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Association of UK University Hospitals

Sussex Partnership NHS Foundation Trust

Slips, Trips & Falls
(Including Patient Falls Prevention Protocol)

(Replaces Policy No. TP/RHS/166 V.4)

Policy Number	TP/RHS/166
Policy Version	V.5
Ratifying Committee	Professional Practice Forum
Date Ratified	03 April 2018
Date of Equality and Human Rights Impact Assessment (EHRIA)	TBC
Next Review Date	03 April 2021
Policy Sponsor	Chief Nurse
Policy Authors	• Deputy Chief Nurse • Director of Occupational Therapy • Head of Incident Management & Safety

Executive Summary

This policy and procedure details the trust arrangements for minimising the risks presented from slips, trips and falls. It covers the legislative requirements, individual responsibilities and training requirements, risk assessment methodology, risk reduction guidance and specific clinical guidance with regards to falls prevention.

If you require this document in another format such as large print, audio or other community language please contact the Corporate Governance Office on 0300 304 1195 or email: policies@sussexpartnership.nhs.uk

Key Points of this Policy:

1) All staff to be made aware of this policy by their managers
   All managers and staff, with supervisory function, are responsible for undertaking risk assessments for all work activities and environments to identify potential risks relating to slip, trips and falls to patients, staff, visitors and contractors.
2) Ensure that risk assessments are completed on the Ulysses web based risk management system.

3) All clinical staff to be aware of and implement the falls prevention bundle at annexe c.

4) All staff to report any incidents of slips, trips and falls.

5) All staff to have relevant training in slips, trips and falls.

Policy

1 Introduction

1.1 Purpose of Policy

The Health and Safety at Work Etc. Act 1974, states that it shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees. Staff also have a duty not to endanger themselves or others and to co-operate with their employer.

The Management of Health and Safety at Work Regulations 1999, Regulation 3, lays out the requirement for risk assessments to be carried out and for control measures to be identified and implemented.

Regulation 3 - (1) every employer shall make a suitable and sufficient assessment of -

a) the risks to the health and safety of his employees to which they are exposed whilst they are at work; - our Staff, and
b) the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking – our patients and visitors

The Workplace (Health, Safety and Welfare) Regulations 1992, Regulation 12 relates to the condition of floors and traffic routes.

The regulations state that so far as is reasonably practicable;

- Floors and surfaces of traffic routes must be suitable for their intended purpose.
- There must not be any holes or slopes, or be uneven or slippery surfaces that might expose anyone to unnecessary risk.
- Where necessary floors should have effective means of drainage.
- Floors and surfaces of traffic routes must be kept free from obstructions and articles or substances that may cause someone to slip, trip or fall.
- Suitable and sufficient handrails and, if appropriate, guards must be provided on traffic routes that are staircases, unless the handrail obstructs the traffic route.

1.2 Definitions

Slip - Lose one's footing and slide unintentionally for a short distance.

Trip - Catch one's foot on something and stumble or fall.

Fall - Move from a higher to a lower level, typically rapidly and without control.

At Height - A place is ‘at height’ if a person could be injured falling from it, even if it is at or below ground level.

The above definitions apply to all persons including those who are likely to become unstable whilst using a walking aid or falling out of a wheelchair or electric scooter.

1.3 Scope of Policy

This policy applies to all employees of the Trust including those seconded to work in the Trust. There will be an active lead from managers at all levels to ensure that the risk management of slips, trips and falls is a fundamental part of the total approach to service delivery, risk management and Health and Social Care Governance.

The Board recognises that the risk management of slips, trips and falls is an integral part of good management practice and to be most effective should become part of the Trust’s culture. The Board is therefore committed to ensuring that risk assessment of slips, trips and

falls forms an integral part of its risk management process and that responsibility for implementation is accepted at all levels of the organisation.

The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

1.4 Principles

All Managers and staff, with a supervisory function, are responsible for undertaking risk assessments for all work activities and environments to identify potential risks relating to slip, trips and falls to patients, staff, visitors and contractors, Managers must ensure that they survey all their areas of responsibility, inside the building and also outside and actions from those assessments are put in place and where necessary, reviewed and updated in light of any significant changes to:

a) Flooring
b) Possible contaminates
c) Footwear
d) Patient factors
e) Cleaning regime
f) Environment maintenance work / refurbishment

Practical measures should be considered at local level by the manager to prevent slip, trip and fall injuries, taking into consideration, environmental conditions such as lighting, storage, cleaning arrangements and type of flooring material.

2 Policy Statement

The Trust places a high value on the physical and mental health of its staff and is committed to putting in place all reasonable measures to secure the health and safety of Trust staff, patients and anyone else who may be affected by the activities of the Trust. It is important to identify and reduce those risks associated with slips, trips and falls. The Trust is aware of the significant risk slips, trips and falls can have on staff, patients and visitors, and therefore will endeavour to manage those risks to the lowest level practicable.

3 Duties

3.1 Board of Directors

The Trust is committed to protecting the health, safety and welfare of its staff and service users and recognises that injuries associated with slips, trips and falls is a health and safety issue and will ensure that effective systems are in place and where appropriate, ensuring that adequate resources are available to support those systems.

3.2 The Chief Executive and Board of Directors

The Chief Executive and Board will satisfy themselves that managers are carrying out risk assessments throughout the workplaces for which they are responsible, and that those assessments are being properly recorded, acted upon and where significant risks are identified, recorded on the Trust Risk Register.

3.3 Directors, Deputy Directors and Department Heads

Ensure that appropriate and effective risk assessment processes are in place within their designated area and scope of responsibility and that all staff are made aware of the risks and the identified controls within their work environment

Prepare specific directorate / care group policies and guidelines to ensure all necessary risk assessments (clinical and corporate) are carried out within their directorate / care group.

Implement and monitor any identified and appropriate risk assessment control measures within their designated area and scope of responsibility (clinical and corporate). In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, directors are responsible for bringing these risks to the attention of the Quality Committee if local resolution has not been satisfactorily achieved.

3.4 Line Managers and Supervisors

a) Ensure that they are carrying out slip, trip and fall risk assessments throughout the wards, team bases or other workplaces for which they are responsible for staff, service users and others and that those assessments are being properly recorded and acted upon.
b) Ensure that staff and where appropriate, service users and others are informed about the risks to their health as identified in the risk assessment and how these can be minimised.
c) Consider the means and time required to address those action plans resulting from the risk assessments.
d) Actively encourage staff to identify and report any hazards that they identify associated to slips, trips and falls.
e) Ensure any incidents associated with slips, trips and falls are reported in line with the Trusts incident reporting procedure, and investigate all incidents to establish root cause as per the incident policy.
f) Ensure that staff attend training in line with the needs identified by the risk assessment, Mandatory Training and Induction Policy and Personal Development Plans (PDPs).
g) Ensure that all staff, including bank and agency staff are given the necessary information and training to enable them to work safely. These responsibilities extend to anyone affected by the Trust's operations including sub-contractors, members of the public, visitors etc.

