Western Health and Social Care Trust

Policy to support reduction of Slips,Trips and Falls for Adult inpatients/residents within Western Health

June 2021

Western Health and Social Care Trust

Title:	Policy for the Prevention of Slips, Trips and Falls for Inpatients/residents within Western Health and Social Care Trust Facilities			
Reference Number:	PrimCare10/01			
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Ownership:	Assistant Director of Nursing Services for Governance/Safe Effective Care			
Original Implementation Date:	October 2010		**Revised Date:**	February 2016 June 2021
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Version Number:	3.0	**Supercedes:**	Policy for the Prevention of Slips, Trips and Falls for Inpatients/residents within Western Health and Social Care Trust Facilities October 2016	
Links to other policies, procedures, guidelines or protocols:	WHSCT – Risk Management Policy WHSCT – Incident Reporting Policy and Procedures WHSCT – Manual Handling Policy WHSCT – Health and Safety Policy WHSCT – Using Bedrails Safely and Effectively Policy WHSCT – Verification of Life Extinct Policy WHSCT – Being Open (Redress) Protocol The Mental Capacity Act (NI) 2016 Standard Operating Guidance for Enhanced Care			
Key changes				

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1.0 INTRODUCTION

Falls are a common cause of injury. People over the age of 65 have the highest risk of falling, with 30% of people older than 65, and 50% older than 80 falling each year. Falls are also the leading cause of accidental death in people over 75 years of age. (Department of Health, 2007.) Falls are among the top five most frequent adverse incidents reported within Health and Social Care (HSC) Trusts.

There will always be a risk of falls in healthcare settings, given the nature of the patients/residents/residents receiving care. It must also be acknowledged that preventing falling can be challenging at times, because a person's safety has to be balanced against their right to make their own choices and decisions about the risks they are prepared to take, their dignity and privacy. However, evidence suggests that a reduction in falls can be achieved by learning from fall incidents, comprehensive and systematic risk identification and co-ordinated multidisciplinary management and interventions.

The Trust aims to take all reasonable steps to ensure the safety of patients/residents and respects the rights of patients/residents to make their own decisions about their care and to promote independence.

2.0 AIM OF POLICY

The aim of this policy is to:-

- Reduce the risk of patients/residents falling in Trust in –patient/resident facilities.

3.0 SCOPE OF POLICY

This policy is for all staff caring for adults who are patients/residents within the Western Trust's inpatient/resident facilities.
In the event of a patient/resident sustaining a fall or a near fall in an assessment, day treatment or out patient/resident area in acute hospitals i.e (Altnagelvin, South West Acute Hospital, Omagh Hospital Primary Care Complex,Grangewood, Waterside Hospital, Tyrone & Fermanagh Hospital or Roe Valley Out Patients/residents) the appropriate post falls review process must be followed (see Appendix 3 &4 on pages 18 - 20).

Policy Objectives:

This policy is to assist staff to:

- Reduce the overall incidence and severity of falls through a multidisciplinary approach.
- Support delivery of safe and effective care for patients/residents, carers and staff in WHSCT
- Outline staff responsibilities in relation to the prevention and management of falls.

4.0 ROLES AND RESPONSIBILITES

It is the responsibility of all Trust employees that come into contact with patients/residents during an inpatient/resident stay to adhere to this policy. They should identify those at risk of falling and signpost to appropriate services within their scope of practice .

This policy must be read in conjunction with current Trust policies and protocols to include :

- WHSCT Risk Management Policy
- WHSCT Moving and Handling Policy
- WHSCT Incident Reporting Policy and Procedures
- WHSCT Health and Safety Policy
- WHSCT Verification of Life Extinct Policy
- WHSCT Being Open (Redress) Protocol
- WHSCT Using Bedrails Effectively Policy

Directors:

- Directors of services have responsibility for ensuring the safe, and effective delivery of services including implementation of this policy.
- They are also responsible for ensuring that a process is in place to effectively manage patient/resident falls within their Directorates.

Assistant Directors of Services are responsible for:

- Implementing this policy within their individual directorates ensuring that the requirements for implementing the policy are included in service action plans. This includes monitoring compliance reviewing of incident reports and sharing the learning within their area(s).
- Ensuring that staff have received and are aware of relevant policies and procedures and guidance to assist with falls prevention.
- Ensuring that staff are trained in the prevention and management of falls in line with the requirements of this policy.
- Cascading learning from falls in their own Directorate through divisional and Trust wide governance groups and across other Directorates as relevant.
- Ensuring that a falls reduction plan is implemented and updated on a quarterly basis.
- Approving all Post Fall Reviews for their areas for sharing with the region and ensure that lessons learned are shared locally as appropriate.
- Where improvements in compliance are required, Assistant Directors must ensure that action plans are implemented and continue to monitor standards of care. This should be done in partnership with their professional leads/head of service.

Governance Leads

Will support and monitor service improvement action plans within their area of responsibility to reduce falls incidents.Will escalate emerging concerns and risks through Goverance processes.

- Will hold to account responsible officers on adherence to standards , guidelines and reporting timelines and investigations.

Lead Nurses, Clinical Leads and Principal / Head / Lead AHPs:

- Must ensure that all staff within their directorate are aware of this policy.
- Ensure that training needs of staff are met and that staff are released to attend training.
- Must monitor compliance with agreed standards within their individual directorates and areas of responsibility eg. Royal College of Physicians fall safe bundle audits; compliance with NICE guidelines re falls. *https://www.nice.org.uk/guidance/cg161*
- Monitor ward / department fall rates and identify local trends that may contribute to falls and implement local improvement plans to reduce the incidence of falls.
- Must ensure that adult inpatient/resident falls incidents resulting in moderate / above harm in areas under their responsibility have a post fall review commenced within 72 hours of the fall incident occurring and updated on DatixwWeb.
- Should ensure that learning identified from falls incidents is shared with appropriate staff within their area of responsibility, updated on DatixWeb and sent to Assistant Directors for approval and onward sharing as appropriate. This will support sharing regionally within 20 days of the incident occurring.
- Must escalate incidents considered to meet the criteria for serious adverse incident (SAI) to their Assistant Director for final decision. Must ensure the learning is shared with appropriate staff / departments outside their area of responsibility through DatixWeb and Trust governance Committees.
- Must use learning identified from falls incidents and near miss reviews to develop and implement falls improvement plans to reduce falls
- Must ensure the Trust Being Open (Redress) Protocol is followed in relation to incidents involving falls.
- Identify and prioritise the purchase of equipment required to assist in the prevention of falls or to move an injured person post a fall.
- Attend Trust Slips, trips and falls prevention sub-group meetings as nominated and feedback to staff.
- Contribute to workstreams and committees within the trust that will support the reduction of falls.

Ward Managers / Team Leaders:

Ward Managers / Team Leaders have the responsibility to adhere to and implement this policy and to monitor compliance within their teams. They must

- Bring this policy to the attention of all relevant staff.
- Identify training needs of all relevant staff.
- Support the development of staff and their release to attend falls training.
- Ensure that records are maintained and kept up to date locally of what staff have attended training.
- Monitor ward / department fall rates and identify local trends that may contribute to falls.
- Audit ward compliance with the Royal College of Physicians Fall Safe Bundles where it is implemented.
- Ensure that information on falls risk assessments and person centred plans of care includes interventions which are individualised to the person at risk of falls. This information must be reviewed and shared regularly with staff.
- Report falls that have resulted in a moderate to severe injury to their Professional Lead within the Division.

