multi Factorial Falls Risk Assessment (Appendix 1) must be reviewed monthly, after a patient has sustained a fall, if the patient’s presentation changes or if there are new risk identified.
	5. All patients over the age of 65 or those with a history of falls must be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s
	6. Patients in younger age groups, or who are identified at risk, or have had a previous fall must be offered a Multi Factorial Falls Risk Assessment (Appendix 1).
	7. Older people and people with an identified falls risk must be offered a home hazards assessment prior to discharge
	8. Older people who are known to have recurrent falls should be offered strength and balance training (NICE, 2013)
	9. Older People must have their medication reviewed as recommended by the NICE Clinical Guidelines CG161 (2013) as part of their Falls Risk Assessment. A brief summary of medications which can contribute to the risk of fall is available in appendix 4.
	10. Each MDT has the opportunity to carry out a more advance multi factorial assessment, as indicted in appendix 2.
	11. Community - Falls Risk Assessment
	12. Patients identified as at risk in the community will be assessed using a multi factorial risk assessment. This will include patients receiving care from the community rehabilitation service, district nurses and community mental health services. Assessments should clearly identify risk factors and demonstrate suitable falls prevention care plan to reduce, remove or manage the risk

#### FALL PREVENTION CARE PLAN

1. All patients who have an identified risk on the Multi Factorial Falls Risk Assessment must have an agreed individualised fallprevention care plan to manage the risk of falling.
2. Where risks have been identified, necessary clinical and environmental actions must be taken and recorded to minimise the risks. These actions will be clearly documented in the patient’s fall preventioncare plan (as per NICE Clinical Guideline CG161, 2013).
3. Recommendations for inclusion in the falls prevention care plan are detailed in Appendix 5.

#### INTERVENTIONS FOLLOWING A FALL

1. When a patient is found to have fallen on the floor (an unwitnessed fall) or is known to have fallen on the floor, staff must attend to their needs and manage the situation in accordance with Trust ‘Best Practice Guidelines for the Management of the Fallen Patient (Post Falls Protocol appendix 3). The Best Practice Guidelines have been developed and reviewed to meet the standards set out in the NICE Clinical Guideline and quality standard (NICE, 2013, 2015). If actual/suspected harm identified the patient may need to be transferred to the Emergency Department.
2. The circumstances surrounding a fall, i.e., unwitnessed / witnessed must be documented, in the patient’s MDT notes. The patient must be reassessed using the Falls Multi Factorial Risk Assessment in light of the changing circumstances.
3. The patient’s care plan must be reviewed, and alternative strategies deployed if appropriate.
4. The goal of any falls prevention care plan must be to reduce the likelihood of falls whilst maintaining the patient’s dignity and independence.
5. Duty of Candour must take place & the patient’s next of kin must be informed that a fall has occurred.
6. A medical physical examination of the patient must take place, with the results documented in the MDT notes.
7. The InPhase electronic incident form must be submitted as soon as possible and before the end of the shift following the incident and details recorded in the MDT notes.
8. Information on the incident form must include:-
	1. Circumstances surrounding the fall
	2. Whether the fall was witnessed and by whom
	3. Identified Risk, prior to the fall occurring
	4. Strategies to be put in place following the fall to reduce chance of a further fall occurring.
9. The InPhase form must be updated by the manager responsible for reviewing the incident detailing the relevant interventions which took place within ten days after the fall.
10. Result of physical assessment and confirmation that it took place
11. Mobility and gait assessment
12. MDT review of the fall
13. Referral to falls clinic (when appropriate)

#### TRAINING

1. The Trust has conducted a Training Needs Analysis to consider training requirements in relation to the management and prevention of slips, trips and falls in hospital. The summary template from the analysis is shown at Appendix 6

#### MONITORING AND PERFORMANCE

1. The Directors and Senior/General Managers/Modern Matrons will monitor all accidents and incidents involving slips, trips and falls. This will be based on the data generate by InPhase on a monthly basis. The Senior/General Managers/Modern Matrons will ensure the incident form is completed so that sufficient information is provided. to inform action plans to be agreed in an aim to minimise and/or prevent falls.
2. The Senior/General Managers/Modern Matrons of the Trust will ensure that an annual
3. audit and review of slips, trips and falls is carried out in line with the Trust policies, ensuring that recommendations are implemented. The results of the audit and recommendations will be made available to the Trust Quality Committee.
4. The Senior/General Managers/Modern Matrons will ensure attend appropriate training.
5. A Trust Falls Group will meet 3 monthly to oversee falls issues and quality improvement initiatives and annually the chair will produce a Trust wide falls report. The key lessons from this process will be shared and utilised to review current practice and policy in the management and prevention of slips, trips and falls. The group will review the previous 3 month InPhase reports for all moderate and severe / any area with emerging themes