3.5 All Staff Must

a) Ensure they work in a manner that prevents or minimises the risk of slip, trip and falls
b) Follow trust and local policies and procedures.
c) Ensure they attend the relevant training at the intervals prescribed in this document
d) Clear up any spillages and / or ensure immediate action is taken to do so
e) Report any defects that may lead to or result in a slip, trip or fall
f) Wear suitable footwear for the environment they work in and any personal protective equipment as provided.

4 Procedure

4.1 Patient Falls

All staff working with service users must be alert to the possibility of falls and the potential consequences of such events, especially if working in Dementia Service and later life, Integrated Wards or Learning Disabilities Services (LDS). Incident data reflects that these services experience high levels of slips, trips and falls.

Falls prevention must be a high priority in care delivery and in ward and unit management, and therefore patients should be assessed for the likelihood of falls and therefore this policy and procedure contains guidance that specifically deals with patient falls (Annexe C).

4.2 Risk Assessment of the Working Environment

Any identified risks should be adequately assessed by managers and a risk assessment form completed using Ulysses in line with the Trusts Risk Management Strategy and Policy.

Annexe A is a worked example of the Trust Risk Assessment form on Ulysses.

Items to consider as potential slip, trip or fall hazards are as follows:

- Spillages, both liquid and solid
- Wet floors from cleaning (timing and pattern of cleaning)
- Loose mats, worn carpets
- External weather conditions, such as ice, snow and rain
- Sloping surfaces, stairs and steps
- Lack of handrails
- Unauthorised access to areas at height
- Trailing cables
- Lighting (low, poor or none)
- Low wall and floor fixtures
- Obstructions, both permanent and temporary (trolleys, cables, items not stowed correctly due to lack of storage)
- Fall from height i.e. bed or from window
- Whether footwear is suitable for the type of tasks being carried out

It is important that a slip, trips and falls generic risk assessment is completed for the work area to identify potential slip, trip or fall hazards to both service users and staff. This assessment must be recorded on Ulysses. This assessment should be reviewed regularly (at least every 12 months) or, if there is a change in the work place, legislation of where it is suspected to no longer be valid. Any actions arising from the risk assessment should be acted upon in accordance with the Risk Management Strategy and Policy. Line Managers must ensure any identified control measures, such as warning signs, cordons or cones are in place as appropriate to raise awareness of hazards and prevent / reduce slips, trips and falls.

4.3 The Health and Safety Executive

The Health and Safety Executive (HSE) have identified four main causes of slips, trips and falls within the healthcare environment and these are:

- Slippery / wet surfaces – caused by water and other fluids
- Slippery surfaces caused by dry or dusty floor contamination, such as plastic, lint or talcum powder
- Obstructions, both temporary and permanent
- Uneven surfaces and changes of level, such as unmarked ramps.

4.4 NHS Floor Surfaces

If a smooth floor is frequently and regularly slippery because of a substance (such as urine) which lies upon it (albeit only temporarily), the surface of the floor may be classified as unsuitable. This is because it has become a health and safety hazard for those who walk or pass (for example wheelchair users getting the substance on their clothes or hands) across it.

There is a duty on employers to ensure that floor surfaces are suitable for the purpose for which they are used, taking account of spillages if they are frequent.

Managers and Safety representatives should update their risk assessments to consider whether a transient substance lies upon the floor's surface on a 'frequent and regular basis'

Line managers should assess the purpose for which the floor is used, who uses it and the likelihood of spillages. If they consider the floor to be slippery, they should request it be replaced it with a non-slip surface in consultation with Estates and Facilities.

Managers must also:

- Introduce and supervise a robust inspection and cleaning system;
- Warn employees of any dangerous or slippery surfaces;
- Erect warning notices in the vicinity of the dangerous or slippery surfaces;
- Instruct employees to report and / or clean any spillages immediately; and
- Maintain a record of such incidents through the incident reporting procedure.

The Workplace (Health, Safety and Welfare) Regulations 1992 were introduced to tackle the hazards associated with slips and trips.

Regulation 12 stipulates that every floor, surface or traffic route in a workplace should be suitable for the purpose for which it is used, and should be properly constructed and maintained for safe usage.

Additionally, the area should (as far as is reasonably practicable) be kept free from obstructions, articles or substances which may cause a person to slip, trip or fall.

4.5 Falls from Height

The risk assessment must consider any falls from height of staff. Falls from height must form part of the risk assessment and this could include office activities such as use of kick stools. This can be incorporated in to the generic risk assessment as identified in Annexe A.

As well as the Trust falls prevention protocol, falls from height of patients/service users' need to be considered as part of the risk assessment process. This must include areas such as falls from beds, windows or any other area where there is a risk of a fall liable to cause personal injury. Windows in health care premises need to ensure appropriate restrictors' to prevent such falls in line with relevant national guidance and alerts.

4.6 Work from Height

No person should work from height before a full risk assessment has been conducted and written down. It is important that any work from height is assessed and suitable control measures are in place to prevent falls from height. It is the responsibility of any person in control of the work or others (i.e. Building Managers) to ensure a risk assessment and control measures are in place by those undertaking the work.

This will require them to ensure:

- All work at height is planned and organised
- All staff are trained and competent to work from height
- That risk assessment and control measures are in place
- That the area where the work from height is done is safe and any other stakeholders e.g. service users are protected
- That all equipment used is maintained and inspected by trained personnel
- That any risks from fragile surfaces and falling objects are properly controlled
- That any work takes into account any weather conditions that could compromise health and safety

Further information on specific safety procedures can be obtained from Estates and Facilities as part of an annual subscription to Health Estates and Facilities Management Association trade rules.

5 Development, consultation and ratification

This policy and procedures were developed by the Risk and Safety Team in conjunction with Staff Side Representatives and members of the Health and Safety Committee, the Staff Disability Network and reducing falls network. The policy and protocol were delegated by the Trust wide Health and Safety Committee and Professional Practice Forum for final consultation and ratification.

6 Equality Impact Assessment

This policy and protocol will be equality impact assessed in accordance with the Procedural documents policy.

7 Monitoring Compliance

Line managers and supervisors will monitor staff training needs and attendance, initially via the Induction process and thereafter annually as part of the Personal Development Review (PDR) process. Where training needs or non-attendance are identified line managers will ensure staff members are booked to attend as necessary. Monitoring of essential training non-attendance will be undertaken as detailed in the Mandatory Training and Induction Policy.

Line managers and supervisors will review, and amend if necessary, all staff and service user slip, trip and fall risk assessment at least annually or whenever circumstances change, whichever is soonest. As part of this review, Line Managers and Supervisors will ensure existing processes for raising awareness and preventing / reducing slips, trips and falls (e.g. control measures such as cordons, cones, signs etc.) are still suitable and sufficient.

As per the Risk Management Strategy and Policy any significant slip, trip or falls risks will be entered on to the Trust risk register.

Directors, Deputy Directors and General Managers will review their risk registers monthly identifying slip, trips and falls risks. They will subsequently liaise with Line Managers and Supervisors to ensure action plans and control measures are implemented and risk registers updated as appropriate. Risk registers will also be reviewed at local trust health and safety forums. Any high and extreme risks will go on the Trust wide risk register for the Quality Committee.