- The ward sister/charge nurse/team leader or nominated deputy must participate in the post fall review to identify learning from the fall.
- Must ensure that falls incidents are investigated within 72 hours of the fall incident, to facilitate identification of learning for sharing and development of action plans.
- Work with the Lead Nurse /Clinician to ensure any learning identified following Post Falls Reviews is completed on Datix to facilitate approval for sharing regionally within 20 days.
- Participate in and share learning identified from reviews and within their teams at safety briefings and other regular forums as appropriate. This includes at relevant Trust patient/resident safety and Governance meetings.
- Assist with the development and implementation of action and improvement plans identified through the Post Falls Investigation process and audits of standards.
- Monitor the use of Trust and Regional agreed systems in use. e.g.professional risk assesssments, and regional nursing assessment documentation, safety brief, multidisciplinary team meetings, falls safety cross and use of falls icon on flow board.
- Participate in the development and testing of service improvementaction plans that may reduce falls.
- Participate in incident reviews as per trust and regional guidance.

All Staff Members have the responsibility to:

- Adhere to the policy.
- Work within their professional codes of conduct (if applicable) and scope of practice.
- Maintain professional competencies when completing assessments and providing interventions to reduce risk of falls.
- Identify training needs, bringing them to the attention of their line manager.
- Identify and report to line manager items within the facility environment which could increase patient/resident and / or staff's risk of falls eg. Broken lights; damaged flooring; space constraints where the individual member of staff cannot address the fall risk factor themselves.
- Adhere to good housekeeping to reduce the risk of falls caused by the environment eg ensure patient's items within reach, bed and / or chair are at a safe height for patient/resident/ client use; ensure walkways are clear and free of obstacles; clean up spillages immediately and where this is not possible, stay until area is safe with warning sign in place and assistance is provided to clean spillage.
- Attend falls prevention training and implement the learning within their area of work.
- Assess patients/residents to identify those at risk of falling asking patients/residents / clients if they have had a history of falls in the past 12 months and / or if they have a fear of falling as recommended in NICE (2013).
- Identify patient/resident falls risk factors (within scope of practice) and implement falls prevention interventions required as part of patient's individual plan of care to reduce the patient's risk of falls to the lowest level reasonably possible. This should take into consideration the patient's right to make their own choices and decisions about the risks they are prepared to take. The discussion regarding this must be documented in the patients/residents notes and where relevant advice shared with their family/ next of kin.
- Ensure effective and timely handover and onward referral to appropriate services to include preparation for discharge.
- Report falls as incidents on DatixWeb.
- Complete all necessary documentation regarding fall incident on DatixWeb; in professional records and on patient/resident safety cross where this is in use.

- Ensure that information recorded regarding the fall incident is accurate and recorded in detail.
- Support Ward Managers / Team leaders with review of falls or near miss falls identifying contributing factors and preventative measures for implementation.
- Record planned preventative interventions in patient/resident / client records.

Additionally Nursing Staff have the responsibility to:

- Assess patients/residents risk of falling within 6 hours of admission using the appropriate nursing assessment booklet(s) to identify those at risk of falling, confirming if the patient/resident has had a history of falls in the last twelve months and/or if they have a fear of falling, as recommended in NICE 2013. Where possible staff should identify cause of previous falls together with the need for onward referrals to prevent and or manage future falls.
- Complete the Additional Falls Risk Assessment Booklet for WHSCT (Appendix 2) for patients/residents identified as being at risk of falls.
- Ensure that other relevant risk assessments e.g. moving and handling risk assessment and bed rails risk assessment are also completed within the approved time frame. This will include updating nursing assessments and care planning on at least a weekly basis to ensure that interventions implemented remain appropriate for the patient/resident.
- Ensure that patient/resident have person centred interventions recorded in additional falls risk assessment based on identified fall risk factors (Appendix 2). Ensure that person centred interventions are implemented to reduce their risk of falls to the lowest level reasonably possible.
- Following this assessment, identified falls risks and interventions implemented MUST be reviewed, updated and documented in nursing notes on an ongoing basis and/or at least daily. This should include changes made to care delivered.
- Consider the level of assistance that could be provided by family members as part of the patient/resident's plan of care. This should be discussed with the patient/resident and/ or their next of kin if possible and appropriate. The outcome of the discussion with the patient/resident and/or their next of kin to include what assistance family or significant others can provide must be documented in the patients/residents notes. This should take into consideration social distancing.
- When transferring patients/residents between wards / departments and/or facilities nursing staff must inform the receiving facility of the patient/resident's risk of fall status as part of the handover process. This should include information on the patient/resident's falls history, the reasons for previous falls if known, the outcome of investigations and / or details of onward referrals made in respect of preventing further falls and / or serious injury. The receiving ward / department / facility should also be provided with information on interventions currently implemented to reduce the patient/resident's risk of falls to the lowest level possible.
- Must follow the relevant post fall emergency response protocol. (Appendix 3 and 4)

Additionally medical staff have the responsibility to:

- Assess and document a comprehensive falls history on admission and arrange appropriate investigations and treatment, examples of which include but are not limited to lying and standing blood pressures, a brief cognitive screen and assessment of visual acuity.
- Review medication on admission and on an ongoing basis as patients/residents clinical condition changes (in particular; sedatives, anti-psychotics, anti-hypertensives and anti-

arrrhythmic) See regional medicines optomisation in older people (MOOP) (Appendix 5).
- Consider investigation and treatment for osteoporosis if appropriate.
- Consider referral to specialist falls services, Pharmacist and AHP services as appropriate.
- Review and document medical interventions for the patient/resident
- Adhere to the relevant post fall medical algorithm.

5.0 DEFINITIONS

Fall - A fall is defined as "an event which results in a person inadvertently coming to rest on the ground or floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects." (WHO 2011).

Patients/residents 'found' on the floor should be assumed as having fallen, unless confirmed as an intentional act.

Controlled Lowering of the Falling Person - When a member of staff attempts to minimize the impact of a fall, by easing the patients/residents' descent to the floor
All slips, trips and falls even those considered as a 'near miss' event must be reported in accordance with the Trust's Incident Reporting Policy.

6.0 IDENTIFICATION OF PATIENTS/RESIDENTS 'AT RISK' OF FALLS AND THOSE AT 'HIGH RISK' OF FALLS

The causes of falls are multi-factorial and therefore will require an integrated multi-disciplinary approach. On admission to hospital all patients/residents who are judged by a clinician to be at higher risk of falling because of an underlying condition should be regarded as being at risk of falling in hospital and should receive an individualised,multi-factorial assessment.

Staff MUST ensure that any multi-factorial intervention addresses the patient/resident / client's identified individual risk and takes into account whether the risk factors can be treated, improved or managed. Staff should ensure onward referrals to multidisciplinary colleagues are sent as appropriate e.g – to a Doctor or Pharmacist to review medication; to Physiotherapist to assesss mobility, strength and balance or to Occupational Therapist to assess cognitive function or environmental risks that could contribute to fall risk.

For patients/residents identified at 'high risk' of falls, the following additional actions MUST be implemented:-
- Icon placed on ward/ department flow board. This is a falling stick-man in the Northern Sector of the Trust and a falling star in the Southern Sector of the Trust). This identifies and communicates across wards / departments that the patient/resident is at risk of falls and can be used to assist with patient/resident care planning.
- Communicated and documented for all of the multidisciplinary team to action.- to include making appropriate referrals.