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#### APPENDIX 1

 **FALLS MULTI-FACTORIAL RISK ASSESSMENT**

 **Notes to user of this tool:**

* To be completed on admission or transfer to the ward/team/unit
* If any risk factors are identified, please complete a falls prevention care plan
* Please repeat the assessment: weekly if a risk is identified, monthly if no risk identified, after a fall and if the patient’s presentation changes, in accordance with the Trust Policy on the Management and Prevention of Slips, Trips and Falls.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| No | Falls Risk Questions | Date | Date | Date | Date |
|  |  |  |  |  |  |
|  |  | Yes/No | Yes/No | Yes/No | Yes/No |
| 1 | Does the patient have a history of falls? How many in the last year?  |  |  |  |  |
| 2 | Does the person have a fear of falling? |  |  |  |  |
| 3 | Does the person report or have any problems with gait? |  |  |  |  |
| 4 | Does the person report or have any problems with gait balance? |  |  |  |  |
| 5 | Does the person have any evidence of muscle weakness |  |  |  |  |
| 6 | Does the person have any limitations and/or mobility issues? |  |  |  |  |
| 7 | Does the person use a mobility aid?Do they have it with them? |  |  |  |  |
| 8 | Does the person suffer from Postural Hypotension (lying and standing blood pressure)? |  |  |  |  |
| 9 | Does the person suffer from dizziness/Faintness (pre-sycope) or faints (syncope)? |  |  |  |  |
| 10 | Does the person have any vision issues? Do they wear glassesDo they have them with them? |  |  |  |  |
| 11 | Is the person taking/prescribed 4 or more medication? |  |  |  |  |
| 12 | Is the person fully orientated to time, place and person |  |  |  |  |
| 13 | Does the person have any problems with continence: urgency/frequency/incontinence? |  |  |  |  |
| 14 | Does the person have any evidence of osteoporosis or known to have osteoporosis? |  |  |  |  |
| 15 | Does the person have any problems with the condition of their feet? |  |  |  |  |
| 16 | Does the person have appropriate footwear? (non-slip & securely fitted |  |  |  |  |
| 17 | Does the person have reduced appetite or dietary intake? Any signs of malnutrition or dehydration? Any difficulty eating or drinking? |  |  |  |  |
| Care plan completed | Yes/No | Yes/No | Yes/No | Yes/No |
| Assessor’s signature & Designation |  |  |  |  |
| Date: | Comments on Assessment 1 | Signature &Designation |
|  |  |  |
| MDTcomment& Date |  |  |
| Date: | Comments on Assessment 2 | Signature &Designation |
|  |  |  |
| MDTcomment& Date |  |  |

|  |  |  |
| --- | --- | --- |
| Date: | Comments on Assessment 3 | Signature &Designation |
|  |  |  |
| MDTcomment& Date |  |  |
| Date: | Comments on Assessment 4 | Signature &Designation |
|  |  |  |
| MDTcomment& Date |  |  |

**APPENDIX 2**

**ADVANCED MULTI- FACTORIAL FALLS RISK ASSESSMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  |  |  |
| **Date of birth** |  |  |  |
| **Ward/unit/team** |  |  |  |
| This assessment must be completed in accordance with the Policy and Procedure for the Management and Prevention of Slips, Trips and Falls in Hospital |
| **Risk Factors & Enquiry** | **Date A1** | **Date A2** | **Date A3** | **Date A4** | **Identified Issue(s) (Please Date****or note A1,2,3 or 4)** | **Suggested interventions** |
|  |  |  |  |
| Yes/No | Yes/No | Yes/No | Yes/No |
| **History of Falls** |  |  |  |  |  | * Review incidents.
* Investigate cause?
* Provide patient/ career leaflet & education
* Ask patient regularly about if they have had a fall
 |
|  |  |  |  |  |  |
| Two or more falls in the last 6 months? |  |  |  |  |  |
| **How many falls in the last 6 months?** |  |  |  |  |  |
| **Explained?** |  |  |  |  |  |
| Unexplained? |  |  |  |  |  |
|  |  |  |  |  |  |
|  |
| **Physical Health related to the fall** |
| Signs of infection? |  |  |  |  |  | * Refer to Dr or GP for furtherr

