Policy for the Prevention and Management of Patient Slips, Trips and Falls

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Purpose of Agreement	To reduce as far as practicable the risk of slips, trips and falls for patients within Solent NHS Trust. To ensure that patients under the care of Solent NHS Trust who are at risk of falling are identified and receive timely evidence- based assessments and interventions to reduce or manage their risk of falling in accordance with current national guidance.
Document Type	[x] Policy
Reference Number	Solent NHST/Policy/ HS05
Version	V7
Name of Approving Committees/Groups	Policy Steering Group, Clinical Executive Group
Operational Date	September 2019
Document Review Date	June 2023
Document Sponsor (Job Title)	Chief Nurse
Document Manager (Job Title)	Falls Clinical Lead Southampton Inpatient Falls Prevention Project Worker
Document developed in consultation with	Falls Lead, Associate Director – Quality and Governance, Quality and Training Lead, Health and Safety Manager, Dementia Thematic Lead, Product Specialist (Electronic patient records), BSS Training Co-ordinator, Clinical Risk and Safety Manager, Modern Matron, Older Persons Mental Health services, Portsmouth, Matron and Clinical Lead, Inpatient and Specialist Palliative Care (Portsmouth City), Matron, Inpatients, Royal South Hants Hospital, Southampton, Clinical Doctoral Research Fellow and Physiotherapist, University of Southampton and Solent NHS Trust, Associate Director Professional Standards and Regulation, Company Secretary, Senior Pay and Remuneration Manager, Policy Group
Intranet Location	Business Zone > Policies, SOPs and Clinical Guidelines
Website Location	Publication Scheme
Keywords (for website/intranet uploading)	Falls, slips, trips, Management of Patient Slips, Trips and Falls, Policy, HS05

Amendments Summary:

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
1	Version 7	1	Document manager amended and date of full review amended.	Oct 2022
2		3	Review Log updated	Oct 2022
3		3	Post falls protocol – applied to outpatient as well as community settings	Oct 2022
4		3	Those responsible for delivering the policy – amended	Oct 2022
5		3	Frequency of falls training amended	Oct 2022
6		7	3.1.2 – the groups of patients who should receive an inpatient multifactorial falls risk assessment has been expanded and made co-terminous with the terminology used in the electronic System One falls assessment.	Oct 2022
7		7	3.1.3 – the timings within which the different levels of inpatient falls risk assessment and care planning should be conducted has been amended.	Oct 2022
8		8	3.1.6 the policy document has been altered to reflect the fact that inpatient falls assessments will be completed on Systm One on all wards from 1/12/22	Oct 2022
9		9	3.3.1.3 the policy document has been altered to reflect the fact that post falls checklists will be completed on Systm One on all wards from 1/12/22	Oct 2022
10		10	3.3.2 – this section now covers outpatient and community settings.	Oct 2022
11		11	3.4.2.1 this section has been amended to reflect new reporting arrangements for falls data within Solent and how data is analysed and acted on.	Oct 2022
12		12 + 13	4.6 and 4.8 Frequency of falls training amended	Oct 2022
13		13	4.8 policy changed to reflect who now conducts Falls Training in the trust.	Oct 2022
14		13	4.11 the title of Falls Lead has been removed and the responsibilities of those replacing the Falls Lead have been adjusted	Oct 2022
15		44	Replacement of Appendix G with new Community and Outpatient Post Falls Guidance	Oct 2022
16		56	Replacement of Appendices L to P with new versions of patient information leaflets	Oct 2022
17		21	A statement has been added to recognise that the trust has moved towards an electronic falls assessment system.	Oct 2022
18		30	The word “medical” has been supplemented in place of “consultant”	Oct 2022
19		30	Names of cognitive tests included previously that are not appropriate to include due to licencing / copyright reasons have been removed.	Oct 2022

20		36	The policy reflects now that ALL patients must be checked for signs of injury if they fall without any age limitation	Oct 2022
21		36	The policy has been changed to give clearer guidance on which patients should and should not be removed from the floor after a fall and if they are to be removed how this should happen	Oct 2022
22		42	Example observations chart removed	Oct 2022

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
5	October 2018	Sally Ann Belward	Policy Steering Group, Trust Management Team Meeting	Slight delay in revising policy, approved at TMTM in September 2019
6	May 2022	Sally Ann Belward / Melody Chawner	Chair's action – expiration date extended to June 2023 to ensure policy remains in date during planned submission to future PSG/CEG Meeting	Minor changes made to policy, all content remains current
7	October 2022	Sally Ann Belward / Melody Chawner	Chair's action – approved amendments made to bring up to date and extend to June 2023 which will allow time for the policy to be reworked and overhauled. Appendixes included as separate zip and uploaded along with policy on SolNet for ease of access.	Relevant changes to bring content up to date for interim time ahead of overhaul – detailed in Amendment Summary table above

SUMMARY OF POLICY

The purpose of this Policy is to reduce, as far as practicable, the risk of slips, trips and falls for patients within Solent NHS Trust. Patients at risk of falling in hospital should receive a Multifactorial Falls Risk Assessment, which results in an individualised multifactorial falls prevention care and intervention plan. The Policy details the requirements for this.

Patients who are at higher risk of falling and who are in contact with any Solent NHS Trust Healthcare professional should be asked routinely whether they have fallen in the last year, and asked about the frequency, context and characteristics of the fall/s. Patients with a history of falling should then be offered a Multifactorial Falls Risk Assessment as part of an individualised, multifactorial intervention. The Policy details the requirements for this.

If a patient falls in an inpatient setting, the Post-Fall Protocol must be followed, and the Post-Fall Checklist must be completed. This includes completion of Neurological Observations when indicated. Staff in community settings and outpatient services who have come across a fallen patient must follow the Community Post-Fall Protocol as agreed for their service. Staff must report the fall in accordance with Solent NHS Trust reporting of incidents policy.

The Solent NHS Trust Quality and Safety Team will hold an incident review meeting for moderate injury or above as a result of a fall in our care. This would commission either a High Risk Incident or a Serious Incident investigation. Trends for falls incidents will be reviewed at Service Line Governance meetings and any trends shared at local Governance meetings.

Falls Champions/Links from each clinical area will assist the Falls Clinical Lead Southampton and Inpatient Falls Prevention Project Worker in the delivery of this policy.

All Solent NHS Trust staff caring for patients known to be at risk of falling should develop basic professional competencies in falls assessment and prevention. Local induction will provide staff with information and guidance on completing the falls risk assessment, falls care pathways, and post-falls management processes appropriate to their area. Staff in contact with older people should routinely ask them whether they have fallen in the past year, and ask about the frequency, context and characteristics of the fall/s. These staff will also complete the national NHS falls e-learning every other year, and attend local, service-specific Falls Training when offered. All training will be recorded via the Learning and Development team.

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Policy for the Prevention and Management of Patient Slips, Trips and Falls

1. INTRODUCTION & PURPOSE

1.1 Slips, trips and falls are a potential cause of injury for patients. The physical, psychological and financial costs associated with falls and their injuries make it a priority for Solent NHS Trust to reduce the risk of patients falling while under our care.

1.2 The purpose of this policy is to:

- Raise awareness of slip, trip and fall injuries to predominantly **adult patients** in our care and this includes **falls from heights** e.g. beds, chairs, etc.
- Ensure appropriate falls risk assessments are undertaken and acted upon
- Reduce the level of harm sustained from any fall that does occur
- Clarify to staff the processes to follow if a patient does sustain a fall whilst in the presence of Solent NHS Trust staff, whether on Trust premises or in the community
- Identify the training the organisation will provide to its staff
- Outline how the organisation will monitor compliance with this policy
- Outline how the organisation plans to monitor the success of its falls prevention measures overall.

1.3 In addition to reducing the risk to patients of a Slip, Trip or Fall whilst on Solent NHS Trust premises or under our care, it is also a priority for Solent NHS Trust to have appropriate falls assessment and management procedures in place so that older people who have been referred to Solent NHS Trust following a fall or fall-related injury have their on-going risk of falling reduced or appropriately managed.

1.4 Staff also have a responsibility to identify and report any environmental hazards which pose a risk of fall to any person on Trust premises. Any potential hazards noted should be escalated to the member of staff's line manager.

2. SCOPE & DEFINITIONS

2.1 This policy is specifically aimed at Solent staff but also applies to bank, locum, permanent and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, Agency workers and other workers who are assigned to Solent NHS Trust who work on or alongside Solent NHS Trust members of staff.

2.2 The following definitions apply:

Slip: A slip is to lose one's footing and slide unintentionally for a short distance, causing the person to lose their balance, this is either corrected or causes a person to fall. (Oxford English Dictionary, 2017).

Trip: A trip is to catch one's foot on something and accidentally stumble or fall, often over an obstacle, causing the person to lose their balance. This is either corrected or causes the person to fall (Oxford English Dictionary, 2017).

Fall: A fall is defined as an event whereby an individual unexpectedly comes to rest on the ground or another lower level (World Health Organisation, 2016). This includes **falls from height** e.g. beds, chairs or other equipment being used in the course of routine patient care.

A Multifactorial Falls Risk Assessment: An in-depth and, where indicated on-going process of identifying falls risk factors that can be treated, managed or improved during the individual patient's hospital stay, with the aim of reducing the patient's risk of falling in hospital.