- Consider where the patient/resident is placed within ward environment, including cohorting and the level of supervision / enhanced care required.
- Confirm level of support that next of kin/ family can provide. The discussion with the patient/resident and /or their next of kin and the outcome of this discussion must be documented in the patient/resident's records.
- Consider the use of assistive technology as one aspect of specific interventions for this individual patient/resident.

6.1 FallSafe Bundle

The Royal College of Physicians 'FallSafe' bundle has been implemented in agreed adult in-patient/resident wards. This bundle is evidence based, with an aim to achieve a reduction in the number of falls. For regionally agreed bundle elements, see appendix- dashboard one .

7.0 FALLS MANAGEMENT

Staff must make appropriate referrals to relevant multidisciplinary staff / teams.

As per National Institute of Health Care Excellence guidelines, patients/residents and their family members or carers, should be provided with relevant oral and written information regarding falls prevention, taking into consideration the patient/resident's ability to understand and retain information. See enclosed example for WHSCT (appendix 6)

7.2 When a Patient/resident Falls

When a patient/resident falls staff should act within their scope of practice seeking help from other staff if required.

Nurses and Doctors should follow the appropriate post falls algorithms for nursing and medicine adapted from NPSA 2011, Essential Care of an Inpatient Fall (see appendices 3, 4 and appendix 6). Staff must record any injuries noted on a body map immediately post the fall and also 24 hours later. (Appendix 3)

Within community hospitals and other in patient/resident facilities where there is not a constant medical or nursing presence an agreed protocol for calling additional help if required must be confirmed for staff working in these areas. The responsibility to complete this will be the Head of Service and this must be approved through usual govenance pathways.

In the event that the General Practitioner is the medical practitioner to be called they or the out Of Hours GP should be advised if a patient/resident sustains a fall. Staff must also use their Professional Clinical Judgement and ring NIAS to transfer any patient/resident for treatment who has sustained an injury.

Any patient/resident found with no signs of life/ deceased after a suspected fall must not be moved until life extinct has been verified and the Coroner has been contacted for advice.

7.3 Unwitnessed Falls

Neurological observations must be carried out on a patient/resident where a head injury has occurred or where it cannot be ruled out. This includes all unwitnessed falls.

Staff must record neurological Glasgow Coma Scale (GCS) observations with a minimum frequency of observations:-

- ½ hourly for 2 hours.
- 1 hourly for 4 hours.
- 2 hourly thereafter as appropriate to the individual patient/resident's clinical picture (refer to Inpatient Post Fall Medical Algorithm. (Appendix 7).

Neurological GCS observations must be carried out ½ hourly until GCS = 15. If a patient/resident with GCS = 15 deteriorates at any time after the initial 2 hour period, then observations should revert to ½ hourly and follow ongoing frequency schedule. If the staff at any stage have any additional concerns about the patient/resident despite or because of their GCS score they should call for medical assistance.

All actual and suspected head injuries must have a medical review, and medical staff must consider onward referral for a CT head scan.
If a patient/resident is on anticoagulant therapy, urgent medical review will be required and consideration should be given regarding reversal of same, as per Safety and Quality Learning Alert – Head Injury in Patients/residents on Warfarin – Treat as Medical Emergency LL/SAI/2014/024 (AS). Adaptations for local use may be developed and could be added as an appendix to this or future policies following governance approval.

REPORTING FALLS / SUSPECTED FALLS

Following a fall / near miss, all falls must be reported online on the Trust Datix system as soon as possible and ideally within 24 hours or before the end of your working shift. It is the responsibility of the person who witnessed the fall or who first came across the fall to complete the incident form on Datixweb.

All fields within the Datix reporting system must be completed with relevant information regarding the circumstances surrounding the fall. Staff must also advise the family as soon as possible and this conversation should be documented in the patients/residents notes where staff have been unable to contact the person's family / next of kin, dates and times of attempts made to contact must be documented in the person's record. Where the person does not consent to have family/next of kin contacted, this must be documented in the patient/resident record.

The information required on datixweb is based upon a minimum dataset of questions provided by the PHA, and will help to identify areas of good practice and areas for improvement.

Staff should refer to and follow the Incident Reporting Policy.

When a fall results in a moderate to catastrophic injury (serious harm) then a Significant Event Audit (SEA) or root cause analysis must be undertaken and completed within 20 working days and recorded on the post falls review section of datix. This process will need to udentify the learning and actions taken to help prevent recurrence.

The following definitions of moderate to catastrophic harm have been provided by the Public Health Agency (PHA).

- Moderate – where the fall resulted in harm that required treatment or prolonged length of stay, but from which a full recovery is expected e.g. fracture to wrist, fingers/toes.
- Major – Where the fall resulted in harm causing permanent disability, of the person is unlikely to regain their former level of independence.
- Catastrophic – Death

If the fall results in death or major injury managers should contact the Trust's Health and Safety Officer to verbally report the incident prior to submitting the incident report form.
If there has been any act or omission in care that may have contributed to the injury the Trust Health and Safety officer will advise if the incident is reportable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR). This can be confirmed with Risk Management.

It will be the responsibility of each operational division / Directorate to decide if a fall should be reported as an SAI in consultation with their Governance and Risk management colleagues.

9.0 EQUIPMENT

Adequate equipment to help reduce the risk of falls/injury and for moving a patient/resident post a fall without causing further injury is essential. It is the responsibility of Directorates to ensure that appropriate equipment is available.

Equipment such as (not an exhaustive list):-
- Low entry beds
- Bedrails/ padded bumpers
- Assistive technology
- Appropriate height chairs
- SLINGS, Hoists and moving devices

Each ward should have 24/7 access to a generic mobility aid, for patients/residents who have not brought their walking aid into hospital, or for patients/residents admitted with mobility issues and have been referred to, and are waiting to be seen by a Physiotherapy.

(Patients/residents admitted with a neurological diagnosis e.g. acute stroke or head injury should have their mobility assessed by a physiotherapist prior to mobilising). Staff providing mobility aids should do so within their scope of practice and level of competence, ensuring that where equipment is provided patients/residents are safe mobilising with same with or without assistance from staff.

10.0 EDUCATION AND TRAINING

Education on the prevention and management of falls must be included in ward induction programmes. Roles and responsibilities for identifying learning needs in relation to falls reduction and ensuring staff receive appropriate training is detailed in section 4 of this document.

11.0 REFERENCES

1. *Falls Assessment and Prevention of falls in Older people (June 2013) NICE clinical guideline 161guidance.nice.org.uk/CG161*
2. *Northern Ireland Occupational Therapy Falls Pathway Prevention and Management of Falls in Adults (March 2018)*
3. *'The Right Time, The Right Place'; an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland The Donaldson Report (December 2014)*
4. *Safe staffing for nursing in adult inpatient/resident wards in acute hospitals (SG1) NICE Safe staffing guideline (2014) www.nice.org.uk/guidance/sg1*
5. *Preventing falls in older people (2017) http://pathways.nice.org.uk/preventing-falls-in-older-people*
6. *Falls and Fractures: Effective interventions in health and social care Department of Health (2009)*
7. *Exploring the system-wide costs of falls in older people in Torbay. The King's Fund, 2013*
8. *Fallsafe resources – original /RCP London (2015) https://www.rcplondon.ac.uk/guidelines - policy/fallsafe-resources-original*

Cohen l, Guin P (1991) Implementation of a patient/resident fall prevention program. ***Journal of Neuroscience Nursing****. 23(5): 315- 319.*

National Patient Safety Agency (2007) ***Slips, trips and falls in Hospital. The third report from the patient Safety Observatory****. National Patient Safety Agency. London.*

Royal College of Physicians (2011) ***The FallSafe Care Bundle.*** *RCP London*

National Patient Safety Agency (2011) ***Essential Care after an Inpatient Fall.*** *National Patent Safety Agency, London.*

PHA ***Thematic Review- report on the regional review of Patients/residents with afall resulting in Moderate to Severe Harm and reporting as an SAI*** *(2015)*

Patient Safety first Campaign (2009) ***The "How to" Guide for reducing harm from Falls.***

Safety and Quality Learning Letter – ***Head Injury in patients/residents on warfarin- Treat as Medical emergency.*** LL/SAI/2014/025(AS)

Western Health and Social Care Trust

Royal College of Physicians

The FallSafe care bundle

Bundle for all patients

1 A history of previous falls and of fear of falling is taken at the time of admission.*
   > Admission processes and paperwork need to be changed to include these items.