As part of raising awareness, the local Trust Health and Safety Forums will review incident reports bi-monthly, that contain slips, trips and falls incidents within the data scope, following up any concerns with the relevant General or Ward Managers.

As part of the policy review the policy sponsor and author will ensure, through consultation, the correct roles and responsibilities for staff and forums / committees are identified within the document.

8 Dissemination and Implementation of policy

8.1 Dissemination

This policy will be displayed on the Trust website by the Corporate Governance Team. Publication will be announced via the Communications e-bulletin to all staff, staff not having access to this e-bulletin will be informed by their supervisor/manager

8.2 Training

The following training requirements fall under the category of 'Essential Training' and individuals should refer to the Mandatory Training and Induction Policy for further information and guidance on how the training is delivered and can be accessed.

8.3 Training, All Staff

All staff and volunteers should undertake Slips, Trips and Falls Awareness training as part of their induction, within 3 months of commencing employment with the Trust.

Thereafter, all staff are expected to undertake in the essential update day, awareness training will consist of:

- Scope of the law
- Flooring
- Contamination
- Footwear
- Patient Factors
- Cleaning
- Environmental maintenance work
- Risk assessment and controls

8.4 Role Specific Training (Clinical)

Clinical staff may need to undertake more in-depth slips, trips and falls training in relation to patients, dependent on their role, as soon after joining the Trust as possible and annually thereafter. Role specific training will consist of:

- Falls Bundle
- Physical and mental health assessment of patients and service users
- Consequences of falls in older people
- Immediate action to be taken post fall

8.5 Managers Training

Managers and some staff with supervisory functions should undertake additional slips, trips and falls management training, which should be undertaken within 12 months of commencing employment with the Trust or a role where this training is applicable.

This one off, Managers training will consist of:

- Legislation
- Method or risk assessment
- Identification of workplace areas that may cause slips, trips and falls
- Development of basic controls for slips, trips and falls
- Responsibilities imposed under UK legislation

9 Document Control including Archive Arrangements

This policy and protocol will be stored and archived in accordance with the requirements detailed in Procedural documents policy.

10 Reference Documents

Management of Health and Safety at Work, Approved Code of Practice & Guidance, L21, HSE Books[1]

Workplace (Health, Safety and Welfare) Regulations 1992, Approved Code of Practice & Guidance, L24, HSE Books

Slips and trips: Guidance for employers on identifying hazards and controlling risks HSG155 HSE Books 1996 ISBN 0 7176 1145 0

Preventing slips and trips at Work (HSE; INDG 225 rev2)

The Health and Safety Toolbox – How to control risks at work (HSE; HSG268)

11 Bibliography

A recent court case in which a worker successfully argued for more stringent care of floor surfaces. Ellis v Bristol City Council (2007) EWCA Civ 685. The Court of Appeal judgment has imposed a greater demand on employers by extending their liability over slippery floors.

http://www.bailii.org/ew/cases/EWCA/Civ/2007/685.html

12 Glossary

Risk Management: The design and implementation of relevant and appropriate strategies, policies and procedures to limit the likelihood of a risk occurring and/or to limit its impact should it occur. Identifying, assessing, analysing, understanding and acting on risk issues in order to reach an optimal balance of risk, benefit and cost.

Risk Assessment: an informed view of the likelihood of occurrence of each particular risk and of its potential impact and consequences on all relevant parties

Control Measure: A way of preventing or minimising an organisation's, group's or person's exposure to a hazard. Can be equipment, processes or actions used to reduce the likelihood of the hazard occurring.

Others: Contractors, Sub-contractors, Visitors, Relatives, Carers, Friends, Family or anyone else who may access the Trusts sites not being an employee.

13 Cross Reference

This policy should be read in conjunction with the following Trust policies:

Risk Management Strategy and Policy

Clinical Risk Assessment and Safety Planning / Risk Management Policy and Procedure

Incidents, Serious Incidents and Learning from Deaths Policy and Procedure

Mandatory Training and Induction Policy

[1] No longer in publication but relevant

14 Annexe A – Example Slips, Trips and Falls Risk Assessment

Risk Register Form

Risk Number	Risk Version	Corporate Risk ?	Date	Review Date	Owner	Assessor	Risk Rating
8964	1		15/01/2018	15/01/2019			2 High (Orange)

Risk Details

Organisation	Sussex Partnership NHS Foundation Trust	**Directorate**	Nursing & Patient Experience
Site	Swandean	**Division**	Trustwide
Site Type	Mental Health Service	**Speciality**	Administration
Department	Risk And Safety (Swandean)	**Handler**	Chief Operating Officer
		Status	Pending
Group	Organisational Factor	**Type**	Slips, Trips & Falls

Description

Example risk assessment for Slips, trips and falls.

Hazard/Reason for Risk Occuring

Slippery / wet surfaces leftover from cleaning processes
Slippery / wet surfaces due to deposited bodily fluids
Slippery / dry surfaces caused by dusty floor contamination (Dust, talcum powder, lint)
Slippery flooring due to regular contamination (kitchen, bathroom, main entrance)
External weather conditions (rain, sleet, snow, ice) causing contamination of floor
Obstructions (temporary and permanent, eg trolleys, wheelchairs, cables, items not stowed away correctly due to lack of storage)
Uneven surfaces, changes of level including sloping floor, steps and stairs
Lack of handrails (eg along corridors, in stairwells or at doorways)
Poor levels of lighting
Poor contrast between adjacent objects (eg dark furniture on dark floors)
Footwear unsuitable for place of work
Fall from access equipment
Fall from roof or other place at height
Lack of fall arrest hardware (eg handrails or other barriers)

Controls & Assurances

Controls

Control	Details	Gaps	Effectiveness
Work Environment	Handrails fitted to all staircases.	Individuals may chose not use the handrails.	Satisfactory
Work Environment	Weather mats at primary entrances/exits.	Individuals not using Weather mats to clean/dry footwear before proceeding further into building	Some Weakness

Assurances

Internal	Independent	Gaps	Adequacy
Workplace Inspections	Not Applicable.	Not Applicable.	Fully Assured
Workplace inspections Supervision	None identified.	None identified.	Partially Assured

Residual Risk Rating

Risk Assessment

Severity	5 Catastrophic	**Likelihood**	2 Unlikely
Rating	2 High (Orange)	**Risk Rate Score**	10

Page: 1 Doc:Risk Register Form - V1.0 15/01/2018

15 Annexe B – Reminders for Completing the Risk Assessment Electronically

In most cases individuals should have received training in completing a risk assessment via Ulysses however the following is designed as a quick reference guide to remind managers of what should be entered.

Risk Number – This is automatically generated by Ulysses.
Risk Level – Self Explanatory

Escalation Reason – Only required if amending a risk that requires escalation to the next level of risk register.

Date Identified – This should be the date you undertook the risk assessment.