2.5 Abbreviations used within the policy are explained in the glossary preceding the appendices.

3. PROCESS/REQUIREMENTS

3.1 Multifactorial Falls Risk Assessment and Interventions - Inpatients

3.1.1 It is essential that the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling is systematically identified and corrective action is taken.

3.1.2 A Mulitifactorial Falls Risk Assessment should be undertaken for the following groups of inpatients:

- all patients aged 65 years or older
- patients who have fallen in the last year
- patients admitted to hospital with a fall
- patients who have fallen since their hospital admission
- patients where a ward they were on immediately prior to admission to their current ward identified the patient as at risk of falling
- patients who try to walk unsupervised and who are unsteady or unsafe
- patients where their behaviour or cognition put them at risk of falls.
- patients who are under 65 who are judged by a clinician to be at higher risk of falling because of an underlying condition, or who have a history of previous falls.

The process for completing the inpatient Multifactorial Falls Risk Assessment is in **Appendix A.**

3.1.3 An Admission Risk Assessment of the patient's falls risk will be completed within the first 6 hours of admission, including initial care planning if needed within 24 hours, and a plan for completion of a more comprehensive falls risk assessment if required within 72 hours.

3.1.4 Where it has been determined that a patient has fallen in the last year, whether during the current admission or not, then a full history of the patient's falls must be taken. A history of falls in the past year is the single most important risk factor for falls and is a predictor of further falls. Taking this history must happen as soon as is clinically appropriate. If it is not possible to gain this history, within the agreed timeframe, i.e. within 24 hours of admission, then the reason for this must be recorded in the patient records.

3.1.5 The multifactorial falls risk assessment should result in an individualised multifactorial Inpatient Falls Prevention Care and Intervention Plan.

3.1.6 The full inpatient falls assessment is now electronic and housed on SystmOne. From 1st December 2022 this SystmOne form of the falls assessment must be used and paper forms (such as the found in appendix B) should be removed from use. The SystmOne Falls Assessment comprises:-

1. An Admission Risk Assessment (within 6 hours of admission)
2. An Immediate Falls Action Plan (within 24 hours of admission)
3. A multidisciplinary assessment with medical, nursing and therapy sections for completion by the respective disciplines within 72 hours of admission.
4. A Falls History that can be completed by nursing or therapy staff but must be completed within 72 hours of admission and each ward is responsible for deciding which discipline will complete this, either in general, or for each patient.
5. A Falls Care Plan review that is completed weekly, or each time the individual falls, whichever should come sooner.
6. A Post Falls Checklist (for completion after every fall)

3.2 Multifactorial Falls Risk Assessment and Interventions - Community Settings

3.2.1 Patients in contact with Solent NHS Trust 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.

3.2.2 Patients reporting a fall or considered at risk of falling will have an initial assessment of immediate risks to their safety and should be referred to an appropriate professional who will assess the patient for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

3.2.3 Patients who present to Solent NHS Trust 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 community multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience. This assessment should be part of an individualised, multifactorial intervention. See **Appendix C** for details.

3.3 Immediate Management of Patients Who Have Just Fallen – Inpatient and Community Settings.

3.3.1 Post Fall Protocol (Inpatients)

3.3.1.1 All inpatient staff within the organisation must follow the Solent inpatient post fall protocol. This protocol includes all elements included in NPSA RRR/2011/RRR001 (**Appendix D**).

3.3.1.2 All inpatient units must have laminated copies of this post fall protocol displayed clearly.

3.3.1.3 This post-fall protocol and the completion of the post fall check list must be included in the local

induction of all clinical staff by their line manager. From Dec 2022 post falls checklists must be completed on SystmOne where it is housed within the CHIRFIT Falls Assessment template and post falls checklists, such as the example in Appendix E, will need to be removed from use.

3.3.1.4 Staff in inpatient settings who have come across a fallen patient must seek help from colleagues if they require help in managing any aspect of the situation

3.3.1.5 Staff in inpatient settings must report the fall in accordance with Solent NHS Trust Incidents Reporting Policy

3.3.1.6 Following a patient falling nursing staff in inpatient settings must review why that patient has fallen involving all relevant multidisciplinary team members and must take action to prevent the patient falling again. This process must be clearly documented in the patient record.

3.3.1.7 Should the individual fall 3 or more times despite appropriate measures being taken to reduce their falls risk, then the case should be escalated for further expert review. This may involve requesting the opinion of relevant expert therapists, nurses or medical staff attached to the unit or the Falls Lead as appropriate. The inpatient Falls Link/Champion for the area must be made aware and may take a lead role, in conjunction with the clinical manager of the unit, in ensuring that all possible measures have been taken.

3.3.1.8 Staff should have access to appropriate equipment to assist patients safely up from the floor and moving and handling training content enables staff to get patients safely up from the floor.

3.3.2 **Post Fall Protocol (Community and Outpatient Settings)**

3.3.2.1 Although there are no national guidelines for managing a patient who has fallen in a community setting, staff in community settings (e.g. a patient's own home) who have come across a fallen patient must assess the patient according to the Community or Outpatient Post-fall protocol, as agreed for their service/locality (see example in **Appendices F&G**). If there are any "Red Flags" indicating possible head injury, spinal injury, limb fracture or significant other injury (e.g. haemorrhage, large skin tears or lacerations), then the staff must call an ambulance.

3.3.2.2 Staff in community settings must report the fall in accordance with Solent NHS Trust Incident Reporting Policy.

3.4 **Reporting and Responding to Falls Incidents**

3.4.1 **Service Level Reporting of Falls Incidents**

3.4.1.1 All falls or near misses must be reported using the Solent NHS Trust Incident reporting mechanisms as outlined in the Incident Reporting Policy.

3.4.1.2 The Solent NHS Trust Quality and Safety Team will hold incident review meetings for incidents of moderate harm or above as a result of a fall. This may result in a High Risk Incident or a Serious Incident investigation. Services have the responsibility to implement the actions that result from the investigation. Relevant action plans will be monitored via the Service Line Governance process.

3.4.1 .3 Modern matrons are responsible for reviewing adverse incidents relating to falls that occur in their inpatient area on the electronic adverse incident reporting system. Investigating Officers perform root cause analysis for falls resulting in moderate to severe harm or death. Action plans will be developed and monitored from the investigations of Serious Incidents or Harm Requiring Investigation. The Head of Quality and Professions, Modern Matrons and Team Managers will feedback to Inpatient Falls Links and Community Teams where there is evidence that reporting detail is suboptimal.

3.4.2 **Higher Organisational Reporting of Falls Incidents.**

3.4.2.1 The Quality and Patient Safety team will provide data on the number, rate, location, timing, severity and causality of falls across the organisation, by ward and by service line. The Inpatient Falls Project Worker will analyse this data and present a synopsis monthly to the Inpatient Falls Prevention Group and quarterly to the QIR group. Wards will also be sent the full data as well as a synopsis and are expected to look at local trends in their ward area and come up with local action plans for presentation at the Inpatient Falls Prevention Group. The Inpatient Falls Prevention Group will consider the actions required based on the data presented.

3.4.3 **Feedback on Falls Incidents to Inpatient Areas**

3.4.3.1 Trends for falls incidents are reviewed at Service Line Governance meetings.

3.4.3.2 Any trends for falls incidents will be shared at local Governance meetings.

4. ROLES & RESPONSIBILITIES

4.1 The **Chief Executive Officer** has overall responsibility for Health and Safety in Solent NHS Trust. The Chief Executive Officer has delegated responsibility to the Chief Nurse to act on their behalf to ensure structures are in place to ensure, so far as is reasonably practicable, the health, safety and welfare of staff, patients and others affected by the Solent NHS Trust's undertakings. This will, in part, be achieved by ensuring this policy on slip trip and falls management is implemented in all clinical areas throughout Solent NHS Trust.

4.2 **The Quality and Professional Standards Team has a responsibility to:**

- Identify falls incidents which require an incident review meeting
- Provide data to services to enable them to analyse reported incidents.

4.3 **The Health and Safety team have a responsibility to:**

- Monitor incidents relating to slips/trips/and falls
- Report to external agencies if required.

4.4 **Local Service Managers/Clinical Leads have the following responsibilities**:

- Ensure all relevant patients are assessed for the risk of falling in accordance with local protocol
- Be aware of and comply with this policy
- Ensure new staff receive induction training as per section 3.5.1
- Ensure staff complete falls e-learning (two hours) as required, and attend the relevant training regarding slips and falls update training

- Monitor incidents or near misses of slips trips and falls, ensuring that any falls are reported on the Trust Incident Reporting form.
- Ensure that where staff are managing adults who are at risk of falling that there is documented evidence that this policy has been highlighted to those staff at induction, or for existing staff, immediately after policy introduction.
- Ensure all staff are aware of and compliant with this policy
- When an incident is linked to moving and handling, and has affected a staff member, the line manager will inform the Occupational Health and Wellbeing Service, if applicable, to support returning back to work. The Occupational Health and Wellbeing Service is notified of the incident when it is reported via the incident reporting system (Ulysses).
- Nominate an appropriate member of staff to act as Falls link/Champion and facilitate their attendance at the Falls Links/Champions meetings.

Managers of staff working with adults in community or inpatient settings must raise awareness during local induction about this policy. They must ensure that **new staff**:

- Are aware of this policy and local documentation and procedures relating to Slips, Trips and Falls pertaining to their area of work
- Complete the on-line Falls Training as outlined in section 5.