 investigation* Take regular lying & standing blood pressure
 |
| Any black outs or LOC before falling? (ACVPU) before falls? |  |  |  |  |  |
| Any dizziness on standing or turning? |  |  |  |  |  |
| Known physical health conditions? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Fear of falling** |
| Do they have a fear of falling? |  |  |  |  |  | * Consider 1:1 therapeutic discussion to explore identified fears
* Consider referral to Psychologist
 |
| Are there any confidence issues? **Identify their concerns** |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Mobility** |
| Can patient stand up from chairIndependently? |  |  |  |  |  | * Mobility Aids- provide details,
* Ferrules - do they need replaced? Consider OT or Physio referral
 |
| Do they use a mobility aid? |  |  |  |  |  |
| Do the use the aid safely? |  |  |  |  |  |
| Do they walk using props i.e., furniture? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Gait and Balance** |
| Is there a problem with balance? |  |  |  |  |  | * Mobility Aids- provide details,
* Ferrules - do they need replaced? Consider OT or Physio referral
 |
| Is there a problem with muscle strength? |  |  |  |  |  |
| Is there a problem with gait? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Appropriate footwear** |
| Closed toe / closed heal? |  |  |  |  |  | * Request career to obtain within 24-hour. Offer temporary replacement slippers. If offer declined-patient choice, document outcome/ discussion in care plan
 |
| Non slipsole? |  |  |  |  |  |
| Securely fitted?  |  |  |  |  |  |
| Mobility assessment completed?  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
| **Check condition of feet** |
| Any identify problems with foot care, bunions, nails, oedema, hard skin, redness or swelling? Pain or discomfort? |  |  |  |  |  | * Refer to podiatry/chiropodist
* Request suitable shoes from family/carers
 |
|  |  |  |  |  |  |  |
| **Pain** |
| Does the pain affect their mobility? |  |  |  |  |  | * Discuss with MDT the pain management plan
 |
| Where is the pain? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Cardiovascular Problems** |
| Postural hypotension?Dizziness?Syncope?Tachycardia? |  |  |  |  |  | * ECG : discuss with MDT & to be reviewed by GP/ ward doctor.
* If Hypotension- daily lying and standing blood pressure
 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Metabolic Disorder** |
| Known diabetic? Retinopathy – when was last eye test? |  |  |  |  |  | * Review from GP / ward doctor
 |
|  |  |  |  |  |  |  |
| **Nutrition and Hydration** |
| Any reduces appetite or dietary intake? |  |  |  |  |  | * MUST assessment, consider referral to dietician, weekly weights
 |
| Any difficulties eating?  |  |  |  |  |  |
| Any specific dietary? |  |  |  |  |  |
| Any signs of dehydration? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Medication** |
| On 4 of more medications? |  |  |  |  |  | * Review with MDT. Involve pharmacist Check when last review by Dr/GP
 |
| Date of last review? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **High risk medication** |
| Explore high risk drugs with Trust list, with particular attention to:Hypotensive?Benzodiazepine/ Hypnotic? Antipsychotic? Antidepressant? |  |  |  |  |  | * If yes, arrange fora medication review with Dr or GP – regular reviews Consider sleep chart
 |
|  |  |  |  |  |  |  |
| **Vision** |
| Do they wear glasses? |  |  |  |  |  | * Changes in vision?
 |
|  |  |  |  |  |  |  |
| **Hearing** |
| Do they have hearing problems? Do they wear a hearing aid? |  |  |  |  |  | * Check battery of hearing aid
 |
|  |  |  |  |  |  |  |
| **Urinary issues** |
| Do they use aids? E.g., Commode, Urinal, Pads Do they require assistance to attend their toileting needs? |  |  |  |  |  | * Consider the need for assistance/aids at night
 |
|  |  |  |  |  |  |  |
| **Alcohol and non-prescribed drugs** |
| Intake of units above the recommended intake? |  |  |  |  |  |  |
| Do they use non-prescription or illicit drugs? |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Mental Health** |
| Memory problems? |  |  |  |  |  | * Bloods, urinalysis, agree level of observation
 |
| Dementia? |  |  |  |  |  |
| Anxiety / depression?  |  |  |  |  |  |
| Known to mental health services? |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Osteoporosis screen** |
| Any bone fracture since age 40? |  |  |  |  |  | * FRAX by doctor/ trained nurse within 2 days of admission