Title – This should be along the lines of "Slips, Trips and Falls – Swandean"

Risk Description – Enter a description for the risk assessment, for example Risk Assessment for slips trips and falls at Swandean HQ

Hazards – Using the guidance within the slips, trips and falls policy/procedure as a starting point. Enter the hazards that were identified during your survey

Source – Select "Risk Assessment"

Group – Select "Organisational Factor"

Type – Select "Slips, Trips and Falls"

Assessor – Enter the assessors name (Surname first) and select them from the list that displays by clicking,

Manager – Enter the managers name (Surname first) and select them from the list that displays by clicking.

Executive / Director Lead – Select the most relevant individual.

Location Details – Enter the location details as relevant to your site, start from the top of the list as options automatically enter as you go in most cases.

Initial Risk Rating – Using the trust risk assessment methodology, select the initial risk rating by clicking on the appropriate box. This is the risk rating with no controls in place.

Controls currently in place to manage the risk – This is where you need to enter controls that will reduce the risk presented by the hazards, click "New" and enter the details in as applicable.

Residual Risk Rating – Using the trust risk assessment methodology, select the residual risk rating by clicking on the appropriate box. This is the risk rating with all of the controls you entered applied.

Actions to be undertaken to further reduce risk – This is similar to controls already in place except that these are needed to reduce the risk further than you currently can. Click "New" and enter the particulars relevant to the action required to be undertaken.

Target risk, following the implementation of suggested actions - Enter the information on whether to Accept, Eliminate, Reduce or Transfer the risk along with the details of treatment and benefits. Then enter the target risk rating by clicking on the appropriate box using the trust risk assessment methodology.

Reviews – Select the review frequency as applicable, in most cases this will be annually unless there is a reason to review sooner based on the assessment contents.

Notifications – If you need to notify anyone of the risk assessments contents do so here.

Attachments and Documentation – Any files that you need to upload can be done so through here, this could be photo's, training records, documents or any other relevant information to support your assessment.

16 Annexe C – Clinical Guidelines for Falls Prevention

16.1 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 and loss of confidence. 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 states that 'nearly 209,000 falls took place in hospitals, in England, between 1st October 2011 and 30th September 2012. While the majority (97%) of these people experienced no or low harm (such as minor cuts and bruises), 90 patients died because of their falls. Around 900 patients experienced severe harm, such as hip fractures and head injuries' (NICE 2013). More than 36,000 falls occurred in mental health units and 38,000 in community hospitals in England and Wales between 1st October 2008 and 30th September 2009 (National Patient Safety Agency [NPSA] 2010, p6).

Updated clinical guidance Falls in Older People – Assessing Risk and Prevention was issued in 2016. (NICE clinical guidance 161) This made no changes to the 2013 update. In 2017 there was also an updated Quality Standard - Falls in Older People (NICE QS86)

16.2 Key Recommendations from NICE

Older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s. [2004]

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi-factorial intervention.[2004]

Regard the following groups of inpatients as being at risk of falling in hospital and manage their care accordingly.

- all patients aged 65 years or older
- Patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. [new 2013]

For patients at risk of falling in hospital consider a multi-factorial assessment and a multi-factorial intervention. [New 2013]

Ensure that any multi-factorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:

- cognitive impairment
- continence problems
- falls history, including causes and consequences (such as injury and fear of falling) footwear that is unsuitable or missing
- health problems that may increase their risk of falling

- medication
- postural instability, mobility problems and/or balance problems
- syncope syndrome
- Visual impairment. [new 2013]

In successful multi-factorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- Strength and balance training (This should be individually prescribed and monitored by an appropriately trained professional)
- Home hazard assessment and intervention (preferable by an Occupational Therapist) effective only in conjunction with follow-up and intervention, not in isolation)
- Vision assessment and referral
- Medication review with modification/withdrawal. [2004]

Individuals at risk of falling, and their carers, should be offered information orally and in writing about:

- what measures they can take to prevent further falls
- how to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- the preventable nature of some falls
- the physical and psychological benefits of modifying falls risk
- where they can seek further advice and assistance
- how to cope if they have a fall, including how to summon help and how to avoid along lie. [2004]

Management of patients at risk of falls should be tailored to individual risk factors.

Additionally the NICE Quality standard (2017) highlighted the following:

- Older people who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved. [2015]
- Older people who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods. [2015]
- Older people who fall during a hospital stay have a medical examination. [2015]
- Older people living in the community who have a known history of recurrent falls are referred for strength and balance training. [2015]
- Older people who are admitted to hospital after having a fall are offered a home hazard assessment and safety interventions. [2015].

16.3 People to be considered high risk

Patients known to be at an increased risk of falls in hospital:

- Patient over the age of 65
- Research suggest that in hospital male patients are more at risk from falls than female patients
- History of falls in the community particularly within the last 12 months
- Current hospital admission being fall related
- Transient risk i.e. surgery, acute onset of confusion, sepsis, epidurals etc
- Mobility and balance impairment
- Patient agitated or confused
- People with dementia
- People with sensory deficits e.g. vision, hearing, sensation
- Neurological changes i.e. stroke, diabetes, peripheral vascular disease, seizures

- Poly-pharmacy or medication known to affect balance/cognition
- Postural hypertension
- History of alcohol misuse

16.4 Role of Medication

Older patients are more sensitive to the effects of medication and evidence suggests that there is a significantly increased risk of falling in those patients that receive poly-pharmacy (i.e. take 4 or more medications per day) and in particular medication from the following groups:

- Anxiolytics (sedatives)
- Antipsychotics
- Anxiolytics (sedatives)
- Antipsychotics
- Antidepressants
- Anticonvulsants
- Hypnotics (night sedation)
- Opiate / opioid analgesics
- Cardiac drugs – especially nitrates
- Diuretics
- Laxatives

Patients, who have fallen should have their medication reviewed by the pharmacist or medical team and, if appropriate, adjusted or reduced (in light of their risk of future falls).

Particular attention should also be given to anticoagulation therapy as although this treatment does not increase the patients risk of falling, the outcome of the fall could be more serious.

16.5 Reducing the likelihood of falls for all inpatients

The essential steps necessary to maintain a safe environment for our patients are outlined below:

- Orientate patients to the ward environment. Ensure they are aware of the nearest toilet/washing facility and light switch.
- Ensure they are orientated to their bed area including locker, bed table, call bell and light switch.
- If there is a clock in the ward/patient's room ensure it is visible, working and correct.
- Ensure that patients have call bells/buzzers within easy reach which work, and that patients can physically use them.
- Bells and buzzers should be regularly checked by local staff to ensure that they are working.
- De-clutter put away things that aren't needed.
- Ensure electrical leads and equipment do not cause an obstruction or risk of tripping.
- De-clutter put away things that aren't needed.
- Ensure electrical leads and equipment do not cause an obstruction or risk of tripping.
- Keep floors non-slip and ensure that any spillages are immediately cleaned up and in particular, ensure that the floor is properly dried afterwards.
- Ensure adequate lighting day and night.
- Ensure bed is in its lowest position with brakes on.
- Ensure the bed is at the most appropriate height for the patient to get into and out of bed.
- Ensure chairs are suitable for patient's needs i.e. correct type, height etc.