4.5 Additionally, **Managers of Patient Areas** must:

- Maintain safe staffing levels and adequate cover in ward/department at all times, especially at times of high risk of falling and report deficits using safer staffing reporting processes.
- Ensure that the appropriate Falls Protocol is followed for patients admitted to the ward/service and support staff at ward level to facilitate the process
- Ensure that updates to this policy are highlighted to **existing staff.**

4.6 All **Clinical Staff** with responsibility for treating adults must:

- Complete the national NHS falls e–learning every other year.
- Undertake falls training at local induction
- Adhere to the processes set out in this policy that apply to their clinical area.

4.7 **All Solent NHS Trust employees (including Bank Staff, Volunteers and NHS professionals) have a responsibility to:**

- Complete the relevant national NHS falls e–learning
- Be aware of, and comply with this policy and local protocol regarding slips, trips and falls
- Be aware of the risk of slips, trips and falls to themselves, colleagues and any patients within their care
- Report incidents, near misses and concerns promptly in line with the Solent NHS Trust Incident Reporting Policy
- Undertake falls risk assessment appropriate to their area of responsibility

4.8 All **Falls Links/Lead/Champions** must:

- Complete the relevant national NHS falls e–learning every other year.
- Encourage and support staff in their service/locality to complete the relevant national NHS falls e–learning annually.
- Act as a link and a specialist resource for staff within their area in matters pertaining to falls prevention
    - Attend Falls Update Training sessions with the Falls Clinical Lead Southampton and/or Inpatient Falls Prevention Project Worker as appropriate, identifying and highlighting any areas of specific training need, and for peer support and development led by the Solent Falls Thematic Lead
- Deliver agreed cascade falls update training to their service/locality, as and when required
- Support new staff so that they know how to respond correctly to any patient falls in accordance with guidance, to include completion of the post-fall checklist and neurological observations, plus
- Ensure new staff know how to report falls in accordance with Patient Safety Federation guidance on reporting falls (2010) and local electronic incident reporting procedures (Ulysses).

Training in the management of the fallen patient will be clearly documented, and monitored.

4.9 **All staff conducting falls prevention training (primarily Solent NHS Falls Champions/Leads/Links) should**:

- Keep a record of who attends training
- Forward that record to Learning and Development for recording and monitoring.

4.10 **Learning and Development have responsibility to**:

- Ensure all falls training is recorded on the system
- Provide reports relating to staff compliance with falls training to Falls Lead.

4.11 **The Falls Clinical Lead Southampton and Inpatient Falls Prevention Project Worker have the responsibility to:**

- Arrange peer support and development meetings for Falls Links/Champions
- Arrange falls update training for Falls Links/Champions as relevant new national guidelines and/or standards are published
- Define the agreed falls update cascade training that the Falls Links/Champions will deliver
- Support the Falls Links/Champions with falls audits
- Undertake professional development relevant to the role
- Facilitate falls assessments for patients attending hospital with fragility fractures, via the Southampton Fracture Liaison Service pathway (**Appendix I**)
- work with other local statutory and voluntary agencies to raise general public awareness about the importance of falls prevention for the older population through local falls awareness events and campaigns where possible

5. TRAINING

5.1 All healthcare professionals caring for patients known to be at risk of falling should undertake appropriate training in falls assessment and prevention.

5.2 At local induction all clinical staff will receive information and guidance on completing the falls risk assessment and falls care pathways and processes appropriate to their area.

5.3 All training will be recorded by Learning and Development team.

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

6.1 In accordance with the Equality Act 2010 equality and diversity issues have been considered in the development of this policy and no equality issues were identified. This policy has been assessed against the requirements of the Mental Capacity Act (MCA) 2005 during policy development (**Appendix H**).

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Monitoring of this policy will be:

- via the incident reporting system
- via investigation of falls incidents reported as moderate or higher harm
- by recommended audit of both falls assessments and interventions, and by use of post-falls protocols, as per each Service Lines' annual audit plan.

Outcomes of this monitoring will be fed back to staff via the Falls Links and Governance processes.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed 3 years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

Solent Policies:

- Reporting of adverse incidents
- Investigations Policy
- Serious Incidents Policy
- Deprivation of Liberty Standards and Mental Capacity Act Policy

1. NICE Clinical Guideline CG161 The Assessment and Prevention of Falls in Older People 2013.
2. NPSA 'The safe use of ultra low beds' (2011)
3. NICE Clinical Guideline CG138 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services'
4. NICE Clinical Guideline CG176 'Head injury. Triage, assessment, investigation and early management of head injury in children, young people and adults (2014),

5. NICE Clinical Guideline CG146 'Osteoporosis: assessing the risk of fragility fracture (2012; updated 2017),
6. NICE Quality Standards QS86 'Falls in older people: Assessment after a fall and preventing further falls' (2015; updated 2017)
7. "What are the risks of using antidepressants together with NOACs and how should these risks be managed?" NHS UK Medicines Information Q&A 225.1 (November 2015). Available through NICE Evidence Search at www.evidence.nhs.uk
8. "How do we assess and manage bleeding risks in patients requiring oral anticoagulation for atrial fibrillation?" UKCPA Haemostasis, Anticoagulation and Thombosis Q&A 436.1 (July 2014). www.evidence.nhs.uk
9. The 'How to Guide : Reducing Harm from Falls' 2009. Patient Safety First
10. Slips, Trips and Falls in Hospital, National Patient Safety Observatory 2007.
11. American Geriatric Society/British Geriatric Society Clinical Practice Guideline. Prevention of Falls in Older Persons. 2010
12. National Institute for Health and Clinical Excellence(NICE) Clinical Guideline 56 :Head Injury.
13. National Health Service Litigation Authority (2007) ***Risk Management Standards for PCTs*** London: National Health Service Litigation Authority
14. National Patient Safety Agency (2007) ***Slips, Trips and Falls in Hospital*** London: National Patient Safety Agency
15. Health & Safety in NHS Acute Hospital Trusts in England, NAO, 1996
16. Reducing slips and trips risk in the health services: 2 year campaign. http://www.hse.gov.uk/slips/campaign.html and http://www.hse.gov.uk/foi/internalops/sectors/public/7_06_06.pdf
17. Solent NHS Trust Learning and Development Policy
18. Solent NHS Trust Induction and Mandatory Training Policy
19. 'Guidelines for the Physiotherapy management of older people at risk of falling', AGILE: Chartered Physiotherapists working with Older People (2012)
20. 'Occupational therapy in the prevention and management of falls in adults. Practice guideline.' College of Occupational Therapists (2015)
21. HS06 Slips Trips and Falls Policy (Premises) – now made a Procedure
22. "The Guide to The Handling of People" 6th Edition published by BackCare; the National Back Pain Association in collaboration with the RCN
23. "Look out! Bedside vision check for falls prevention" (2017) Royal College of Physicians (Falls and Fragility Fracture Audit Programme)

10. GLOSSARY

ABC	Airway, Breathing & Circulation
ACP	Anticipatory Care Plan
AGILE	Association of Chartered physiotherapists working with older people
AGS	American Geriatric Society BGS British Geriatric Society
BIODEX	Balance retraining platform
BM	Blood glucose monitoring
BP	Blood Pressure
CHIRFIT	Community Hospitals Identification of Risk of Falls and Intervention Tool
COT	College of Occupational Therapists
CRS	Clinical Record System
CT head	Cat scan of head
DNACPR	Do not attempt cardiopulmonary resuscitation

ECG	Echocardiogram
ELK	Easy Lifting Cushion
FLS	Fracture Liaison Service
FRAX	Fracture Risk Assessment tool
GCS	Glasgow Coma Scale
HRI	Harm requiring investigation
HSE	Health & Safety Executive
IR	Intentional rounding is a structured process whereby nurses conduct one to two hourly checks with every patient using a standardised protocol
Leuc	Leucocytes
LOC	Loss of consciousness
L/S or L+S BP	Lying and standing (postural) blood pressures
MHRA	Medicines and Healthcare Products Regulatory Agency
MMSE	Mini Mental State Examination
MSU	Mid-stream Urine sample
Neuro Obs	Neurological Observations
NEWS	National Early Warning Score
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Clinical Excellence
Nit	Nitrates
NOK	Next of Kin
NPSA	National Patient Safety Agency
NSF	National Service Framework
OA	Osteoarthristis
Obs	Observations
OPMH	Older Person's Mental Health
OT	Occupational Therapist
PSF	Patient Safety Federation
PUH	Portsmouth University Hospitals
PVD	Peripheral Vascular Disease
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RR/Resp rate	Respiratory rate
RRR	Rapid Response Report
Sats/SPO2	Oxygen saturation levels in the blood
SI	Serious Incident
Temp	Temperature (of body)
UTI	Urinary Tract Infection
# Fracture	

Appendix A: The Inpatient Multifactorial Falls Risk Assessment and Care Plans

The Multifactorial Falls Risk Assessment should identify the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These should include:

- Falls History
- cardiovascular examination
- presence/absence of orthostatic (postural) hypotension
- medication review
- syncope syndrome
- visual impairment & other sensory deficits
- neurological examination
- health problems that may increase their risk of falling
- assessment of bone health and fracture risk
- cognitive impairment/ psychological status
- continence problems/ toileting issues
- foot health
- footwear that is unsuitable or missing
- postural instability
- mobility/gait problems and/or balance problems
- fear of falling
- lower limb muscle strength
- ability to get up after a fall and summon help after a fall
- assessment of the level of and need for social care support
- environmental risk (pertaining to inpatient environment)
- ability to summon help (pertaining to inpatient environment, not home environment)
- assessment of home hazards

Falls History:- as stated in the Inpatient Falls Prevention Care Plan with specific reference to the presence or absence of syncope or unexplained falls.
The history must include:-

- Number of falls in last year.
- Date and time of last fall
- Activity at time of fall
- Preceding symptoms (chest pain, dizziness, palpitations) Whether the patient remembers falling
- Whether the patient remembers hitting the floor
- Whether the patient lost consciousness
- Injuries sustained
- Ability to get up from the floor
- Ability to summon help after the fall Any previous fractures including dates Fear of falling
- Details of any previous falls

Cardiovascular examination:-heart rate and rhythm, lying and standing blood pressure, presence or absence of cardiac murmurs.