2 Urinalysis is conducted on admission

3 New prescriptions of night sedation are avoided.

4 A call bell is in reach.
   > The existing call bell system must be able to reach all patient beds and chairs.
   > Systems are needed for rapid repair of faulty call bells.

5 Appropriate footwear is available and in use.
   > Supplies need to be made available for patients without relatives or friends.

6 There is immediate assessment for and provision of walking aids.
   > Physiotherapists must train nursing staff to provide appropriate walking aids at the time of admission to the ward, or as soon as they might be required.
   > Walking aids need to be made available for each ward area, and need a suitable storage area.

Bundle for older and more vulnerable patients

7 A cognitive assessment (mini-mental state examination (MMSE) or abbreviated mental test score (AMTS)) is conducted in all admissions aged >70yrs.

8 Those at risk are tested for delirium (confusion assessment method).
   > Trusts must implement delirium screening as per NICE guidelines.

9 An assessment of risk versus benefit for use of a bedrail is conducted.

10 Visual assessment is conducted.
   > The ability to recognise objects from end of the bed can be used as a screen for severe eyesight problems, and fuller assessment should be carried out if required.

11 Lying and standing blood pressure are taken with a manual sphygmomanometer.

12 Medication is reviewed with respect to cardiovascular and central nervous system acting medications (see enclosure).
   > Nurses should request a review of medication to try and reduce the burden of drugs, particularly those associated with falls, and in patients who are unsteady, hypotensive, or have orthostatic hypotension.

13 Based on observation, toileting arrangements are assessed and planned (tailored to needs rather than the standard two-hourly arrangement).

Bundle for after a fall

14 After a fall, appropriate assessments and procedures are followed (see enclosure), including neurological observations in those who have hit their head or had an unwitnessed fall.
   > Trusts have been mandated to include these procedures within their policies by July 2011.

15 A post-fall review (how can further falls be prevented for this patient) is conducted.

16 A complete incident report (all falls) is created.

17 A root cause analysis (lessons to prevent falls for future patients) is carried out for severe harm falls.

* Long stay units may wish to amend to 'at least monthly' rather than 'on admission'

† For rehabilitation units, community hospitals, stroke units, orthogeriatrics units, care of the elderly units, and dementia units this should equate to all patients. In wards and units with a more mixed population, patients with a high vulnerability to falls is likely to be determined by local policy e.g. positive response to any of the NPSA 'four questions', total of Morse score or STRATIFY score, or all patients not fully independent and mobile.

Supported by:

The Health Foundation Improving Improvement

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National Patient Safety Agency

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Appendix 2 – Additional Falls Risk Assessment for WHSCT

Western Health and Social Care Trust

Patient Details/ Addressograph

Name .....

Address .....

.....

Date of Birth .....

Hospital No. .....

Additional Falls Risk Assessment for WHSCT

(to be used alongside the HSC Person-centred Nursing Assessment)

If the patient is identified as being at risk of falling or has fallen in the last 12 months the enclosed individually targeted falls risk assessment and intervention plan must be completed on admission.

The intervention plan has a range of potential interventions that are to be considered. The interventions that are appropriate to the patient's individual needs must be described and an appropriate person centred plan of care implemented.

Frequency of Risk Assessment:
All patients must be reassessed using the falls risk assessment and intervention plan following:

- After a fall, a suspected fall or a near fall.
- If they demonstrate high risk behaviour.
- At least once a week in a hospital setting.
- If there are any other concerns re increased risk of falls advised by the patient, family, nursing, AHP or medical staff in relation to falls.

Date of fall / suspected fall	Time of fall	Ward/ Department	DATIX web number	Injury?

Vers 3 : Aug 2020

Patient name_____ H&C Number _____ D.O.B_____

SIGNATURE REGISTER					
To be completed by all staff making an entry into this document *This section will serve as a record of your full signature and thus satisfy professional and legal requirements*					
DATE	**FULL NAME (BLOCK CAPITALS)**	**DESIGNATION** (Staff Nurse, Student Nurse)	**INITIALS**	**FULL SIGNATURE**	**STATUS** (Permanent = P Temporary = T Bank = B Agency = A)

Date of Admission:		Time of Admission:		
Date	**Time**	**Problem Identified**	**Action Plan**	**Signature**
		□ Patient admitted after a fall □ Patient identified as being at increased risk of falls □ Patient has fallen in hospital / inpatient setting	□ Falls care bundle commenced □ Falls Risk Assessment/ Care Plan Implemented	

Ward: **Date Completed:** **Time:** **Printed Staff Name:**

If the patient has a fear of falling/ history of falling in the last 12 months/fallen since admission, please complete the plan below		
Risk Factors	**Preventative Interventions (not an exhaustive list)**	**Record specific intervention to support care of the patient**
Mental state	Orientate patient to time and place Record the level of supervision required ie one to one Review/ request a medical assessment re: delirium/cognitive impairment/disorientation	
Environmental Hazards	Check call bell is in reach (inappropriate for confused, disorientated patients) Keep personal possessions in easy reach Nurse in direct line of view if possible Nurse on lowest bed height/use low bed Ask for chair assessment/ use suitable chair Consider the use of alarm sensors Consider bed rails assessment Keep area clutter free Consider leaving on the bed side light overnight	
Restricted Mobility	Ensure moving and handling assessment is completed Record the assistance required – one/ two staff, Identify equipment required If patient uses/ requires walking aid – ensure it is correct height	
Footwear	Ensure well fitting footwear, no trailing laces, non-slip sole Offer non slip slippers	
Bladder & Bowel Management	Assess and treat any cause of frequency Assess and treat any possible constipation Record the assistance required to and from the bathroom Are continence aids accessible? Consider further Urinalysis/ MSU	
Medications	Ask Doctor to review medications / times associated with a risk of falls Request review of night sedation Do not stop abruptly	
Patient's Vision / Hearing	Ensure patients glasses are worn if/as appropriate Check if eyes require testing and initiate if required Leave personal objects within easy reach Hearing aid working and in use (if used)	
Medical Conditions	Requires referral to Doctor to detect and treat cardiovascular disease, postural hypotension or osteoporosis Check as appropriate Lying / standing BP recorded	
Communication	Discuss with patient/ carer and gain agreement on the use of interventions which may infringe on their personal freedom and autonomy Information leaflet on falls prevention given	
Referrals	Consider Referral to e.g Physiotherapy Occupational therapy / Rehabilitation Team, Orthoptics/ Dietetics/ Podiatry	
Signature: ***Date:*** **When was this reviewed?** **Post a fall/ suspected fall?** ☐ **On admission** ☐ **Post high risk taking behaviour** ☐ **When transferred to a new ward/ department** ☐ **Weekly review** ☐		**Following this assessment please ensure that identified falls risks and required intervention are reviewed and documented in nursing notes on a daily basis.**