- Assess toilet facilities are at a reasonable distance from patient and offer frequent assistance with toileting.
- Keep walking aids, drinks, books etc. within easy reach.
- If patient normally wears glasses ensure they are worn and are clean.
- If patient normally uses a hearing aid ensure that it is worn and is working.
- Ensure patient footwear is flat and well fitting. Encourage family to bring in appropriate footwear if necessary.
- Ensure patient does not wear clothing that trails on the floor.
- Maintain staffing levels appropriate to levels of dependency.
- Adequate staff should be available for specific manual handling procedures in order to reduce the risk of injury to patients.
- Equipment (e.g. hoists, slings, wheelchairs, trolleys, beds, commodes) that is used by patients should be suitable for purpose, safe and well maintained in order to minimise risk of patient falls.

16.6 Reducing the likelihood of falls for at moderate / significant risk of falls

The following additional preventative measures must be considered for patients identified:

- Nurse in high visibility bed
- Nursing staff to accompany/be within arm's reach of patient for high risk activities i.e. dressing, toileting etc.
- Implement "Comfort/Toileting rounds" 2 hourly and before meals
- Ensure medication review is undertaken on ward round
- Consider referral to falls clinic
- Refer to physiotherapist for range of movement, strength, balance and/or gait exercises.
- Ensure that all staff are aware of risk status.
- Check Lying and Standing B/P at least three times a week at different times of day. Report any postural drop to medical staff for their review.
- Assess the need for increased supervision/enhanced observation- consider one to one specialling.
- Consider low level bed.
- Assess for suitability for bed/chair alarms.

16.7 Assessment and Intervention Planning

16.7.1 Dementia-In Patients

Each patient will have a Multi-factorial In-Patient Falls Risk Assessment and Care Plan within 24 hours of admission. It will be the responsibility of the clinician co-ordinating the care to ensure that this is completed.

16.7.2 Adult Mental Health Services Inpatients/Learning Disability Inpatients/ Residential Services/ Forensic Services

The Multi-factorial In-Patient Falls Risk Assessment and Care Plan must be completed for patients who have mobility problems, history of previous falls, medical or physical conditions which may predispose them to falls. It will be the responsibility of the clinician co-ordinating the care to ensure, when indicated, that the assessment is completed.

16.8 Reviewing risk assessments (all areas)

The decision as to how often multi factorial risk assessments are reviewed should be based on clinical judgement, related to the individual's specific needs.

If unsure staff should discuss further with other members of the Multidisciplinary Team (MDT).

It must be remembered that all identified falls risk factors and care needs must be addressed and reviewed in an on-going way as part of the continuous care planning process.

For patients at highest risk this may be daily or more frequently for example at each shift change particularly if they have acute or fluctuating difficulties which affect their mobility, judgement and safety.

For medium to low risk reviews should occur weekly.

If the patient's condition alters, there is a change in their medication or in the event of a fall, repeat assessment must be undertaken.

16.9 Care Planning / Actions to take

Where specific risks are identified, the necessary clinical and environmental actions will be taken. Actions will be recorded in the falls care plan.

For patients assessed as being at increased risk of falling overall, or who have had recurrent falls, individualised multi-factorial interventions should be considered to reduce risk factors and create a safer environment (as per NICE Clinical Guideline)

These interventions may include: education and information giving; strength and balance training; exercise programmes; home hazard assessment and intervention; vision assessment and referral; medication review with modification / withdrawal of medication implicated in falls risk. (N.B. some physical healthcare medication and some psychotropic medication are known to be strongly associated with an increased falls risk. See section 4).

For patients who may be at increased risk of osteoporosis, a pro-active approach to osteoporosis screening and treatment is advocated.

Patients who have fallen will require interventions to reduce their likelihood of further falls. These interventions will be decided upon during the review of the service user's care post fall: e.g. as part of care planning, Care Programme Approach (CPA) review, MDT meetings etc. Any actions taken and/or referrals made regarding such interventions will be clearly recorded in the patient's care plan.

If patients have recurrent falls then the Ward Manager/ Matron will discuss the case with staff and if necessary will themselves lead further review of the falls prevention risk assessments and care plan.

It is, however, recognised that patient safety should be balanced with the promotion of patient recovery and independence, with the aim of discharging patients home safely.

16.10 Home Hazards Assessment

The assessment tool used to identify any falls hazards in the home environment is HOMEFAST (See Appendix) this is an evidenced based tool developed by the University of Newcastle in Australia. Where possible this assessment should be completed by an Occupational Therapist in consultation with the patient and carer if appropriate. Recommendations must be in place before the patient is discharged home, or an indication of why this is not possible.

Older people who are admitted to hospital after having a fall should be offered a home hazard assessment and safety interventions.

16.11 Action following a slip, trip or fall involving patients

Immediate Actions

In brief, in the event of a fall, immediate response and assessment of the seriousness of the situation and of the patient's need's will take place, actions will be taken accordingly. Older people who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury must only be moved using safe manual handling methods. – Other actions may include:

Physical observations/Early Warning Score (NEWS) should be recorded and if a head injury is present or cannot be ruled out, neuro observations should be commenced, using AVPU in adherence to NEWS Protocol:

- Alert - is alert and responsive; eyes open spontaneously when approached.
- Voice - responds to voice.
- Pain - responds to painful stimuli.
- Unresponsive - does not respond to painful stimuli.

and immediate advice sought, followed by referral to acute medical services for on-going diagnosis and treatment.

If a patient with a suspected head injury is currently prescribed anti-coagulation therapy they should be assessed by acute medical services within 8 hours of the incident (National Institute for Health and Clinical Excellence 2007 Clinical guideline 56: Head injury; triage, assessment, investigation and early management of head injury in infants, children and adults)

Take immediate actions to prevent falls recurrence safeguard others. e.g. moving hazards, moving other patients.

16.12 Follow Up

The circumstances surrounding the fall and actions taken/needed will be documented in the patient record; staff will provide handover to colleagues at the next shift change of the falls incident and of any further actions needed/ immediate changes in care delivery.

At the earliest opportunity following the fall the patient will be re-assessed using the Multi-factorial Falls Risk Assessment and the care plan reviewed to include any necessary changes or actions required to minimise further falls risk. (If it is suspected Discussion will also be held at the review/MDT meeting and any actions identified. Referral for physiotherapy assessment/ re-assessment will follow the guidelines in place in the particular service area.

Staff, patients and their carers may need to discuss and agree the balance between supervision and privacy for patients at high risk of falls in areas such as toilets and bathrooms.

In more complex cases, or where the patient has had recurrent falls, staff are also encouraged to call a multi-disciplinary case review re: falls risks and falls prevention using the After Action Review Format (Step 4) to explore any emerging patterns or issues.
Staff will encourage patients to discuss their experiences and anxieties following falls and, where possible, develop strategies for preventing further falls collaboratively with the patient.
If the patient has a fear of falling which is affecting their activities and wellbeing, then a structured approach to help them regain confidence should be considered. Other members of the Multi-Disciplinary Team (MDT) e.g. Physiotherapist, or Occupational Therapist may be best placed to offer this.
It should be noted that NICE do not recommend the following interventions to address falls risk factors due to insufficient or conflicting evidence, although they may result in other health benefits:

- low intensity exercise combined with incontinence programmes
- group exercise (not individually prescribed)
- cognitive behavioural interventions
- referral for correction of visual impairment as a single intervention
- vitamin D
- hip protectors
- Brisk walking.