Compliance with osteoporosis meds |

# Appendix 3

**BEST PRACTICE GUIDELINES FOR THE MANAGEMENT OF THE FALLEN PATIENT**

**(Post Fall Protocol)**

|  |
| --- |
| ***ASSESSMENT*** |
| ***BEFORE ASSISTING THE PATIENT TO RISE:*** |
| **At all times maintain safe moving and handling techniques to ensure the clients, your colleague and your own safety and well being** |
| 1 | Assess the immediate environment for hazards & call for assistance. |
| 2 | Communicate with client–Observe level of consciousness and response and ascertain events leading to the fall where possible. **If the patient is unconsciousmove directly to point 14.** |
| 3 | Determine if the patient responds to touch/pain (spinal injury). |
| 4 | Question and observe the patient for any evidence of pain (particularly in the pelvic area). |
| 5 | Observe and then examine all limbs and joints to determine if there is full movement androtation in each limb and joint (working from head to toe, as instructed in the Fall Workshop) |
| 6 | Observe and then examine each limb and joint for redness and/or swelling. |
| 7 | Observe and then examine the patient’s legs and observe for any evidence of shortening or impaired rotation. |
| 8 | Observe and then examine the patient for evidence of any bruising, lacerations or further injury. |
| N.B. IF A PATIENT RISES FROM THE FALLEN POSITION INDEPENDENTLY, ASSIST THE PATIENT TO A PLACE OF COMFORT& PRIVACY. STEPS 1 - 8 M UST BE COMPLETED IMMEDIATELY AND THEN CONTINUE TO CARRY OUT ACTIONS FROM POINT 9. |
| **ASSISTANCE / INTERVENTION** |
| ***IF THERE IS FULL M MOVEMENT AND ROTATION OF LIM BS AND JOINTS AND NO INDICATION OF PAIN:*** |
| 9 | The patient must be assisted to rise and mobilise using safe moving & handling techniques. |
| 10 | Examine the patent’s level of weight bearing, mobility and transfer and compare it with their functioning prior to the fall. |
| 11 | Re-examine for any evidence of redness and/or swelling of limbs and joints, particularly the pelvic area and re-examine for other injury. |
| ***IF PATIENT IS IN PAIN:*** |
| 12 | If there is any evidence of pain or concerns about the limbs/joints (shortening and/or impaired rotation, swelling and/or redness) then the patient must be made comfortable where they are – maintain their privacy & dignity as far as possible. **DO NOT MOVE THEM** |

|  |  |
| --- | --- |
| 3 | **DO NOT MOVE THEM – ensure someone stays with the patient, verbally reassuring them and explaining the process.** |
|  | Inform the Duty Doctor**\***/emergency services (dependent on local policy) immediately and act on direction anadvice received. **If specialist equipment is required for client care, ensure this is clearly communicated on the phone to the emergency services, to allow them to come prepared**.*Duty Doctor and or GP must be informed within 30 minutes of the fall occurring.****The patient must be offered a medical examination after sustaining a fall.*** |
| **N.B. \* THE CLINICAL DECISION IN RELATION TO THE ACTION TAKEN IS THE RESPONSIBILITY OF THE EXAMINING HEALTHCA RE PROFESSIONAL (HCP).**  |
|  A patient who has sustained an unwitnessed fall must have neurological observations completed. |
|  A patient who is witnessed to have banged or injured their head must have neurological observations Completed. |
|  |  |
|  | Neurological observations must be completed and recorded every 15 minutes or until such time as the Duty Doctor/Doctor responsible for the clinical area examines the client or instructs otherwise. **(If Neurological Observations to continue then carry out in line with NICE Clinical Guidelines****CG176: Head Injury). Neurological Observation chart is available on Trust Intranet** |
|  | **CG176: Head Injury). Neurological Observation chart is available on Trust Intranet.**An in-patient who sustains an unwitnessed fall, who bangs or injures their head as a result of a fall; must be observed for signs of: loss or fluctuating consciousness; persistent headaches; seizures; amnesia, vomiting or Glasgow Coma Scale of less than 15. If there are any concerns following an unwitnessed fall or head bang/injury**, please seek immediate medical advice (CG176: Head Injury). (NICE, CG176: Head :** **Head Injury).** **Injury)** |
|  | ***AFTER THE PATIENT HAS BEEN ASSISTED TO RISE:*** |
|  |
|  | Verbally reassure the patient. |
|  | Assist the patient to a comfortable chair or place of their choice. |
|  | Ensure someone remains with the patient and blood pressure, temperature, pulse and respiration rate are recorded and monitored. **(6 hourly for 48 hours, lying and standing BP)** |
|  |
|  | Inform the Duty Doctor/Senior Nurse (according to local policy) immediately. |
|  | Complete the incident form and record all details in the MDT notes, including the baseline observations. The information must be recorded as soon after the incident as is possible. |
|  |
|  | **NB: Complete the InPhase** **incident form** **at indicated in the Trust Policy for the Management and Prevention of Slips, Trips and Falls. Ensure the time and the location of the fall are all recorded on the InPhase incident form and the MDT records. Ensure you record on the incident form and MDT records that you cared for the client in accordance Best Practice Guidelines****#**Inform the next of kin as soon after the incident as possible and always before the end of your duty and recorded details in the MDT notes |
|  |