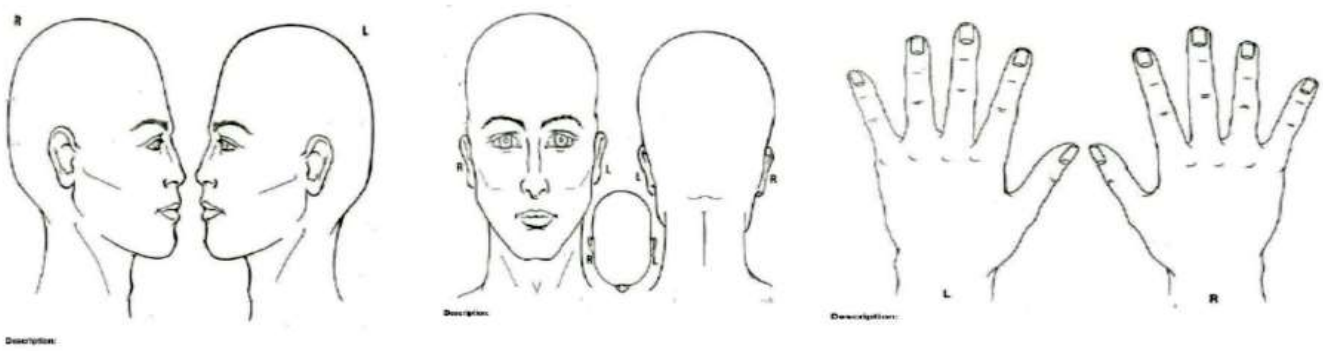
Appendix 3: Post Fall Adult Body Map for WHSCT

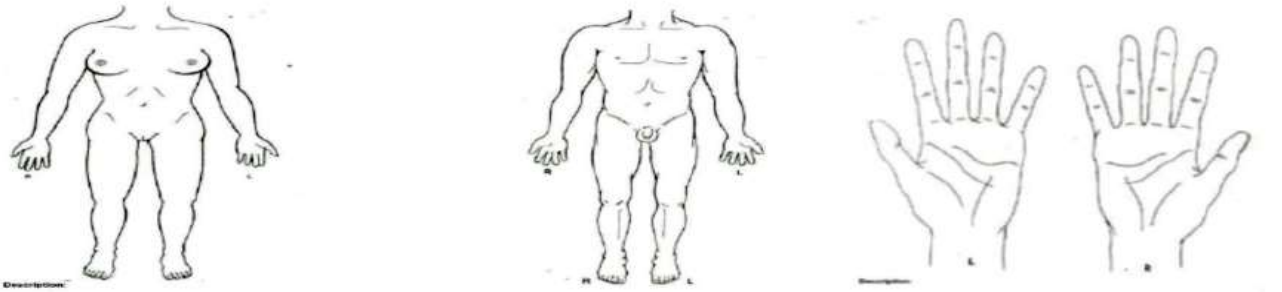
This form must be completed after the patient has fallen and 24 hours later.

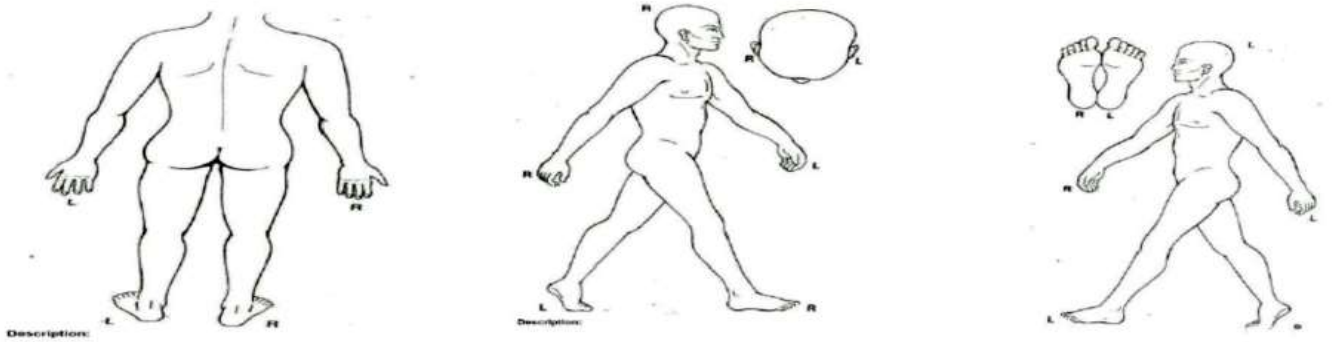
Please use the body map to record the location of the injury and description. For example, if a person presents with a bruise on their arm, please indicate the position of the bruising and give a brief description of the appearance and colour.

Please ensure that you seek consent from the adult who has fallen prior to carrying out any examination. If the adult who has fallen lacks capacity to consent to an examination, please follow the principles of the Mental Capacity Act 2005 and ensure that the decision is made in the persons best interests and is the less restrictive option.

Date	Time	Name of person completing Body Map post fall	Job title / Designation	Location / Ward / Department	Signature







Appendix 4: Acute Hospital Inpatient Nursing Post Fall Emergency Response Protocol

Immediate Response (DRSABC)
Danger
Response
Shout Help
Airway
Breathing
Circulation

- Check for immediate danger;
- Check for the response of the person fallen.
- Call for assistance.
- Assess airway, breathing, circulation and activate crash team response if required.

Any patient found with no signs of life/deceased after a suspected fall must not be moved until life extinct has been verified and the Coroner has been contacted for advice.

Check for Injuries.
If serious head injury, spinal injury or possible lower limb fracture suspected:-
It is BEST PRACTICE NOT TO MOVE THE PATIENT and to contact the Medical Team immediately for urgent assessment.
If there is no option but move the patient due to risk of additional injury, a risk assessment must be undertaken before doing so and should include consideration of how to immobilise an injury. **Hoist and fabric slings are not recommended for patients with a suspected spinal or hip fracture.**

- Carry out preliminary assessment including vital signs and level of consciousness. Neuro observations must be completed if a head injury is suspected or it cannot be ruled out (e.g unwitnessed fall) Complete NEWS / Neuro obs chart.
- Neuro Observations should be carried out half-hourly until GCS equal to 15. The minimum frequency of observations for patients with GCS equal to 15 should be as follows,
  - half-hourly for 2 hours
  - then 1-hourly for 4 hours
  - then 2-hourly thereafter.

  Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs should revert to half -hourly and follow the original frequency schedule
- Check for any signs of injury including abrasions, contusions, lacerations, fracture and head injury.
- Refer to inpatient post fall Medical algorithm if suspected head injury, cervical / pelvis fragility/ spine injury/fracture

Moving and Handling Assessment

Access Specialist Equipment

Altnagelvin Equipment Library 3rd floor
Hoist, stretcher, Spinal Board (including bariatric board), Head Immobilisers

SWAH
Manual Handling Room
2ndFloor
Spinal Board (Including Bariatric Board), Head Immobilisers
Hoist Stretchers and slings

Emergency Department
ICU
Hoist Stretchers and slings

- Assess whether it is safe to move the person from their position and any special considerations in moving them.
- DO NOT MOVE if patient exhibits any pain, loss of sensation, visible injury or limb deformity until appropriately immobilised. * Contact medical team immediately for urgent assessment and following medical assessment agree appropriate moving and handling requirements. In some Community hospital this will be GP or GP Out Of Hours Service
- Access appropriate moving and handling equipment, flat lifting equipment, hard collars or spinal boards.
- Follow appropriate moving and handling procedures including using staff who have received appropriate training.
- If NO head injury / spinal injury / lower limb fracture suspected then hoist or assist to stand / sitting position.