17 Annexe D – Multi-factorial Falls risk assessment

This assessment should be completed on admission, post fall, if condition deteriorates or weekly

Name **Patient Number** **Ward**

Date & Time						
Age						
0 – Under 65 years; **1** – 65 years or over						
Gender						
1 – Female; **2** – Male						
History Of Falls						
0 – No history of falls **1** – Patient have a fear of falling **2** – History of falls						
Mobility						
0 – Independently mobile **1** – Unsteady needs assistance but knows to call for help **2** – Bed / Chair bound and/or hoist transfer **3** – Unsteady / wandering / restless **4** – Requires constant observation / specialing						
Comprehension						
0 – Alert and able to call for help **1** – Impaired awareness but responds appropriately **2** – Needs / requires assistance to voice needs **3** – Disorientated / confused / unable to voice needs						
Sensory Impairment - score 0 if no problems						
1 – Visual OR Hearing Impairment (Glasses / Hearing Aids) **2 –** Visual AND Hearing Impairment						
Medication						
0 – No meds **1** – Patient on any medication with sedative effects **2 –** Patient on medication likely to contribute to risk of falling such as anti-hypertensive, diuretics, dexane, Warfarin / polypharmacy / anti-psychotics						
Sleep Pattern						
0 – Sleeps well **1** – Broken sleep **2** – Reversed day / night pattern **3** – Minimal / no sleep / exhausted						
Diagnosis / Neurological Problems - Score 0 if no problems						
1 – Diabetes / Peripheral Vascular Disease **2 -** Dementia / Alzheimer's / Delirium **3 –** Acute confusional state **4** – Unconfirmed						
Continence - Score 0 if no problems						
1 – Catheter and/or ostomy **2** – Incontinent / needs assistance **3** – Incontinent and dependent for care 4 – Incontinent needs assistance but refuses this.						
Other risk factors						
0 – Fully co-operative **1 – Regular re-assurance / instruction** 2 – Unpredictable / variable mood **3** – Physically aggressive / resistive / reluctant						
Score						

Carer View
Please record here any factors raised during discussions with carers which may influence how the person's risk of falling is managed.

Multi-Factorial Falls Care Plan

To be completed at time of initial falls assessment, weekly or when falls risk assessment is updated (after a fall / change in patient's condition). For significant changes complete a new care plan.

Name	**Patient Number**	**Ward**	
Risk Score	**Interventions**	**Date and Time**	**Actions / Variations** **A = Achieved, Specify variation if any.**
Score **0 - 10** **Low Risk** **Undertake all of these actions** ➔	Assess environment; ensure furniture/ equipment positioned appropriately. Keep surrounding bed area clear of hazards.		
	Ensure personal belongings are within easy reach.		
	Patient to be orientated to the environment, including toilets, If patient requires frequent orientation, staff to be aware and do so.		
	Provide Continence Aid (state what aid) if required.		
	Use of commode by bed at night if required		
	Monitor patient toilet patterns as required		
	Respond to requests for toilet facilities within 5 minutes (consider communication needs).		
	Ensure call bell within reach, that it is working and patient understands how to use it (consider other ways of communication if required).		
	Ensure footwear is non-slip, low heeled and well fitting. Check slipper socks daily for grip. Check feet, refer to podiatrist as needed.		
	Ensure spectacles, if worn, are within reach and are clean.		
	Ensure correct use of hearing aids if worn.		
	Bed to be maintained in lowest position.		
	Assess need for / ensure walking aids are appropriate and within reach at all times.		
	Contacts identified in inpatient assessment document.		
	Discuss normal activities of daily living with patient & carers and include in decision making processes.		
	If patient experiencing dizzy spells, record lying and standing blood pressure.		
	If patient on medication likely to contribute to risk of falling such as antihypertensive, diuretics, clexane, warfarin / polypharmacy, review medication.		
	Consider nutritional concerns, review need for assistance with eating, and provision of snacks and supplements.		
	Complete MEWS and MUST, and other physical health checks		

Score 11 - 20 Moderate Risk  **Undertake all of the above actions and these actions** 	Nurse in room / bed close to nursing station if possible..		
	Nursing staff to accompany for high risk activities / ADLS.		
	Assess for sensor mat / bed / chair alarms		
	Consider referral to falls service if available.		
	Refer to physiotherapist / occupational therapist for assessment / intervention.		
	Ensure that all staff are aware of risk status.		
	Provide supervision/assistance whilst using or mobilising to toileting facilities if required.		
	Check Lying and Standing B/P as agreed by MDT in accordance with MEWS protocol. Report any postural drop to medical staff for review.		
	Assess the need for increased supervision/observation		
Score 21 - 30 Significant Risk  **Undertake all of the above actions and these actions** 	Consider needs for within arms length/eyesight observations.		
	Identify high risk activities		
	Review physical health plan including pressure area care		
	Put de-escalation plan in place – describe mitigation		
	Nurse with mattress on the floor.		

For significant changes complete a new care plan.

Date & Time	Updates to Care Plan	Signature

For significant changes complete a new care plan.

Date & Time	Updates to Care Plan	Signature

With acknowledgement to Brighton and Sussex University Hospitals Trust Falls Service.

NHS
Sussex Partnership
NHS Foundation Trust

Post Falls Protocol-
"Looking after Patients who have Fallen"

Check for signs of physical injury

- **Not being able to lift, move or rotate (turn) leg**
- **A shorter leg, or leg turning outwards more on the injured side**
- **Loss of sensation to limbs**
- **Pain / bleeding and swelling in any area of the body**
- **Known or suspected head injury**

No significant signs of injury

- Return patient to bed/chair using appropriate moving and handling technique and equipment
- Record Neurological Observations if known or suspected head injury using AVPU
- Record baseline observations using NEWS, inform Duty Doctor and next of kin
- Assess for pain/administer pain relief as prescribed - Patients with head injury should not receive systemic analgesia until fully assessed

- Repeat NEWS and Neurological Observations hourly. If stable repeat 4 hourly, then daily
- Re-check for signs of physical injury, swelling, pain, bruising, loss of sensation, deformity of limbs, reduced mobility
- Consider pain relief, monitor fluid intake and pressure area care

Significant signs of injury
DO NOT MOVE PATIENT

- Dial 999 for **URGENT** ambulance
- Administer first aid to any bleeding points
- Record Neurological Observations using AVPU and NEWS
- Assess for pain/administer pain relief as prescribed - Patients with head injury should not receive systemic analgesia until fully assessed
- Keep patient Nil by Mouth
- Refer patient taking anti-coagulant medication to secondary care immediately

- Repeat NEWS and Neurological Observations half hourly until ambulance crew arrives
- Inform Duty Doctor and next of kin
- Complete Urgent Transfer form
- Nominate senior nurse to liaise with designated hospital