|  |  |
| --- | --- |
|  | At the first available opportunity review the client’s Falls Risk Assessment; review and discuss the falls MDT Multi Factorial Assessment and care plan with the MDT. |
|  | Report the incident and the actions taken to colleagues on duty, to new staff taking over the shift, DSN and members of the MDT. |

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|  |  |

**(APPENDIX 4)**

**Medicines that can contribute to falls and disorientation in older people**

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**Side-effect of drug**

**Antimuscarinic Low BP Antimuscarinic**

**Low BP Antimuscarinic**

**Low BP Low BP Osteoporosis**

**Disorientation Drug induced Parkinson’s**

**Disease**

**Low BP Sedation, Drug Induced**

**Parkison’s Disease**

**Low BP Antimuscarinic Antimuscarinic Disorientation**

**Low BP Sedation, disorientation,**

**dizziness Low BP**

**Drug induced Parkinson’s Disease**

**Sedation, low BP, muscle rigidity**

**Low BP Low BP Sedation**

**Drug induced Parkinson’s**

**Disease Antimuscarinic Disorientation**

**Low BP**

**Notes on the use ofcolour**

**Red = drugsthat have antimuscariniceffects (see notes atend)**

**Green = drugs that cancause sedation (see notes at end)**

**Blue = drugsthat can lower the bloodpressure**

**Purple = drugs that have a highrisk of causing disorientation**

**Black = drugs which do not specificallyfit inany of the above**

Yellow: - drugs that have a risk of

bleeding on older people

|  |  |  |
| --- | --- | --- |
| **Drug** | **Type of Drug** | **Side-effect of Drug** |
| **Amitripytline** | **TCA\*** | **Antimuscarinic** |
| **Amlodipine** | **Ca Channel blocker\*** | **Low BP** |
| **Aspirin** | **Thromboembolism Hae** |  |
| **Atenolol** | **Beta Blocker** | **Low BP** |
| **Atropine (eye drops)** | **Antimuscarinic** | **Antimuscarinic** |
| **Baclofen** | **Muscle relaxant** | **Muscle spasticity, dizziness** |
| **Bendroflumethazide** | **Diuretic** | **Low BP** |
| **Benzhexol** | **Antimuscarinic** | **Visual impairment** |
| **Bromocriptine** | **Anti-Parkinsons** | **Antimuscarinic** |
| **Captopril** | **ACE inhibitor** | **Low BP** |
| **Carbamazepine** | **Anti- epileptic,** | **Lack of control of movements** |
| **Chlordiazepoxide** | **Benzodiazepine** | **Sedation** |
| **Chlormethiazole** | **Sleeping tablet** | **Sedation** |
| **Chlorpheniramine** | **Antihistamine** | **Antimuscarinic** |
| **Chlorpromazine** | **Antipsychotic** | **Sedation** |
| **Cimetidine** | **Reduces stomach acid** | **Disorientation (usually if kidney/liver impaired)** |
| **Citalopram** | **SSRI antidepressant\*** | **Disorientation** |
| **Clonidine** | **Antihypertensi ve,** | **Low BP** |
| **Co-beneldopa** | **Anti-Parkinsons** | **Disorientation** |
| **Co-careldopa** | **Anti-Parkinsons** | **Disorientation** |
| **Co-codamol** | **Analgelsic** | **Sedation** |
| **Codeine** | **Analgelstic** | **Sedation** |
| **Co-proxamol** | **Analgelstic** | **Sedation** |
| **Cyclizine** | **Nausea/dizziness** | **Sedation** |
| **Dantrolene** | **Muscle relaxant** | **Antimuscarinic** |
| **Diazepam** | **Benzodiazepine** | **Sedation** |
| **Dicycloverine** | **Anti-spasmodic** | **Antimuscarinic** |
| **Digoxin (usually associated with toxicity)** | **To treat heart failure** | **Visual disturbances, Drowsiness, disorientation, dizziness.** |
| **Dihydrocodeine** | **Analgesic** | **Sedation** |