Communication

- Reassure fallen person at all times.
- Refer to medical staff even if injuries are not apparent.
- Refer to inpatient falls algorithm regarding medical assessment and treatment.
- At earliest convenience notify next of kin.
- Inform Nurse in Charge / HSM / H@N/ Lead Nurse

Treatment and Care

- Assess for any injuries. Initiate diagnostic care and treatment interventions for any contributing causes.
- Continue to carry out vital signs including neuro observations if applicable as clinical condition requires as per inpatient protocol
- Treat and dress any wounds / lacerations. Refer to surgical / orthopaedic team if required in liaison with Medical staff.
- Provide analgesia if required and not contra-indicated.
- Ensure adequate hydration and all nursing care needs are attended to.
- Ensure on-going monitoring of the person as some injuries may not be apparent at the time of fall.
- On-going communication between patient / relatives/multidisciplinary team
- Review the implementation of any falls prevention strategies for the person and discuss with the multidisciplinary team.
- Implement a targeted individual plan of daily care.
- Ensure medical review regarding possible reason for fall and review of medications which may contribute to fall.
- Consider investigations and treatment for osteoporosis.
- Complete Post Fall Adult Body Map after the fall and repeat 24 hours later.

Documentation

- Document all details regarding fall into the persons nursing record.
- Complete Trust Incident Form / Datix.
- Refer to Inpatient Post Falls Medical Algorithm for completion by medical staff.
- Undertake or review falls assessment.
- Document discussions in nursing notes with patient/relatives/ multidisciplinary team regarding care and treatment

Communication

Ensure effective communication of assessment and management recommendations with the multi-disciplinary team. Detail in safety briefings.

Learning the Lessons

- Complete safety cross if being used in the department.
- Complete initial post falls review and share initial learning and/or action for improvement with the multi-disciplinary team as soon as possible after the fall.
- Complete Datix post falls review for falls that result in moderate and within 20 days and share learning locally at Ward Sister/ Charge Nurse meetings, Multidisciplinary meetings and at Safe and Effective Care and other Governance meetings.

Appendix 5: Non-Acute Hospital / Facility Inpatient Nursing Emergency Response Post Fall Protocol

Immediate Response (DRSABC)
Danger
Response
Shout Help
Airway
Breathing
Circulation

- Check for immediate danger;
- Check for the response of the person fallen.
- Call for assistance.
- Assess airway, breathing, circulation and activate crash team response if required.

Any patient found with no signs of life/deceased after a suspected fall must not be moved until life extinct has been verified and the Coroner has been contacted for advice.

Check for Injuries.
If serious head injury, spinal injury or possible lower limb fracture suspected:-
It is BEST PRACTICE NOT TO MOVE THE PATIENT and to contact the Medical Team / NIAS immediately for urgent assessment.
If there is no option but move the patient due to risk of additional injury, a risk assessment must be undertaken before doing so and should include consideration of how to immobilise an injury. **Hoist and fabric slings are not recommended for patients with a suspected spinal or hip fracture.**

- Carry out preliminary assessment including vital signs and level of consciousness. Neuro observations must be completed if a head injury is suspected or it cannot be ruled out (e.g unwitnessed fall) Complete NEWS / Neuro obs chart.
- Neuro Observations should be carried out half-hourly until GCS equal to 15. The minimum frequency of observations for patients with GCS equal to 15 should be as follows,
  - Half-hourly for 2 hours
  - Then 1-hourly for 4 hours
  - Then 2-hourly thereafter.

  Should a patient with GCS= 15 deteriorate at any time after the initial 2-hour period, obs should revert to half -hourly and follow the original frequency schedule
- Check for any signs of injury including abrasions, contusions, lacerations, fracture and head injury.
- Refer to inpatient post fall Medical algorithm if suspected head injury, cervical / pelvis fragility/ spine injury/fracture

Moving and Handling Assessment

Access Specialist Equipment

Altnagelvin Equipment Library 3rd floor
Hoist, stretcher, Spinal Board (including bariatric board), Head Immobilisers

SWAH
Manual Handling Room
2ndFloor
Spinal Board (Including Bariatric Board), Head Immobilisers
Hoist Stretchers and slings

Emergency Department
ICU
Hoist Stretchers and slings

- Assess whether it is safe to move the person from their position and any special considerations in moving them.
- DO NOT MOVE if patient exhibits any pain, loss of sensation, visible injury or limb deformity until appropriately immobilised. * Contact medical team immediately for urgent assessment and following medical assessment agree appropriate moving and handling requirements. In some Community hospital this will be GP or GP Out Of Hours Service
- Access appropriate moving and handling equipment, flat lifting equipment, hard collars or spinal boards.
- Follow appropriate moving and handling procedures including using staff who have received appropriate training.
- If NO head injury / spinal injury / lower limb fracture suspected then hoist or assist to stand / sitting position.

Communication

- Reassure fallen person at all times.
- Refer to medical staff even if injuries are not apparent.
- Refer to inpatient falls algorithm regarding medical assessment and treatment.
- At earliest convenience notify next of kin.
- Inform Nurse in Charge / HSM / H@N/ Lead Nurse

Treatment and Care

- Assess for any injuries. Initiate diagnostic care and treatment interventions for any contributing causes.
- Continue to carry out vital signs including neuro observations if applicable as clinical condition requires as per inpatient protocol
- Treat and dress any wounds / lacerations. Refer to surgical / orthopaedic team if required in liaison with Medical staff.
- Provide analgesia if required and not contra-indicated.
- Ensure adequate hydration and all nursing care needs are attended to.
- Ensure on-going monitoring of the person as some injuries may not be apparent at the time of fall.
- On-going communication between patient / relatives/multidisciplinary team
- Review the implementation of any falls prevention strategies for the person and discuss with the multidisciplinary team.
- Implement a targeted individual plan of daily care.
- Ensure medical review regarding possible reason for fall and review of medications which may contribute to fall.
- Consider investigations and treatment for osteoporosis.
- Complete Post Fall Adult Body Map after the fall and repeat 24 hours later.

Documentation

- Document all details regarding fall into the persons nursing record.
- Complete Trust Incident Form / Datix.
- Refer to Inpatient Post Falls Medical Algorithm for completion by medical staff.
- Undertake or review falls assessment.
- Document discussions in nursing notes with patient/relatives/ multidisciplinary team regarding care and treatment

Communication

Ensure effective communication of assessment and management recommendations with the multi-disciplinary team. Detail in safety briefings.

Learning the Lessons

- Complete safety cross if being used in the department.
- Complete initial post falls review and share initial learning and/or action for improvement with the multi-disciplinary team as soon as possible after the fall.
- Complete Datix post falls review for falls that result in moderate and within 20 days and share learning locally at Ward Sister/ Charge Nurse meetings, Multidisciplinary meetings and at Safe and Effective Care and other Governance meetings.

Medicines and Falls Risk

- ✓ Below is a list of medicines which have been shown to be commonly associated with falls.
- ✓ Where a patient has been identified to be at risk of falls/has fallen and on one or more of the medicines listed, they should have their drug burden reviewed.
- ✓ **Medication review** is an essential step to minimising risk of falls, by reducing the number and dosage of medicines known to contribute to falls.
- ✓ This list is not exhaustive and only intended to raise awareness .