- Liaise with Duty Doctor and undertake holistic reassessment
- Contact nearest relative/ family and inform them of incident (if appropriate)
- Complete incident report and follow Duty of Candour procedure for severe to moderate harm.
- Review and update patient records, falls risk assessment and update falls care plan
- Complete After Action Review and implement recommendations

JB/KB Nov 2014 Reviewed Feb 2018

19 Annexe F – After Action Review

Patient Name Ward Date of fall
AFTER ACTION REVIEW- Only to be completed if fall is complex and team wish to examine the circumstances surrounding the fall

Describe/explore the following when completing an AAR post Fall		Notes
What was happening on the ward leading up to the fall e.g. what was the acuity/dependency on the ward.	Ask the staff to describe in their own words what was happening on the ward at the time. Where staff were what were they doing, the general busyness, skill mix etc.	
What is the normal **Staffing Level** for the ward?		
What was the **Nurse to Patient Ratio** on the day of the fall?	Please comment on skill mix and any bank/agency staff	
When looking at the falls risk assessment has it been completed weekly, if condition changes or after a fall?		
Are the signatures on the risk assessment form all from a qualified registered nurse?		
Is the falls risk assessment score accurate?		
Have all actions in the falls action plan been completed?		
If there are “Variances” to any actions is there documentation to say why?		
If staff are documenting N/A against any actions is there documented rationale for this?		
Is the description of the fall accurate i.e. What was the patient doing when they fell? **Talk to all staff involved and the patient**		

Is the fall related to toileting? If the patient was on the commode ask the staff to position exactly where the commode was placed? Is "Arms reach approach use" Has a urinalysis been taken? Has a Continence assessment /and or a toileting chart been commenced?	Is it common practice to turn the commode to the bedside? Do staff wait outside curtains/bathrooms	
Has the patient's condition changed leading up to the fall i.e. Worsening Confused state, diarrhoea, UTI etc.? Was the falls risk considered in view of this?	Greater risk of dehydration which exacerbates postural hypotension & can lead to confusion.	
Were post fall observations undertaken as per "Managing a patient post fall flow chart"?		
How was the patient moved off the floor?		
Describe/explore the following when completing an AAR post Fall		**Notes**
Has the post falls checklist been completed? Has a Doctor seen and assessed the patient?		
Review the medication chart with particular focus on polypharmacy and night sedation post admission?		
Has the patient had a lying and standing Blood Pressure taken manually since admission? Please comment on findings and any actions taken?	**Orthostatic hypotension defined as drop of at least 20mm Hg Systolic or 10mm Hg diastolic BP on moving from supine to upright position.**	
What is the footwear being used /condition of feet?	**Poor footwear, bunions, ulceration, toe abnormalities or malformed nails an alter gait and balance and affect the patients performance during ADL's.**	
Environmental Factors		
Check the environment where the patient fell "walk the walk of the patient" **Ask the patient/nurse**	considering are there hazards or obstacles, lighting, uneven flooring footwear inappropriate furniture height	
Was the patient nursed in a high visibility area on the ward?	If not is there a reason for this what other measures have been put in place	

Was a low level bed in use?		
Was the call bell within reach? Can the patient physically use it? If not, were alternative methods considered.		
How has the learning been shared with the team?	Was the fall verbally discussed at bedside handover documented on handover sheet/discussed at "SAFETY" briefing?	
Is the wards falls counter up to date/or Safety Cross up to date?	Check ward board and discuss if want to use Safety Cross in pilot	
Was the patient on enhanced observations?	Were the expectations relating to this role met?	
Did the patient suffer "Harm" please describe		

20 Annexe G – Community Guidance

Management and Prevention of Falls in Mental Health and Learning Disability Community Services.

20.1 Introduction

20.1.1 NICE clinical guidance for Falls 2013 (reviewed 2016) recommends that older people in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.

20.1.2 The guidance goes on to recommend that older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi-factorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multi-factorial intervention.

20.1.3 The Trust community mental health and learning disability services are provided in a range of geographical locations. The provision of community based falls prevention services provided in primary care, differ based on the locality.

20.1.4 Supporting service users/ patients to maintain active and healthy lifestyles is an important component of maintaining good mental health and wellbeing.

20.1.5 Community staff should therefore follow the falls assessment and prevention procedures in their locality, and work collaboratively with the providers of these services as is required.

20.2 Groups at high risk of falling

20.2.1 Service users/ patients in high falls risk groups should receive falls screening and/ or further assessment of individual multi-factorial falls risks as part of the patient pathway.

20.2.2 Indicators of potential high risk include people with:

- mobility problems,
- physical health problems
- fear of falling
- medication use which increases falls risk
- history of falls
- visual impairment
- syncope syndrome
- cognitive impairment
- continence issues
- unsuitable footwear

(NICE Clinical Guidance 261 2013)

20.2.3 For patients with **dementia**, there is evidence that early identification and management of falls risks, participation in activities and programmes aimed at maintaining bone health, strength and balance, mobility and physical wellbeing reduces the risk of falls and fractures longer term. The health benefits of a proactive approach to falls prevention, include increased independence and a better quality of life for people with dementia and their carers. It is also now accepted that physical exercise and activity and good nutrition and hydration may improve cognitive function as well as reduce falls risks.

20.2.4 Older people **with a diagnosis of depression** are also at increased risk of falls and suffer more serious consequences when they fall i.e, they have increased morbidity following a fall, are slower to recover from a fall, and are more likely to lose independence and have long term disability if they are injured in a fall. Fear of falling and the psychological effects following a fall are known to be contributory factors in some cases of depression and anxiety.

20.3 Medication

20.3.1 Medical management and medication review with relation to falls risks, especially of psychotropic medication, should also occur as part of routine care planning and review by medical staff and other MDT members. (appendix 4)

20.3.2 Evidence suggests that there is a significantly increased risk of falling in those patients that receive poly-pharmacy (ie. take 4 or more medications per day) and in particular medication from the following groups:

- Anxiolytics (sedatives)
- Antipsychotics
- Antidepressants
- Anticonvulsants
- Hypnotics (night sedation)
- Opiate / opioid analgesics
- Cardiac drugs – especially nitrates
- Diuretics
- Laxatives

20.4 Assessment

20.4.1 Staff working in Community Services have a responsibility to familiarise themselves with the falls risk screening/ assessment procedures in their locality and what community services are available to support service users.

20.4.2 All service users who belong to one of the high risk areas identified in section 2 should be assessed using the Falls Assessment – Community Services tool.

20.4.3 Staff in the community learning disability service should follow the locally agreed falls pathway.

20.5 Interventions

20.5.1 Certain staff working in community mental health services for older people (e.g. Physiotherapy, Occupational Therapy) may have an identified role in leading on falls prevention and the delivery of associated interventions. Interventions delivered in these services (in line with recommendations of NICE CG161 2013) may include:

- Falls education and information giving,
- Strength and balance training,
- Exercise and activity programmes,
- Home hazard assessment and intervention

NICE Quality Standard Falls in Older People (NICE QS86 2017) additionally recommends that Older people living in the community who have a known history of recurrent falls are referred for strength and balance training.