The cardiovascular examination must include an assessment for postural hypotension, adhering to the procedure set out in "Measurement of lying and standing blood pressure as part of a Multifactorial Falls Risk Assessment" (Royal College of Physicians, Falls and Fragility Fracture Audit Programme, 2016, **Appendix J**)
Performance and interpretation of an Electrocardiogram (ECG) where indicated or documented evidence of why an ECG was not indicated.

Medication Assessment & Review:-including a list of current medication and consideration of whether the patient is taking psychotropic or night sedation medication. There must in all cases be documented evidence that a level 3 medication review has taken place, whether any changes were needed and what those changes were.

Visual Assessment:- The Bedside vision check should be attempted for all patients at risk of falls, in accordance with the Royal College of Physicians (Falls and Fragility Fracture Audit Programme) document "Look out! Bedside vision check for falls prevention" (2017).
The first three assessments should be attempted for all patients at risk of falls. Assessments 4 & 5 should be attempted whenever possible:
1. Ask the patient some questions
2. Check distance vision
3. Check near vision
4. Check side vision
5. Check eye movements.

Cognition:-A standardised assessment of cognitive function such as the Abbreviated Mental Test Score (AMTS 10) or the Mini Mental State Examination (MMSE) or scored Clock Drawing Test must be documented. If these are not appropriate then this must be stated and a specific statement about cognitive ability
made.

Continence:- including an assessment of urinary function which must include noting the presence of any long term urinary catheter, urgency, frequency and nocturia.

Gait and Balance:- using a standardised, nationally used assessment tool e.g. timed walk test, Berg Balance Scale,

Fear of falling:-using a standardised, nationally used assessment tool e.g. Falls Efficacy Scale- International (FES-I)

Assessment of Osteoporosis and of Fracture Risk
The assessment of osteoporosis and of fracture risk should be considered for all women over the age of 65 and all men over the age of 75, plus in women aged under 65 and men aged under 75 in the presence of risk factors for secondary osteoporosis.

A Multifactorial Falls Risk Assessment is not a fall risk prediction tool. A falls risk prediction assessment tool (resulting in the patient being labelled High, Medium or Low risk of falling) should not be used to predict inpatients' risk of falling in hospital.

The purpose of the Inpatient Multifactorial Falls Risk Assessment is to:

- Identify the cause/s for any previous fall/s the patient has had

- Identify the patient's individual risk factors for falling
- Identify modifiable causes and risk factors
- Enable practitioners to refer the patient for effective interventions targeted at their specific risk factors, with the aim of reducing subsequent falls
- Create a Care Plan in order to modify those causes and risk factors that are able to be reduced
- Identify any non-modifiable falls risk factors
- Put in place management strategies for any causes or risk factors that which are not modifiable, with particular emphasis on reducing level of harm from any future falls.
- Communicate, in a meaningful, appropriate way, the conclusions and action plans from this assessment process to the patient and,
- after seeking consent, to share information under information governance policy, with the patient's General Practitioner (GP) and any other relevant health and social care agencies at the point of discharge.

Ensure that patient footwear is monitored & advice given to patients and / or relative with regard to any risks and how to reduce these.

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

- Home hazard assessment undertaken in the person's home, and intervention if needed, has been identified as a component in successful multifactorial intervention programmes.
- It is important that home hazard assessment is undertaken after a Multifactorial Falls Risk Assessment has been completed (NICE QS86).
- Home hazard assessment should be completed using a standardised nationally used assessment tool, such as the Home FAST (Home Falls Accident Screening Tool), Westmead or SAFER (Safety Assessment of Function for Rehabilitation) (Royal College of Physicians, 2011: National Audit for Falls and Bone Health in Older People). **(Appendix K:** HomeFAST**)** in the patient's usual home environment or the environment they are planning to return to as their permanent place of residence. If a home visit assessment has been completed which covers all of the elements of the HomeFAST or Westmead assessment then a HomeFAST or Westmead does not need to be completed in addition to the full Occupational Therapy Home Visit.

Individual components of the Multifactorial Falls Risk Assessment may be undertaken by different staff, but each element has to be combined to form a single multifactorial assessment..

Inpatient Falls Prevention Care Plan
The Multifactorial Falls Risk Assessment should result in an individualised multifactorial Inpatient Falls Prevention Care and intervention Plan, which must be completed soon after admission. The purpose of this care plan is to minimise the risk of the patient falling whilst an inpatient. It must be ensured that any multifactorial intervention: promptly addresses the patient's identified individual risk factors for falling in hospital

and takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay.

Only falls prevention interventions that are tailored to address the patient's individual risk factors for falling must be offered (i.e. **Not** a list of interventions for all patients on a ward who are at risk of falling, such as at Intentional Rounding).

There must be documented evidence that the actions identified in the care plan have been shared with all relevant staff caring for that patient. This might take the format of documented discussion at handover and/or Multidisciplinary Meetings.

Information for patients

Relevant oral and written information and support must be provided for patients, and their family members and carers if the patient agrees. This should take into account the patient's ability to understand and retain information. Information should include:

- explaining about the patient's individual risk factors for falling in hospital
- showing the patient how to use the nurse call system
- encouraging them to use it when they need help
- informing family members and carers about when and how to raise and lower bed rails
- providing consistent messages about when a patient should ask for help before getting up or moving about
- helping the patient to engage in any multifactorial intervention aimed at addressing their individual risk factors (NICE CG161).

Patients should be given either a copy of the Royal College of Physician's booklet "Falls prevention in hospital: a guide for patients, their families and carers", or a locally written falls fact sheet**.** (**Appendix L**)

Patients may also be given the following Solent NHS Trust fact sheets

- "Falls Service. What to do if you fall. Information for patients" (**Appendix M**)
- "Stay safe at home. Falls prevention. Information for patients" (**Appendix N**)
- if postural hypotension was identified, then "Advice to patients with dizziness due to postural hypotension"(**Appendix O**)
- may also be given "Healthy Bones. Caring for your bones. Information for patients" (**Appendix P**)

At the point of completing the Inpatient Falls Prevention Care Plan initially, an appropriate review interval must be decided on. If no falls occur then the Inpatient Falls Prevention Care Plan must be routinely reviewed at this agreed interval and there must be documentary evidence of this.

The Inpatient Falls Prevention Care Plan must be reviewed each time the individual falls and there must be documentary evidence of this.

There must be documentary evidence of all of the above in the Inpatient Multifactorial Falls Assessment (which must be complete at the point of discharge).

Solent has replaced its previous variety of inpatient falls assessment documentation systems with standardised electronic assessment, care planning and clinical intervention documentation. This applies to the following inpatient areas acknowledging that whilst core elements as stated above must remain the same there

may need to be some local differences due to the differing patient populations:

1. Palliative care / NHS continuing care facilities
2. Inpatient older persons' rehabilitation facilities
3. Inpatient older persons' mental health facilities
4. Adult mental health facilities

It is acknowledged that at times in inpatient areas there can be a conflict of interest between measures deemed appropriate to reduce falls risk as far as possible and an individual's need to participate in appropriate therapeutic activity to improve their physical independence. Where this is the case a risk assessment must be completed and the conclusions as to whether it is advisable to allow an individual to pursue activity which may increase their falls risk as well as their independence on a risk / benefit analysis must be documented.

If the patient has fallen in the year prior to admission, falls were a contributing factor to the admission or the patient has fallen during the admission then the patient there must be documented evidence that the patient has been given information on falls prevention and promoting good bone health. The Solent NHS Trust fact sheets should be given in the first instance, but it is recognised that there are a variety of other appropriate patient information resources available (e.g. Staying Steady by AgeUK, and Get up And Go, by the Chartered Society of Physiotherapy and Public Health England).

Bed Rails
Patients should only use bed rails where a Bed Safety Rails Risk Assessment has been completed.

Ultra Low Beds
For patients with delirium who are at risk of falling out of bed, but who cannot be given bed rails as they might climb over them, ultra-low beds can help to prevent harm from falls.
Ultra low beds

- must be left in the lowest position (must not be left at working height)
- must not be used with bed rails
- can be used with crash mats. Crash mats cannot be used with mobile patients, who might trip over the crash mat
- must be placed flush to any walls, or completely clear of walls, to prevent asphyxial entrapment if the patient slipped between the side of the mattress and the wall
- Must not be placed near to potentially injurious floor level fittings or furniture, such as radiators, pipes or lockers.