High Risk Medicines	Reason why we should review and examples (These medicines can cause falls alone or in combination).
Antidepressants	Can cause drowsiness, impaired co-ordination, poor balance and confusion. *E.g. include amitriptyline, dosulepin, itrazodone, venlafaxine, duloxetine, sertraline, citalopram.* Monoamine oxidase inhibitors (MAOIs) e.g. moclobemide, phenelzine, isocarboxazid, tranylcypromine are little now used but cause severe orthostatic hypotension.
Anti-muscarinics	May cause acute confusional states in the elderly especially those with pre-existing cognitive impairment. *E.g. include oxybutynin*
Antipsychotics (including atypical)	Can cause sedation, slow reflexes and loss of balance. All have some alpha receptor blocking activity and can cause orthostatic hypotension which is dose related. *E.g. include chlorpromazine, haloperidol, risperidone, quetiapine, prochlorperazine .*
Benzodiazepines and hypnotics	Can cause drowsiness, slow reactions and impaired balance. *E.g. include temazepam, diazepam, chlordiazepoxide, zopiclone.*
Dopaminergic drugs used in Parkinson's	Falls are common as reduced mobility, stability and orthostatic hypotension (OH) are part of the disease. Sudden excessive daytime sleepiness can occur with levodopa and other dopamine receptor agonists. *E.g. Levadopa, Ropinirole, Pramipexole, Selegiline.*

Medium Risk Medicines	Reason why we should review and examples (These medicines can cause falls, especially in combination).
Alpha-blockers	Can cause severe orthostatic hypotension. Used as 4th line treatment for resistant hypertension. Also used for lower urinary tract symptoms (LUTS). Doses used for treatment of BPH less likely to cause hypotension than those required to treat hypertension . *E.g. include tamsulosin, doxazosin, indoramin, prazosin, alfluzosin, moxonidine, clonidine, methyldopa*
(ACEIs) Angiotensin converting enzyme inhibitors/ (ARBs) Angiotensin receptor blockers	Risk of hypotension is potentiated by concomitant diuretic use. Incidence of dizziness affects twice as many patients with heart failure than hypertension *E.g. ACEIs include lisinopril, ramipril, perindopril. ARBs include losartan, candesartan, valsartan, irbesartan.*
Antihistamines	Somnolence may affect up-to 40% of patients with older antihistamines. The newer antihistamines cause less sedation and psychomotor impairment. Risk of hypotension with cinnarizine is a dose related side effect. *E.g. include chlorphenamine, hydroxizine, promethazine*
Anti-arrhythmics	May cause bradycardia and other arrhythmias. Dizziness and drowsiness are possible signs of digoxin toxicity. Risks of toxicity are greater in renal impairment or in the presence of hypokalaemia. Flecainide has a high risk for drug interactions and can also cause dizziness. *E.g. include digoxin, amiodarone, flecainide*
Anti-epileptics	Can cause sedation , dizziness and slow reaction times. Phenytoin may cause permanent cerebellar damage and unsteadiness in long term use at therapeutic dose. Excess blood levels cause unsteadiness and ataxia. *E.g. include carbamazepine, phenobarbitone, phenytoin .* There is insufficient data to know if the newer agents *(lamotrigine, pregabalin, levatiracetam, topiramate)* cause falls.
Beta blockers	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension (can affect up to 10% of patients) and vasovagal syndrome. Atenolol and sotalol are water soluble and renally excreted and can accumulate in renal impairment. Be vigilant to the additive effect of beta-blocker eye drops co-administered with an oral agent. *E.g. include atenolol, bisoprolol, metoprolol, propranolol, carvedilol, timolol eye drops.*
Diuretics	Postural hypotension, dizziness and nocturia are the most common problems seen in the elderly. Diuretics should **NOT** be prescribed for long-term use in the treatment of gravitational oedema. *E.g. include furosemide, bumetanide, bendroflumethiazide, chlorthalidone, metolazone.*
Opiates	All opiates and related analgesia sedate, slow reactions, impair balance and cause delirium. Drowsiness is common with initiation, but tolerance to this is usually seen within 2 weeks of continuous treatment. Drowsiness is rare with codeine unless used in combination with other CNS drugs. Confusion widely reported with tramadol in the elderly. *E.g. codeine, morphine, tramadol .*

Low Risk Medicines	Reason why we should review and examples (These medicines possibly causes falls, particularly in combination)
Antianginals	Can cause postural hypotension (dizziness/light-headedness).GTN spray use is a common cause of syncope due to a sudden drop in blood pressure. Educate patients to sit when using GTN spray. *E.g. include glyceryl trinitrate (GTN), isosorbide mononitrate, nicorandil*
Calcium channel blockers	Cause hypotension and paroxysmal hypotension. Diltiazem and verapamil also slow the pulse and can cause hypotension or bradycardia. *E.g. include amlodipine, nifedipine, lercanidipine*
Oral anti-diabetic drugs	Can cause dizziness due to hypoglycaemia. Avoid long acting sulphonylureas e.g. glibenclamide. *E.g. include gliclazide, glibenclamide*

V1. April 2019

Western Health and Social Care Trust

In-Patient Fall / Suspected Fall Medical Algorithm

Follow algorithm to assess for suspected Head Injury, Cervical Spine Injury, Hip/Pelvis fragility and any other injuries following a patient fall.

Complete, Sign and Print name at the end of the Algorithm indicating outcomes.

Further notes can be made in the patient's medical notes if required regarding treatment or discussion.

The form must be filed in the patient medical notes.

Patient Details/ Addressograph

Name _____

Address _____

_____

Date of Birth _____

Hospital No. _____

IT IS BEST PRACTICE NOT TO MOVE PATIENT IF PATIENT EXHIBITS ANY PAIN LOSS OF SENSATION, VISIBLE INJURY, LIMB DEFORMITY UNTIL APPROPRIATELY IMMOBILISED

IF THERE IS NO OPTION BUT TO MOVE THE PATIENT DUE TO RISK OF ADDITIONAL INJURY, A RISK ASSESSMENT MUST BE CARRIED OUT AND MUST INCLUDE CONSIDERATION OF HOW TO IMMOBILISE THE INJURY

COMPLETE FULL MEDICAL ASSESSMENT OF PATIENT FOR HEAD INJURY, SPINAL INJURY, HIP/PELVIS FRAGILITY AND ANY OTHER POTENTIAL INJURIES OR FRACTURES.

ALGORITHM 1: HEAD INJURY following initial ABCDE assessment Immediate Action

Is there evidence of head / clinically important brain injury?
Including where it cannot be ruled out

☐ YES

If YES, are any of the following present?
- ☐ Patient on Anticoagulants
- ☐ GCS <13 on initial assessment
- ☐ GCS <15 at 2 hours after injury on assessment in ED
- ☐ Suspected open or depressed skull fracture
- ☐ Any sign of basal skull fracture
- ☐ Post-traumatic seizure
- ☐ Focal neurological deficit
- ☐ More than one episoxde of vomiting since the head injury

GCS observations: Half hourly (2 hours), Hourly (4 hours), and 2 hourly thereafter. Should a patient with GCS=15 deteriorate at any time after the initial 2 hour period. Observations should revert to half hourly and the original frequency schedule.

If YES, request CT Scan immediately

After review by supervising doctor IF GCS drop by 1 ≥30 min; or ≥2 points in motor; ≥3 or severe headache; new neurology then request review.

If YES, request CT Scan within 8 Hours
GCS observations: Half hourly (2 hours), Hourly (4 hours), and 2 hourly thereafter. Continue to record NEWS
Should a patient with GCS=15 deteriorate at any time after the initial 2 hour period. Observations should revert to half hourly and the original frequency schedule.