20.5.2 In some localities these interventions are delivered in collaboration with or solely by specialist falls services. Each locality should have referral systems and procedures in place to ensure patients have access to the range of services available.

20.6 Environment

20.6.1 A comprehensive assessment of the home environment can help identify trip hazards, which if addressed can significantly reduce the risk of falls.

20.6.2 The assessment tool used to identify any falls hazards in the home environment is HOMEFAST this is an evidenced based tool developed by the University of Newcastle in Australia. Where possible this assessment should be completed by an Occupational Therapist in consultation with the patient and carer if appropriate.

20.7 Information Leaflets

20.7.1 Information on how to avoid falls should be made available to service users and carer. A copy of the leaflet *Get up and Go* by Saga is available as a free PDF or as a bulk order for hard copies from the Chartered Society of Physiotherapists. *'Staying Steady' keep active and reduce your risk of falling,* is also available from Age UK (both contained in Appendix).

20.8 Clinical Staff

20.8.1 In addition to routine falls risk screening (and onward referral as necessary), staff should also make available falls prevention and health education information (including information about healthy lifestyles and the importance of exercise and activity) to patients and carers. Any patient or carers education groups being run in these services, or similar settings (e.g. day services) should also include falls prevention and related health and wellbeing information/ components.

Developed with reference to *Falls Prevention and Bone Health Policy* Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH

21 Annexe H – Community Fall Risk Assessment Tool

Notes for users:

1) Complete the assessment form below. The presence of more positive factors indicates a higher risk of falling.

2) If there is a **positive response to questions on the form,** then please see the guidance for further assessment, referral options and interventions for the different risk factors.

3) Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.

Name	**Date of Birth**
NHS Number:	

		YES	**NO**
1	**History of falls** Is there a history of any fall in the previous year? **Comments**		
2	**Number of medications** Is the patient / client on four or more medications per day **Comments**		
3	**Medical conditions** Does the patient / client have a diagnosis of stroke or Parkinson's Disease? Any other medical conditions e.g. osteoporosis**?** **Comments**		
4	**Balance** Does the patient / client report any problems with his/ her balance? Are they wearing adequate/appropriate footwear? **Comments**		
5	**Transfers** Is the patient/client **unable** to rise from a chair of knee height? (Ask the person to stand up from a chair of knee height without using their arms.) **Comments**		

6	Ask if they have experienced dizziness on standing or feelings of a 'muzzy head' (possible postural hypertension) **Comments**		
7	**Sensory impairment** Does the person have a visual impairment which is not corrected by glasses/contact lenses Does the person have any hearing impairment? **Comments**		
8	**Dementia** Does the person have a diagnosis of dementia **Comments**		
9.	**Reduced confidence** Does the person have reduced confidence – a fear of falls, or has made changes in lifestyle due to previous falls **Comments**		
10.	**Alcohol and drugs** Are alcohol or drugs an issue which may be leading to falls? **Comments**		
11.	**Environmental hazards** Are there any factors in the environment which may be a trip hazard **Comments**		
12.	**Carer Involvement and View** Does the carer express any concerns? What support are they providing? **Comments**		

Guidance for further assessment, referral options and interventions

Risk factor present	Further assessment	Referral Options	Interventions
1) History of falling in the previous year	Review incident(s), identify factors which may have caused or contributed to the fall. Check medical records, ask relatives if present.	Occupational Therapy Physiotherapy Local Falls Service	Discuss fear of falling and realistic preventative measures. Information leaflet.
2) Four or more medications per day	Identify types of Medication prescribed – ask patient, check actual medication if patient has them present, check medical records, ask GP. Ask about symptoms of dizziness.	General Practitioner Local Falls Service Pharmacist Psychiatrist	Review medications, particularly sleeping tablets Discuss changes in sleep patterns which could be normal with ageing.
3) Stroke or Parkinson's disease	Recent/old stroke? Functional decline? Medically stable? Confusion?	Occupational Therapy Physiotherapy Local Falls Service	Review medications, particularly Parkinson's medication.
4) Balance and gait problems	Can they talk while walking? Do they sway significantly on standing? Is their footwear appropriate?	Occupational Therapy Physiotherapy Local Falls Service	Teach about risk. And how to maneuver safely, effectively and efficiently. Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises. Transfer exercises. Evaluate for assistive devices. Consider home environmental modifications to compensate for disability and to maximize safety, so that daily activities do not require stooping or reaching overhead. Home Hazards assessment by Occupational Therapist

5) Is the patient/client **unable** to rise from a chair of knee height without using their arms/hands?	If not, can they rise using hands?	Physiotherapy. Local Falls Service GP	Discuss why they cannot rise
6) Postural hypotension (low blood pressure) Reports feeling dizzy on standing or when sitting up in bed.	Three readings taken 1) After rest five minutes supine (laying down, or sitting if this cannot be done) 2) 1 minutes later Standing 3) 3 minutes after standing Drop in systolic BP greater than 20mmHg and or drop in diastolic greater than 10mmgHg	District Nurse Practice nurse General Practitioner Falls Service	Offer extra pillows or consider raising head of bed if severe. Review medications. Teach to stabilize self after changing position and before walking. Avoid dehydration
7) Sensory problems	Do they wear glasses/contact lenses/hearing aid if prescribed? When did they last have an eye exam/hearing test?	Referral to optician and/or hearing aid dispenser	Discuss need to wear glasses/hearing aids. Check condition and cleanliness of glasses/hearing aid
8) Dementia	Do they have a diagnosis of dementia and does this affect their ability to stay safe at home and outdoors.	Refer to specialist dementia services Refer to occupational therapy	Occupational therapist for Home Hazards Assessment and recommendations. Discuss prevention and management of falls with relative/carer.
9) Fear of Falling	Have they fallen before and been unable to get up unassisted/had previous long lie? Do they lack confidence in their physical abilities and have made changes in their lifestyle due to falls?	Refer to local falls service Occupational therapy Physiotherapy	Discuss fear of falling and realistic preventative measures. Explore coping strategies Assistive technologies – alert systems.
10) Alcohol and/or drugs	Do they misuse drugs or alcohol?	Refer to specialist drug and alcohol services GP	Discuss link with increased risk of falls.

11) Environment	Consider pets, rugs, un-even flooring	Refer to occupational therapist	Occupational therapist for Home Hazards Assessment and recommendations
12 Carer Involvement	Ensure carer knows of any support they can access	Local carer organisations	Falls Leaflet, General advice and support

Recommendations	**Person Responsible**
Clinician Name and Designation (Print)	
Clinician signature	

Developed with reference to Falls Prevention and Bone Health Policy Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

22 Annexe I – Falls Pathway

FALLS PATHWAY

Step 1	• Clinical Guidance for Falls Prevention
Step 2	• Falls Risk Assessment & Care Plan • Within 24 hours of admission
Step 3	• Post Falls Protocol : “Looking after Patients who have fallen” • Immediately on fall occurring
Step 4	• Post Falls Investigation: “After Action Review” • Completed at the discretion of the clinical team. • To be used where falls are complex or re-occurring, **not for every fall.**
Step 5	• For Serious Incidents only: Post Fall Serious Incident Investigation Tool