Falls Alarms
Bed exit monitors/alarms may be used where it is not possible to observe a patient who is at high risk of falling when they attempt to either get out of bed or stand up from their chair unsupervised or without assistance. These alarms alert staff that the patient is moving, and is at risk of an imminent fall, but they do not prevent patients from falling. Alarms are not a substitute for nursing observation. See Falls Alarm Decision Flow Chart (**Appendix Q).**

Exit monitors alarm when either the patient unweights the bed or chair mat, or passes

through an infrared beam. Other sensor mats alarm when weighted, such as when a patient stands on a mat on the floor. Infra-red beams that are integral to the bed, and which alarm when the beam is broken by the patient moving to get out of the bed, are used in some services.
A patient's alarm must be regularly checked for both functionality and positioning. Defective alarms must be withdrawn from service until repaired.

One-to-One Nursing Observation
One-to-one nursing observation is usually requested for a patient who has been assessed at high risk of injurious falls if unobserved. These patients are often mobile and confused. One-to-one observation may prevent the patient attempting unwise or dangerous activities that could result in a fall (e.g. mobilising to the toilet without their walking aid). One-to-one observations will not prevent all falls, as Manual Handling regulations prevent staff from "catching" the falling patient.

Hip Protector Pants
Hip protector pants are plastic shields (hard) or foam pads (soft), usually fitted in pockets in specially designed underwear. They are worn to cushion a sideways fall on the hip. They are not routinely or uniformly issued to inpatients on Solent NHS Trust wards.
But to be effective in preventing a hip fracture from a fall, the patient must

- have been measured for and issued with the appropriate size of hip protectors
- be wearing them correctly (with the pads positioned over the greater trochanter of the femur)
- have been assessed for the appropriate style of hip protectors (full garment, open crotch, with an access flap, accommodating incontinence pads, etc.)
- not be so confused as to try to don and doff the hip protectors independently (such as in the toilet), as this would increase the risk of falling.

Hip protectors should not be worm if there is a wound on the hip area. They are ineffective if the patient has had bilateral prosthetic hips.

It must be ensured that relevant information is shared between services when a patient moves from the care of one service to another. The principles in Patient experience in adult NHS services in relation to continuity of care should be applied.

Falls Links/Champions
Each inpatient ward area must identify a member of staff who will act as the Falls Link/Champion/Lead for that area. The responsibilities of this staff member are outlined in section 4. The training requirements for this staff member are outlined in section 5.

Appendix B- Example of an Inpatient Multifactorial Falls Risk Assessment (CHIRFIT)

Patient Sticker Name: Date of birth: Hospital number: NHS number:	Date and time of admission to Spinnaker ward: _____

Solent NHS
NHS Trust

CHIRFIT & Falls Prevention Intervention Plan

Community Hospitals Identification of Risk of Falls and Intervention Tool

Admission Risk Assessment		
Was the patient *originally* admitted to hospital due to a fall?	Yes	No
Any falls in the last year?	Yes	No
Any falls since admission (on Spinnaker or previous ward)?	Yes	No
Fear of falling?	Yes	No
Is the patient confused/agitated/anxious to a level which puts them at risk of falling?	Yes	No
Is the patient on antiepileptics (e.g. sodium valproate)?	Yes	No
Is the patient on benzodiazepines (e.g. diazepam)?	Yes	No
If yes to any of above, complete the Immediate Falls Action Plan.		

Immediate Falls Action Plan (within 6 hours of admission)			
Observation			
Patient in bedspace where observation easy	Yes	No	Not necessary
Patient in easy view of staff in day area	Yes	No	Not necessary
Call bell near patient, and patient knows how to use it	Yes	No	No, intentional rounding needed
Furniture and Sensors			
Bed / floor / chair sensor used	Yes	No	Not necessary
Crash mats used	Yes	No	Not necessary
Bed rails assessment done	Yes	No	Not necessary
High / low bed used	Yes	No	Requested on:
Chair type looks appropriate for patient	Yes	No	If no, state action:
Sensory Awareness			
Glasses near patient	Yes	No	Requested on:
Hearing aid near patient	Yes	No	Not necessary
Walking aid near patient	Yes	No	Not necessary
Suitable footwear in place	Yes	No	If no, state action:
Hip protectors used	Yes	No	Not necessary
Current shift staff are aware of falls risk	Tick when completed ☐		
Name Job title Signature Date and time			

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Patient Sticker Name: Date of birth: Hospital number: NHS number:

Nursing CHIRFIT

Solent NHS Trust

Lying-standing blood pressures	<table><tr><td>Date of reading</td><td>1</td><td>2</td><td>3</td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table>			
	Any extra measurements:			
Assessment of urinary and faecal continence	Urinary continence status		Continent	Incontinent
	If catheterised, state date of insertion:			Long-term catheter? ☐
	Faecal continence status		Continent	Incontinent
	Risk of falls associated with continence problems? *If yes, consider:* - *Continence assessment* - *Urine dip +/- MSU (only if nit + **and** leuc +)* - *Stool sample* - *Physio referral if mobility restricts continence* - *Intentional rounding*		Yes	No
Brief assessment of mobility	Unsteady transfers / unsteady whilst walking / unsteady use of walking aids? *If yes, consider:* - *Labelling walking aid with patient's name* - *Placing aid within easy reach of patient* - *Appropriate footwear* - *Referral to podiatrist if poor foot health*		Yes	No
Brief assessment of cognition	Confused / agitated / disorientated / lacking insight? Is this usual for the patient?		Yes Yes	No No
Name	Job title	Signature		Date and time

Patient Sticker Name: Date of birth: Hospital number: NHS number:

Medical CHIRFIT

Solent NHS
NHS Trust

Falls history	No. of falls in last yr		
	Falls history - *When, where, activity at the time* - *Preceding symptoms* - *LOC, long lie* - *How did they call for help* - *Previous fall* - *Fear of falling*		
	Impression *e.g. OA, PVD*		
Drugs review	Medication stopped or changed:		
Assessment of cognitive function	On admission	To QA:	To Spinnaker:
	Results and dates of additional tests		
	Notes *OPMH? CT head?*		
Assessment of osteoporo-sis risk	Bone protection on admission If none, calculate FRAX		
	Vitamin D		
	No. of # <65y		
Name	Job title	Signature	Date and time

Patient Sticker Name: Date of birth: Hospital number: NHS number:

Joint Physiotherapy & Occupational Therapy CHIRFIT

Solent NHS Trust

	On admission	Pre-discharge
Assessment of footwear		
Assessment of balance		
Assessment of transfers and mobility		
Perceived functional ability		
Assessment of home hazards		Interventions *e.g. commode*:
How do they call for help? *e.g. pendant alarms*		
Completed by	Physiotherapist name and signature: Date and time:	Occupational therapist name and signature: Date and time:

Patient Sticker Name: Date of birth: Hospital number: NHS number:

Falls during Admission

Solent NHS Trust

Date	Time	Possible cause of fall	Modifications made to prevent recurrence	Post-fall	Name and signature
				Yellow sticker ☐ Falls risk sign ☐ Fall checklist ☐	
				Yellow sticker ☐ Falls risk sign ☐ Fall checklist ☐	
				Yellow sticker ☐ Falls risk sign ☐ Fall checklist ☐	
				Yellow sticker ☐ Falls risk sign ☐ Fall checklist ☐	

Use continuation sheets if necessary

Patient Sticker Name: Date of birth: Hospital number: NHS number:

Falls Prevention Care Plan Review

Solent NHS Trust

Use this section to highlight ongoing problems and interventions.

Date and time	Description of problem and intervention	Frequency of review	Signature
EXAMPLE *1/1/16 00:00*	***EXAMPLE*** *Postural hypotension. Fludrocortisone 50 micrograms added. Complete daily LSBP for 3 days.*	***EXAMPLE*** *Review after 3 days.*	***EXAMPLE*** *Dr A B C*

Appendix C – The Community Multifactorial Falls Risk Assessment and Interventions

The Community Multifactorial Falls Risk Assessment should include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness/lower limb muscle strength
- assessment of osteoporosis risk
- assessment of fracture risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment
- neurological examination
- assessment of urinary incontinence
- foot health
- foot wear
- assessment of home hazards
- cardiovascular examination and
- medication review
- ability to get up after a fall and summon help after a fall in the patient's usual home environment.
- assessment of the level of and need for social care

Falls History :- with specific reference to the presence or absence of syncope or unexplained falls.

The history must include:

- Number of falls in last year.
- Date and time of last fall
- Activity at time of fall
- Preceding symptoms (chest pain, dizziness, palpitations) Whether the patient remembers falling
- Whether the patient remembers hitting the floor
- Whether the patient lost consciousness
- Injuries sustained
- Ability to get up from the floor
- Ability to summon help after the fall
- Any previous fractures including dates
- Fear of falling
- Details of any previous falls

Cardiovascular examination:- as a minimum heart rate and rhythm and lying and standing blood pressure, adhering to the procedure set out in "Measurement of lying and standing blood pressure as part of a Multifactorial Falls Risk Assessment" (Appendix K) (Royal College of Physicians, Falls and Fragility Fracture Audit Programme, 2016). Whether or not an ECG was considered, and whether or not an ECG was performed, should be documented.