☐ NO

If NO, no action required. Record NEWS / vital signs Action as per NEWS

If NO, is there any unexplained amnesia or loss of consciousness since the injury?

If NO, no action required.

☐ YES

If YES, are any of the following present?
- ☐ Age ≥65
- ☐ Fall from ≥1M (5 Stairs)
- ☐ History of bleeding / Clotting disorder

NB If GCS ≤8 consideration should be given to involving Anaesthetist. Clinical judgement needs to be applied regarding changes in behaviour / neurology

ALGORITHM 2: CERVICAL SPINE INJURY / Suspected Immediate Action

Are any of the following present? (Check both lists)

☐ YES

- ☐ Patient cannot actively rotate neck to 45° to left / right
- ☐ Not safe to assess range of movement in neck
- ☐ Neck pain or midline tenderness AND >65 years or fall >1m (5 stairs)
- ☐ Definitive diagnosis required urgently e.g. to facilitate emergency

If YES, Immediate 3 view X-Ray, Record NEWS

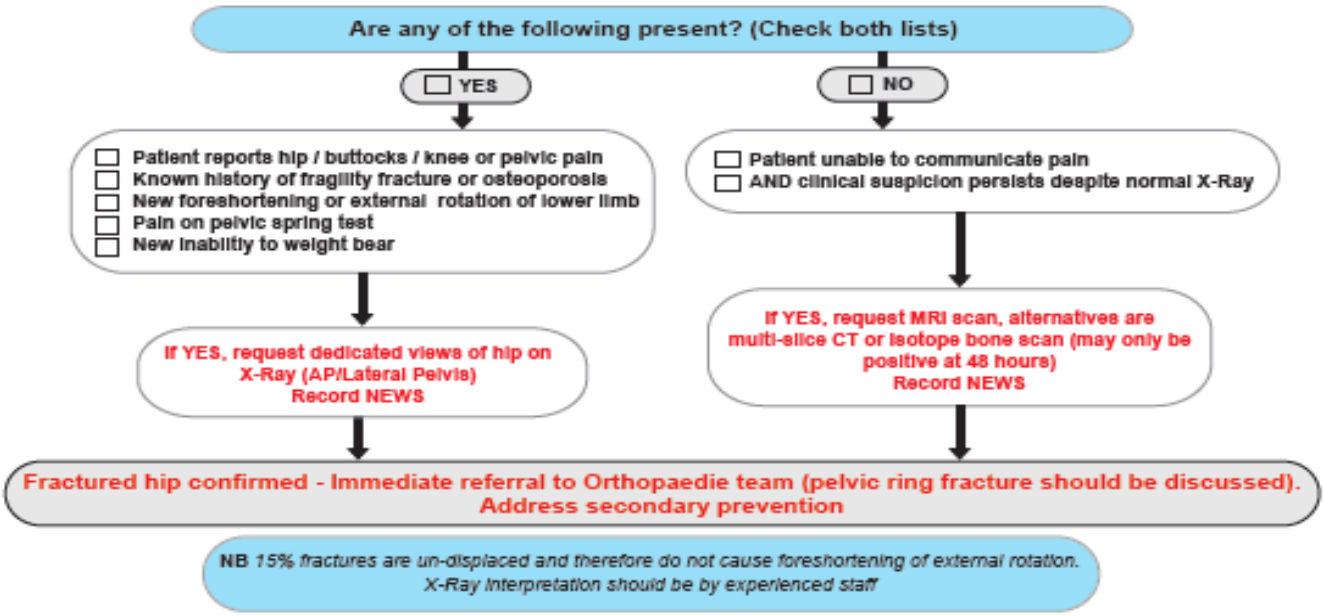
☐ NO

- ☐ GCS ≤13 on initial assessment and/or intubated
- ☐ Plain film series technically inadequate, suspicious or definitely abnormal e.g failure to view trabeculae lor cortices of bone due to overlying tissue/objects or poor quality film e.g. angle of beam.
- ☐ Clinical suspicion despite normal X-ray

If NO, no imaging required. Record NEWS

If YES, Immediate CT or if you are unsure of X-Ray interpretation

ALGORITHM 3: HIP OR PELVIS FRAGILITY / Suspected Immediate Action



Algorithm Reviewed for: **Findings:**

Head Injury ☐ _____

Cervical Spine Injury ☐ _____

Hip/Pelvis Injury ☐ _____

Brain Imaging Yes ☐ No ☐ Bone Imaging Yes ☐ No ☐ Site: _____

Any other injuries / factors / issues: _____

_____

_____

_____

_____

Further investigation ordered? Yes ☐ No ☐ N/A ☐

Referred / discussed with other medical teams? Yes ☐ No ☐ N/A ☐

If YES, who? _____ Date _____ Time _____

Further treatment indicated and time scale agreed? Yes ☐ No ☐ N/A ☐

_____

Degree of harm (see below*)

No Harm ☐ Low Harm ☐ Moderate Harm ☐ Severe Harm ☐ Death ☐

Medical assessment to ascertain cause of fall: Yes ☐ No ☐

Medications reviewed for contributing factors: Yes ☐ No ☐

Secondary prevention treatment commenced: Yes ☐ No ☐

If NO to any of above, please indicate when and by whom these will be completed:

_____

Print Name: _____ Grade: _____ Bleep: _____

Signature: _____ Date: _____ Time (24hrs): _____

Appendix 8 – Patient/resident Information Leaflet

If you feel dizzy - stop, sit down and let the ward staff know.

Do simple leg exercises before getting up from your bed or chair:

- point your toes and release a few times.
- move your legs up and down if you can, to get the circulation going.

Have a healthy diet, eat and drink regularly.

Make sure your shoes or slippers fit well, grip well and cannot fall off.

Take care in the bathroom and toilet use handrails for support. Ask for help if you need assistance.

Whilst you are in hospital a Doctor or Pharmacist may review your medication to ensure that they are not contributing to any dizziness or falls that you may have had.

Ver 7 April 20

Western Health and Social Care Trust

A guide for patients, relatives and carers to help reduce falls in hospital

The Trust has endorsed John's Campaign which welcomes families and carers on to the wards to provide care to their loved ones but is mindful of social distancing.

Your family are welcome to stay outside normal visiting hours to provide extra support, assistance and reassurance if you so wish.

Please ask the nurse in charge if you need further information about reducing the risk of falls for your relative. This may need to be reviewed depending on health care challenges.

It is not always possible to prevent patient falls in hospital, however we can work together to reduce the chances of this happening.

It is important that you, your family or carer inform the nursing and medical staff

If you have fallen in the last year, are worried about falling, or have a history of falls.

Use your call bell if you need help to move, in particular, if you need help going to the toilet.

Visitors when you leave please place call bell beside the patient

Make sure glasses are clean and used as prescribed. Ask for help if you are having trouble with your eyesight.

Make sure hearing aids are brought in and are working properly. If not please tell a member of staff.

If the bedrails are in use and you put them down please replace them before you leave or tell a member of staff before you leave the bedside.

Use your own walking aid, keep it close by and check for wear and tear on the rubber feet. Never lean on hospital furniture as it's often on wheels.

Visitors please avoid moving furniture and take home any unnecessary belongings or bags from the bedside

When getting up:

- sit upright for a few moments on the edge of your bed before standing.
- get up slowly, making sure you feel steady before walking, ask for help if you need assistance.

Appendix 9 – DATIXweb flow chart