|  |  |
| --- | --- |
| **Drug** | **Type of Drug** |
| **Diphenydramine** | **Antihistamine** |
| **Dipyrimadole** | **Anti-platelet** |
| **Dosulepin (dothiepin)** | **TCA\*** |
| **Doxazosin** | **Alpha blocker** |
| **Doxepin** | **Antidepressant** |
| **Enalapril** | **ACE Inhibitor** |
| **Felodipine** | **ACE Inhibitor** |
| **Fludrocortisone** | **Steroid** |
| **Fluoxetine** | **SSRI antidepressant\*** |
| **Flupentixol** | **Antipsychotic** |
| **Furosemide (frusemide)** | **Diuretic** |
| **Haloperidol** | **Antipsychotic** |
| **Hydralazine** | **Vasodilator** |
| **Hydroxyzine** | **Antihistamine** |
| **Imipramine** | **TCA\*** |
| **Indomethacin** | **Analgesic** |
| **Lisinopril** | **ACE inhibitor** |
| **Methocarbamol** | **Muscle relaxant** |
| **Methyldopa** | **Antihypertensive** |
| **Metoclopramide** | **To treat nausea** |
| **Morphine** | **Analgesic** |
| **Nifedipine** | **Ca channel blocker\*** |
| **Nitrates** | **Vasodilator** |
| **Nitrazepam** | **Benzodiazepine** |
| **Olanzapine** | **Antipsychotic** |
| **Oxybutynin** | **Antimuscarinic** |
| **Paroxetione** | **SSRI antidepressant\*** |
| **Pergolide** | **Anti-Parkinsons** |

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|  |  |  |
| --- | --- | --- |
| **Drug** | **Type of Drug** | **Side-effect of Drug** |
| **Phenobarital** | **Anti-epileptic** | **Sedation** |
| **Phenytoin** | **Anti-epileptic** | **Lack of movement****control** |
| **Prazosin** | **Alphablocker** | **Low BP** |
| **Prednisolone** | **Steriod** | **Osteoporosis** |
| **Prochlorperazine** | **Nausea/dizziness** | **Drug induced****Parkinsons Disease** |
| **Procyclidine** | **Antimuscarinic** | **Antimuscarinic** |
| **Promazine** | **Antipsychotic** | **Sedation** |
| **Promethazine** | **Antihistamine** | **Antimuscarinic** |
| **Propantheline** | **Antipasmodic** | **Antimuscarinic** |
| **Propranolol** | **Beta Blocker** | **Low BP** |
| **Sertraline** | **SSRI antidepressant\*** | **Disorientation** |
| **Temazepam** | **Benzodiazepine** | **Sedation** |
| **Timolol (inc eye drops)** | **Beta blocker** | **Low BP** |
| **Tolterodine** | **Antimuscarinic** | **Antimuscarinic** |
| **Tramadol** | **Analgesic** | **Sedation** |
| **Trazadone** | **Antidepressant** | **Antimuscarinic** |
| **Trifluoperazine** | **Antipsychotic** | **Sedation** |
| **Verapamil** | **Ca channel blocker\*** | **Low BP** |
| **Warfrin****Zopiclone** | **Thromboembolism****Sleeping Tablet** | **Haemorrhage****Sedation** |

#### APPENDIX 5

Actions Recommended to be included Falls Prevention Care Plans

**Key recommendations from the Royal College of Physicians to be included in a Falls Prevention Care Plan.**

* **Blood pressure** – We recommend that all patients aged over 65 years have a lying and standing blood pressure performed as soon as practicable, and that actions are taken if there is a substantial drop in blood pressure on standing.
* **Medication review** – We recommend that all patients aged over 65 years have a medication review, looking particularly for

medications that are likely to increase risks of falling.