Referral to a doctor for a more comprehensive cardiovascular assessment, including an ECG, must happen where:-

- heart rate or lying and standing blood pressure readings are abnormal.
- the patient has had more than one fall in the last year
- the fall is unexplained.

Patients who have had a Community Multifactorial Falls Risk Assessment must be considered for a **medical assessment**. The main reasons for a medical assessment and intervention will be unexplained falls, or unexplained transient loss of consciousness.
Southampton: This may comprise discussion about the findings of the multifactorial falls risk assessment with a community consultant (with a view to potential home visit comprehensive geriatric medical assessment (CGA) by that consultant)
Portsmouth: It may be where following assessment and intervention by the community team the risk of falling has not been reduced and more detailed investigations are required. A referral must only be made in this instance following documented discussion with the GP and only once the GP has assessed the patient 1st to eliminate unnecessary referrals where the patient's fall risk could have been modified by their primary care physician. Referral may be made for consultant medical intervention at a Specialist Falls clinic run by another organisation (PUH).

Medication assessment and review :- All patients should receive a medication review, to include a list of current medication and consideration of whether the patient is taking psychotropic or night sedation medication. Referral to a geriatrician, or Solent pharmacist for a level 3 medication review must be made where indicated. The outcome of that medication review and any changes to the patient's medication must be documented.

Cognition: A standardised assessment of cognitive function must be documented, or if not clinically possible, a specific statement of cognitive ability must be made.

Visual assessment:- A vision check should be attempted for all patients at risk of falls, in accordance with the Royal College of Physicians (Falls and Fragility Fracture Audit Programme) document "Look out! Bedside vision check for falls prevention" (2017).

The first three assessments should be attempted for all patients at risk of falls.

Assessments 4 & 5 should be attempted whenever possible:
1. Ask the patient some specific questions
2. Check distance vision
3. Check near vision
4. Check side vision
5. Check eye movements.

Assessment for other sensory deficits e.g. peripheral neuropathy.

Continence:- including an assessment of urinary function which must include noting the presence of any long term urinary catheter, urgency, frequency and nocturia.

Fear of falling:- using a standardised nationally used assessment tool e.g. Falls Efficacy Scale- International (FES-I) or by assessment of the older person's perceived functional ability and fear relating to falling

Assessment of osteoporosis and of fracture risk

The assessment of osteoporosis and of fracture risk should be considered for all women over the age of 65 and all men over the age of 75,plus in women aged under 65 and men aged under 75 in the presence of risk factors:

- Previous fragility fracture
- Current or frequent use of oral or systemic glucocorticoids
- History of falls
- Family history of hip fracture
- Low Body Mass Index (BMI); Lower than 18.5
- Smoking
- Alcohol intake more than 14 units per week in women and more than 21 units per week in men.

Other secondary causes of osteoporosis should also be considered:

1. Endocrine
    - Hypogonadism in either sex
    - Premature menopause (under age 45) and treatment with aromatase inhibitors or androgen depravation therapy
    - Hyperthyroidism
    - Hyperparathyroidism
    - Hyperprolactinaemia
    - Cushing's disease
    - Diabetes
2. Gastrointestinal
    - Coeliac disease
    - Inflammatory bowel disease
    - Chronic liver disease
    - Chronic pancreatitis
    - Other causes of malabsorption
3. Rheumatological
    - Rheumatoid Arthritis (RA)
    - Other inflammatory arthropathies
4. Haematological
    - Multiple myeloma
    - Haemoglobulinopathies
    - Systemic mastocytosis
5. Respiratory
    - Cystic fibrosis
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Pulmonary Disease
6. Metabolic
    - Homocystinuria
7. Chronic renal disease
8. Immobility
    - E.g. due to neurological injury or disease

Screening for fracture risk can be undertaken using the FRAX online tool.

The following process-based standards must apply across the organisation when managing

patients who have sustained falls in outpatient or community settings:

Where teams are routinely recording their clinical intervention on a computerised health record the Trust is working towards having a commonly agreed 'red flag' or alert that should be used clearly identifying that a Multifactorial Falls Risk Assessment has been completed. This need only be done where the computerised recording system has the facility to do this (e.g. on SystmOne).

Very urgent falls referrals must be responded to by integrated rehabilitation teams, health and social care teams or Rapid/Urgent Response services within 2 hours, following clinician to clinician handover and agreed acceptance of the referral. This will include referrals from the South Central Ambulance Service, which are RAG rated "Red". These patients do not require hospital admission with regards to their fall or other medical conditions, but are considered to be at risk of admission to hospital within the following 24 hours unless urgent support is provided at home. There may also be referrals requiring a more urgent response from the Emergency Department or the GP where the patient is in need of urgent assessment to prevent a health or social crisis, a serious deterioration in their health/physical condition, or admission to hospital.

Other community falls referrals must be responded to as per triage criteria for the waiting list by the appropriate team.

Patients must receive a Multifactorial Falls Risk Assessment (Community Interdisciplinary Falls Assessment in Portsmouth; Comprehensive Falls Assessment in Southampton) and all the elements of this must be documented. If possible this documentation should be on the patient's electronic record. If this is not possible then the electronic record should clearly state which team has completed a paper based assessment, contact details for that team and where the assessment is held

Any registered professional or associate practitioner who has been trained to complete a community Multifactorial Falls Risk Assessment within Solent NHS Trust may provide this initial assessment

The quality of the content of the Multifactorial Falls Risk Assessments will be monitored by twice yearly documentation audits, to ensure that all appropriate elements of the assessments have been completed in adequate detail, and that care planning has taken place. A key worker/case manager will monitor the case until discharged from the service to ensure all actions are taken and appropriate clinical conclusions have been reached. They will monitor care planning documentation.

Care/Action Plan
The care/action planning documentation for patients must identify :-

- Identify the cause/s for any previous fall/s the patient has had
- Identify any other individual risk factor/s for falling for that patient
- Identify modifiable causes and risk factors
- Detail interventions in order to modify those causes and risk factors that are able to be reduced
- Identify any non-modifiable falls risk factors
- Detail any management strategies for any causes or risk factors that which are not modifiable, with particular emphasis on reducing level of harm from

any future falls.

To whom the outcomes of the falls assessment has been communicated. As a minimum this should include the patient and, after seeking consent to share information under information governance policy, the patient's family and GP.

There should be evidence following assessment that the patient has been given relevant written information relating to how they may reduce their own risk of falling. Where it is deemed clinically inappropriate to provide this directly to the patient (e.g. where the patient has significant cognitive impairment) then this information should be provided to their carer/family.

Older people assessed as being at increased risk of falling should have an individualised multifactorial intervention. Multiple interventions can then target the person's specific risk factors and reduce several components of falls risk. The interventions delivered should be tailored to the individual's needs, delivered and documented. Specific components common in successful individualised multifactorial interventions, and which should be included, are:

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification or withdrawal.

Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

Physiotherapy

Patients who are referred for Physiotherapy Assessment as part of their Multifactorial Falls Risk Assessment must be assessed using assessment that identify risk factors relating to balance and mobility limitations, such as muscle strength and gait, and establish which factors are modifiable with exercise or rehabilitation interventions.

The outcome measures used for assessing balance should be selected with consideration taken in relation to the properties of the measure (reliability, validity, sensitivity to change).

The most frequently reported tools for the assessment of balance and gait administered in community dwelling and extended care settings are:

- Timed up and go test (TUAG)
- Turn 180º
- Performance-oriented assessment of mobility problems (Tinetti scale/POAM)
- Functional reach
- Dynamic Gait Index
- Berg balance scale

Physiotherapists involved in Multifactorial Falls Risk Assessments should follow the AGILE Guidelines:

1) To prevent falls
2) To improve the older person's ability to withstand threats to their balance
3) To prevent the consequences of a long lie

4) To optimise confidence and reduce fear of falling

Exercises

Older people living in the community who have a known history of recurrent falls should be referred for strength and balance training. Strength and balance training has been identified as an effective single intervention and as a component in successful multifactorial intervention programmes to reduce subsequent falls.

It is important that strength and balance training is undertaken after a Multifactorial Falls Risk Assessment has been completed.

Patients identified as having gait, strength and/or balance problems will be offered gait re-education and a home exercise programme, targeted at the problems identified at assessment. This individualised and evidence-based strength and balance programme will be prescribed by an appropriately trained health care practitioner (a physiotherapist, or another staff member who has completed OTAGO training or Postural Stability Instructor training).

Effective exercise prescription must be specific to purpose & remain evidence based. It requires the application of the fundamental principles of training to each of the variables of training.

i.e. All exercise prescription should document in detail how often the patient is to do each exercise, how hard (e.g. numbers of repetitions, or time of hold, or resistance used, etc.), how long to do each exercise, exactly what type of exercise (detailed instructions), etc.

Following prescription of a home exercise programme patients must be considered for onward referral to Falls Prevention Exercise groups. There must be documentary evidence of this and also of the reasons why a patient was not referred for exercise if that is not deemed appropriate.

- The Falls Prevention Exercise groups in Portsmouth are organised and delivered by Solent NHS Trust staff.
- Patients in Southampton are referred on to Falls Recovery classes that have been commissioned as Third Sector provision.
- On occasion, alternative exercise referrals may be made (e.g. to the student exercise instructors at Southampton Solent University).