* **Visual impairment** – We recommend that all patients aged over 65 years are assessed for visual impairment and, if present, that their care plan takes this into account.
* **Walking aids** – We recommend that trusts and health boards develop a workable policy to ensure that all patients who need

walking aids have access to the most appropriate walking aid from the time of admission. Regular audits should be undertaken to assess whether the policy is working and whether mobility aids are within the patient’s reach, if they are needed.

* **Continence care plan** – We recommend that all patients aged over 65 years have a continence care plan developed if there

are continence issues, and that the care plan takes into account and mitigates against the risks of falling.

* **Call bells** – We recommend that all trusts and health boards regularly audit whether the call bell is within reach of the patient and embed change in practice if needed.

*\*Please note that only patients aged 65 or over were included in this audit. However, NICE CG161 also applies to people aged 50 to 64 who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition, and all patients aged 65 and*

*RCP, 2015*

**Multi Factorial Interventions which may be included in the care plan:**

* + Strength and balance training
	+ Environment/Home hazard assessment and interventions
	+ Vision assessment and referral
	+ Medication review with modification/withdrawal

(NICE, 2013)

#### APPENDIX 6

**STATUTORY & MANDATORY / RISK M ANAGEM ENT TRAINING NEEDS ANALYSIS TEMPLATE**

**SUBJECT AREA: Management & prevention of slips, trips and falls**

**TRAINING LEAD(S) / SUBJECT MATTER EXPERT (NAM E & JOB TITLE):** Tracy Lindsay – Lecturer Practitioner

#### SUM M ARY OF HOW TRAINING NEED WAS IDENTIFIED (e.g. national guidance/legislation, requirements of regulatory body, Trust policies etc.):

* + - Standard 6 of the NSF for older people (DH, 2001).
		- NICE clinical guidelines on the Management of Falls CG 161 (2013)
		- NICE Quality Standard QS86: Falls in older people: assessment after a fall and preventing further falls (2015)
		- NPSA, report on falls (2007)
		- NPSA, update on falls statistics (2010)
		- Trust policy on the Management and prevention slips, trips and falls (2018)
		- NHSLA Risk Management Standards (NHSLA 2008)

#### SUM M ARY OF WHO WAS CONSULTED / INVOLVED THE TRAINING NEEDS ANALYSIS PROCESS:

* + - Workshops offered to staff evaluated in a very positive way by staff who attended and they requested a regular update.
		- General Managers of the MHCOP service have identified a need for an update on falls management over the last 18 months.
		- As part of the commissioning consultation, general managers, modern matrons and PINs requested the falls workshop for this academic year and stated it was part of staff PDPs.
		- All professional leads within the MHCOP services across the Trist were consulted with via email and some in person, on the content of the policy and training/workshop. Also discussed the content and delivery with Ms Evans- Head of Assurance.

#### DESCRIPTION OF HOW THE STAFF GROUPS REQUIRING THE TRAINING WERE IDENTIFIED:

* **Modern Matrons, PIN’s and professional leads are responsible for identifying those in need of the training. However this is mandatory for all inpatient nurses in M HCOP services, in accordance with Trust policy.**

**TRAINING NEEDS ANALYSIS TEMPLATE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Target staff groups** | **Target****directorates for training** | **Type of training***Mandatory / Statutory / recommended* | **Content***Brief overview of the content of the training* | **Delivery Method & Duration** | **Delivery mode***(Induction / update / corporate training / site specific / other)* | **Frequency****of update** *(if applicable)* |
| Nurses andOTsNurses & OTs | MHCOP, OlderPeople In patient areas& high risk areasCommunity, Adult& Forensic services | Mandatory for MHCOPInpatient areas.Recommended for all other high risk areas and at the discretion of the manager in accordance with the Trust policy on the management and prevention of slips, trips and falls.Recommended for all areas with service users over the age of 50 | Background to falls inhospitalFalls prevention and managementMedicine management & implication for risk of fallsFalls assessment & care planningFalls Risk Awareness | ½ day workshopOnline programme | City Universityin practical rooms with hoist and spaceOnline within the Trust | 2 yrs.As indicated by line manager |