Patients who decline onward referral to the commissioned, evidence-based Falls Prevention Exercise classes may be sign posted to alternative exercise provision in their locality.

All group exercise programmes are to be supported by the patient receiving an individually tailored home exercise programme.

The Falls Prevention Exercise Programmes provided within Solent NHS Trust (Portsmouth) should meet national standards of according to the agreed evidence base. This requires:

- Content to follow that prescribed in Otago or FaME (Falls Management with Exercise) programmes
- Duration of programmes to be 24 weeks or more for those meeting criteria for the full FaME programme
- Shorter programmes for frailer patients to be 12 weeks or more in length with sessions twice per week with the main emphasis being on exercise rather than education
- Wait times to enter classes from the time of referral ideally should be no more than 4 weeks.

Occupational Therapists
Occupational Therapists involved in Multifactorial Falls Risk Assessments should follow the COT Practice guideline (2015)

Home hazard assessment
It is important that home hazard assessment is undertaken after a Multifactorial Falls Risk Assessment has been completed.

Home hazard assessment should be completed using a standardised nationally used assessment tool, such as the Home FAST (Home Falls Accident Screening Tool; Westmead or SAFER (Safety Assessment of Function for Rehabilitation) (Royal College of Physicians, 2011: National Audit for Falls and Bone Health in Older People) in the patient's usual home environment or the environment they are planning to return to as their permanent place of residence. If a home visit assessment has been completed which covers all of the elements of the HomeFAST or Westmead assessment then a HomeFAST or Westmead does not need to be completed in addition to the full Occupational Therapy Home Visit.

Patient Information
Patients should be given the following Solent NHS Trust fact sheets:

- "Falls Service. What to do if you fall. Information for patients"
- "Stay safe at home. Falls prevention. Information for patients"
- if postural hypotension was identified, then "Advice to patients with dizziness due to postural hypotension"
- may also be given "Healthy Bones. Caring for your bones. Information for patients"

Discharge
At the point of discharge, a discharge summary and patient self- management plan should be documented.
An Ambulance Anticipatory/Urgent Care Plan should be written for patients who present with a history of frequent falls

Emergency Department referrals
Solent NHS Trust has staff working within Community Emergency Department (ED) Teams in Portsmouth and Southampton. Appropriate referral and care pathways are in situ to ensure that patients who attend the EDs in Portsmouth or Southampton following a fall, but who are discharged back into the community (and not admitted) are referred on for a full Multifactorial Falls Risk Assessment by the relevant community team.

Community services are considered important because there is a strong evidence base supporting the use of Falls Prevention Exercise in reducing falls. Where services have capacity issues in providing this level of intervention then this must be highlighted to Solent NHS Trust senior managers who should work with Solent NHS Trust associate directors to agree business transformation schemes or to work with local commissioners to find funding to enable this level of service to be provided.

Appendix D – Responding to falls incidents (inpatients)

All patients who fall during a hospital stay must be checked for signs or symptoms of fracture and potential spinal injury before they are moved. When a person falls it is important that they are assessed and examined promptly to see if they are injured. This will inform decisions about safe handling and ensure that any injuries are treated in a timely manner. Checks for injury are included in the post-fall protocol that must be followed for all older people who fall during a hospital stay.

There are a number of options for assisting a fallen person from the floor:

- The person gets up from the floor independently, without any assistance from the handlers.
- The person is instructed by the handler to get up from the floor (without any assistance from the handlers).
- The use of an inflatable cushion.
- The use of a hoist/ other mechanical or electrical equipment.
- Manual lifting in an emergency or exceptional circumstances (This is a high risk activity). ("The Guide to The Handling of People" 6th Edition published by BackCare; the National Back Pain Association in collaboration with the RCN).
- Therapy staff with appropriate training can facilitate the fallen person to get themselves up from the floor.

When a person falls, it is important that safe methods are used to move them, to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery. Safe manual handling methods must be used for patients with signs and symptoms of a fracture or potential for spinal injury. If a patient is known to have communication problems, or a cognitive impairment resulting in unreliable communication, then they should be managed as though they have a lower limb fracture. Standard hoists must not be used for patients with signs and symptoms of a fracture or potential for spinal injury. If staff suspect a lower limb fracture and do not have access to, or have had not had appropriate training in, the use of specialist equipment (e.g. Hoverjack etc.) then the patient must be made safe and comfortable on the floor and emergency assistance summoned via the ambulance service. Where an ambulance response is delayed to over an hour, care must be taken to prevent the complications of a long lie on the floor. If staff suspect a lower limb fracture, have access to and are familiar with the use of a Hoverjack, they may remove the patient from the floor with this device. ALL patients suspected of spinal injury MUST NOT be moved and an ambulance summoned requesting a Category A blue light and sirens response. The ambulance service MUST be informed that the patient has a spinal injury or a suspected spinal injury.

The first set of observations should be completed whilst the fallen patient is still on the floor, and before moving the patient, including checking the Glasgow Coma Scale. If there is concern about the possibility of an acute head injury, the patient should be left on the floor until stable, or consider the use of flat lifting equipment where available.

When an older person falls, it is important that they have a prompt medical examination to see if they are injured. This is critical to their chance of making a full recovery. Older people who fall in hospital should receive a medical examination within **12 hours**.

Neurological observations must be commenced following any fall with a potential head

injury where:

- The patient is more likely to bleed:
- history of bleeding
- clotting disorder
- current treatment with anticoagulants (e.g. Warfarin, Dabigatran, Rivaroxaban, Apixaban & Low molecular weight Heparin), especially if also on an Selective Seratonin Reuptake Inhibitor (SSRI) anti-depressant
- current treatment with an anti-platelet medication (e.g. Clopidogrel, Asprin)
- Fall was unwitnessed
- Struck head or face
- Lumps, grazes or lacerations on scalp or face
- Black eye
- Head pain or headache
- Nose bleed
- Vomiting
- Altered/reduced consciousness
- New dizziness
- New confusion
- New speech disturbance
- New double vision

The frequency and duration of neurological observations for all patients must be based on the NICE Clinical Guideline 176: Head Injury:

- Every 30 minutes for 2 hours
- Then hourly for 4 hours
- Then 2 hourly for a further 4 hours.

The clinical decision for any deviation from this protocol must be documented.

Neurological observations (Neuro Obs) must include:

- 15 point Glasgow Coma Scale:
    - Eye opening (1-4)
    - Best verbal (1-5)
    - Best Motor (1-6)
- Pupil size and reactivity
- Limb movements / muscle power
- Blood Pressure (lying/sitting & standing)
- Respirations.

Patients who have sustained a head injury or other suspected serious injury, must be transferred to the emergency department for medical assessment.

The Criteria for calling an ambulance are also:

- Glasgow Coma Scale (GCS) score less than 13 on initial assessment
- GCS less than 15 at 2 hours after injury
- Suspected open or depressed skull fracture
- Signs of basal skull fracture
- Post-traumatic seizure
- Focal neurological deficit
- More than one episode of vomiting
- Loss of consciousness or amnesia since injury (up to 8 hours post injury) plus one

of:

- Age 65+
- History of bleeding or clotting disorders
- More than 30 minutes retrograde amnesia

Staff must not attempt to get even an **uninjured** patient up from the floor unless they have had appropriate training and feel confident they can do so safely

If the wait for an ambulance response to a patient lying on the floor may exceed one hour, follow the precautions to prevent the complications of a long lie:

- Keep warm
  - Cover the patient with a blanket, rug or quilt
  - Move the patient out of draughts if safe to do so
- Keep the patient moving (unless you suspect a serious injury)
  - Don't let them lie in one position for too long
  - Encourage them to roll from side to side & move arms & legs if possible
- If they need to empty their bladder while on the floor:
  - Use a bottle/continence pad/towel to soak up the wet
  - Try to move the patient away from the wet area if safe to do so.

The Inpatient Falls Prevention Care Plan must be reviewed each time the individual falls and there must be documentary evidence of this.

Appendix E - Post-Fall Checklists (Inpatients)

ADDRESSOGRAPH

	Item	Tick when done or circle yes/no	Outcome	Action
1	Check ABC (airway, breathing, circulation)			
2	Inspect for signs of suspected spinal injury or fracture[1]			
3	Has a head injury occurred?[2]	Yes / No		
4	Was fall unwitnessed?[2]	Yes / No		
5	Does the patient present with vomiting, headache, altered consciousness or dizziness, head pain or tenderness.[2]	Yes / No		
6	If Yes to 3, 4 or 5 please complete neuro obs as per post fall protocol.	Done as per protocol ☐ Not able to do ☐ State why:- Started but not continued ☐ State why:-		(tick as appropriate)
7	Is the patient more likely to bleed? (history of bleeding, clotting disorder, current treatment with warfarin?) [3]	Yes / No See guidance notes over		
8	State any other injuries sustained and action taken			
9	Were obs taken whilst the patient was still on the floor, including pulse, blood pressure, oxygen saturations,	Yes / No		

	temp and [if indicated] blood sugars?				
10	Was urinalysis needed later on?	Yes / No / not needed			
11	Did loss of consciousness cause this fall?	Yes / No See guidance notes over			
12	How did the patient get up from the floor?				
	Date and time medical staff informed. (if medical staff not informed immediately state why)				
	NOK notified				
	Incident report completed		Incident report number:		
	Inform all staff on shift that patient fell?				
	Add to handover sheet that patient fell				
	Review of falls care plan completed				
NAME		**SIGNATURE**		**DATE**	**TIME**

POST FALL CHECKLIST ADVICE NOTES

1. GUIDANCE ON FRACTURES AND SPINAL INJURIES

Signs of **lower limb fracture** might include**:-**

- New deformity
- Pain
- Bruising
- Shortening of the leg
- The leg facing outwards

There might also be other signs therefore this is not an exhaustive list.

Signs of a **spinal injury** might include:-

- Altered sensation in the limbs like numbness or tingling
- Inability to move limbs
- Problems with coordination
- Loss of bladder / bowel control
- Twisted head / neck / back position.

There might be other signs therefore this is not an exhaustive list.

IF EITHER FRACTURE OR SPINAL INJURY SUSPECTED DO NOT MOVE PATIENT.

Summon an emergency ambulance by calling:-

- **SJH/ SMH = 2222**
- **JUBILEE HOUSE = 0300 123 9806**
- **RSH/WCH = 0300 123 9806**

Ensure the team calling the ambulance states clearly to ambulance control that spinal injury or lower limb fracture is suspected and that you have not moved the patient.

Commence observations: temp, oxygen saturations, pulse, blood pressure, respiratory rate and [if indicated] blood sugars. Take measures to maintain privacy and dignity. Proceed to check for head injury as in post falls protocol..

2. GUIDANCE ON HEAD INJURIES

Suspect head injury if:

- Fall unwitnessed
- Vomiting/Nausea
- Headache
- Altered consciousness
- New dizziness
- Head pain or tenderness or visible trauma
- New speech disturbance
- Double vision

Neurological observations (Neuro obs) should then be commenced, & recorded on the appropriate chart.

Neuro obs must include :-

- 15 point Glasgow Coma Scale
- Pupil size and reactivity
- Limb movements / muscle power

Neuro obs must be done:-

- Every 30 minutes for 2 hours
- Then hourly for 4 hours
- Then 2 hourly for a further 4 hours.

IF GCS LESS THAN 15, OR PUPIL SIZE AND/OR REACTIVITY ABNORMAL INITIALLY THEN CALL EMERGENCY AMBULANCE (see numbers above) AND DO NOT MOVE PATIENT. CONTINUE ALL OBS.

IF GCS CONTINUES TO DETERIORATE DETERIORATES THEN KEEP AMBULANCE CONTROL INFORMED. IF GCS DETERIORATES TO 13, CALL AN AMBULANCE.

SHOULD THE PATIENT GO TO THE EMERGENCY DEPARTMENT AND RETURN WITHIN THE PERIOD WHEN NEURO OBS ARE NEEDED THEN CONTINUE THE OBS ACCORDING TO THE TIMINGS STATED. The clinical decision for any deviation from this protocol must be documented.

3. INCREASED RISK OF BLEEDING

Ensure immediate medical review (at the Emergency Department if needed) for all patients with head injury or unwitnessed fall if they have a history of bleeding, clotting disorder or are on currently on anticoagulants or antiplatelet therapy.

Anticoagulants include:

- Warfarin
- Low molecular weight Heparin
- Dabigatran (Pradaxa)
- Rivaroxaban
- Apixaban

Antiplatelet therapies include:

- Clopidogrel
- Asprin

4. GUIDANCE ON LOSS OF CONSCIOUSNESS

If loss of consciousness occurred the patient should be removed to the Emergency Department for assessment. Seek immediate advice of doctor, and if doctor unavailable straight away then call ambulance. Commence Neuro Obs and record on appropriate chart. **NOTE EXAMPLE CHART REMOVED**

Appendix F – Responding to falls incidents in the community

The Community Post-fall protocol must be followed **(Appendix E),** checking for Red Flags (serious injury).

If the risk assessment at the time indicates that an **uninjured** patient is unable to get up from the floor safely and with verbal prompting only, staff must follow the locally agreed procedure for obtaining help.

There are a number of options for assisting a fallen person from the floor:

- The person gets up from the floor independently, without any assistance from the handlers.
- The person is instructed by the handler to get up from the floor (without any assistance from the handlers).
- The use of an inflatable cushion.
- The use of a hoist/ other mechanical or electrical equipment.
- Manual lifting in an emergency or exceptional circumstances (This is a high risk activity).

("The Guide to The Handling of People" 6th Edition published by BackCare; the National Back Pain Association in collaboration with the RCN).

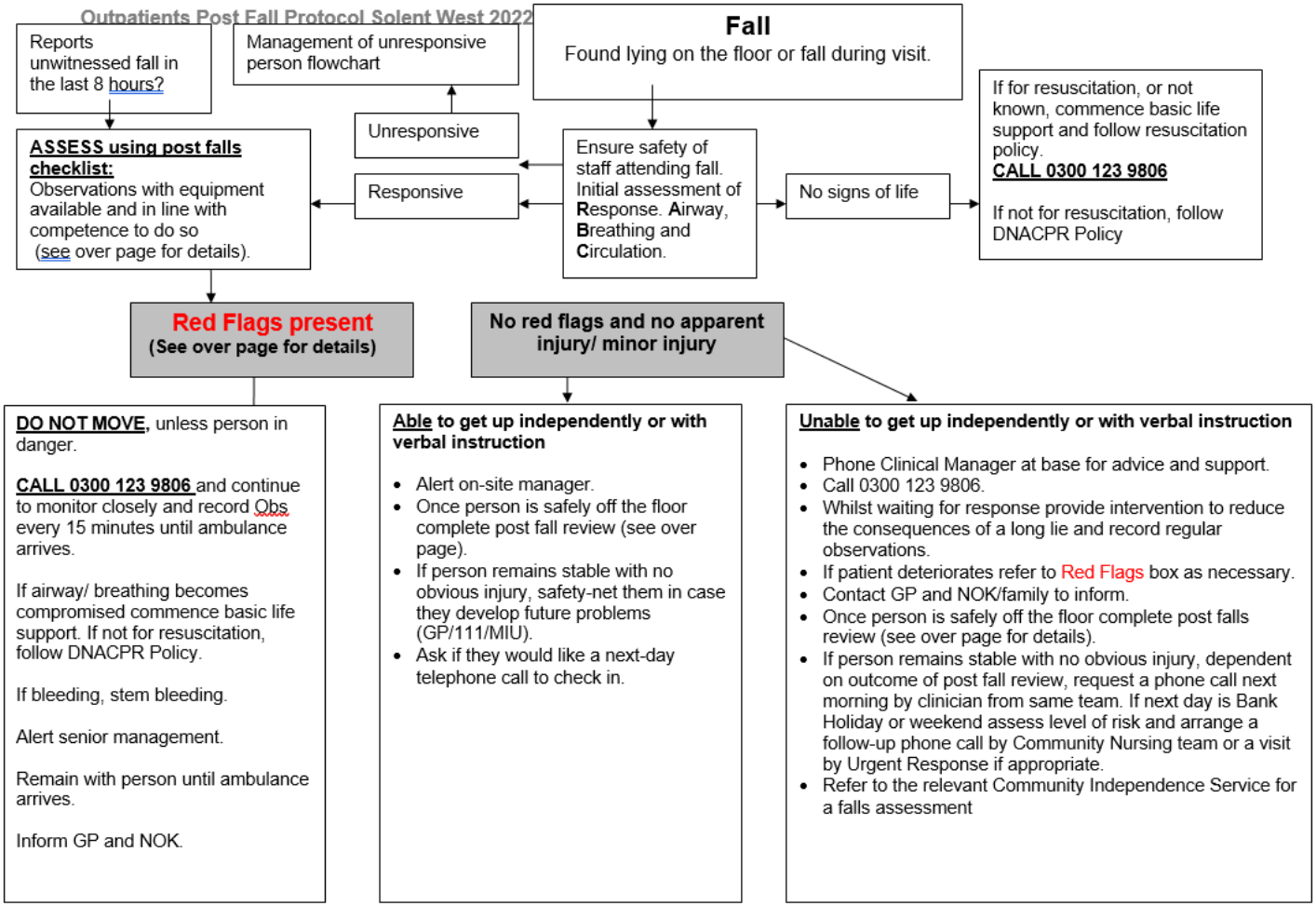
Where access to a lifting device is available (e.g. A Raizer chair or a Mangar ELK from the Urgent Response Service in Southampton), this could be used to assist the patient off the floor. Where this is not accessible, staff will need to call 999 or 0300 123 9806.

If the wait for an ambulance response to a patient lying on the floor may exceed one hour, follow the precautions to prevent the complications of a long lie:

- Keep warm
- Get them to cover themselves with a blanket, rug or quilt
- Move out of draughts if safe to do so
- Keep moving
- Don't let them lie in one position for too long (unless you suspect a serious injury)
- Roll from side to side & move arms & legs if possible
- If they need to empty their bladder while on the floor:
- Use a continence pad/towel/cushion/blanket/cardigan to soak up the wet
- Try to move the patient away from the wet area if safe to do so.

Staff finding a patient on the floor in their own home must ensure that the patient's GP is notified as soon as possible of their fall in all circumstances, as soon as the immediate needs of the patient have been met and the patient is safe to leave.

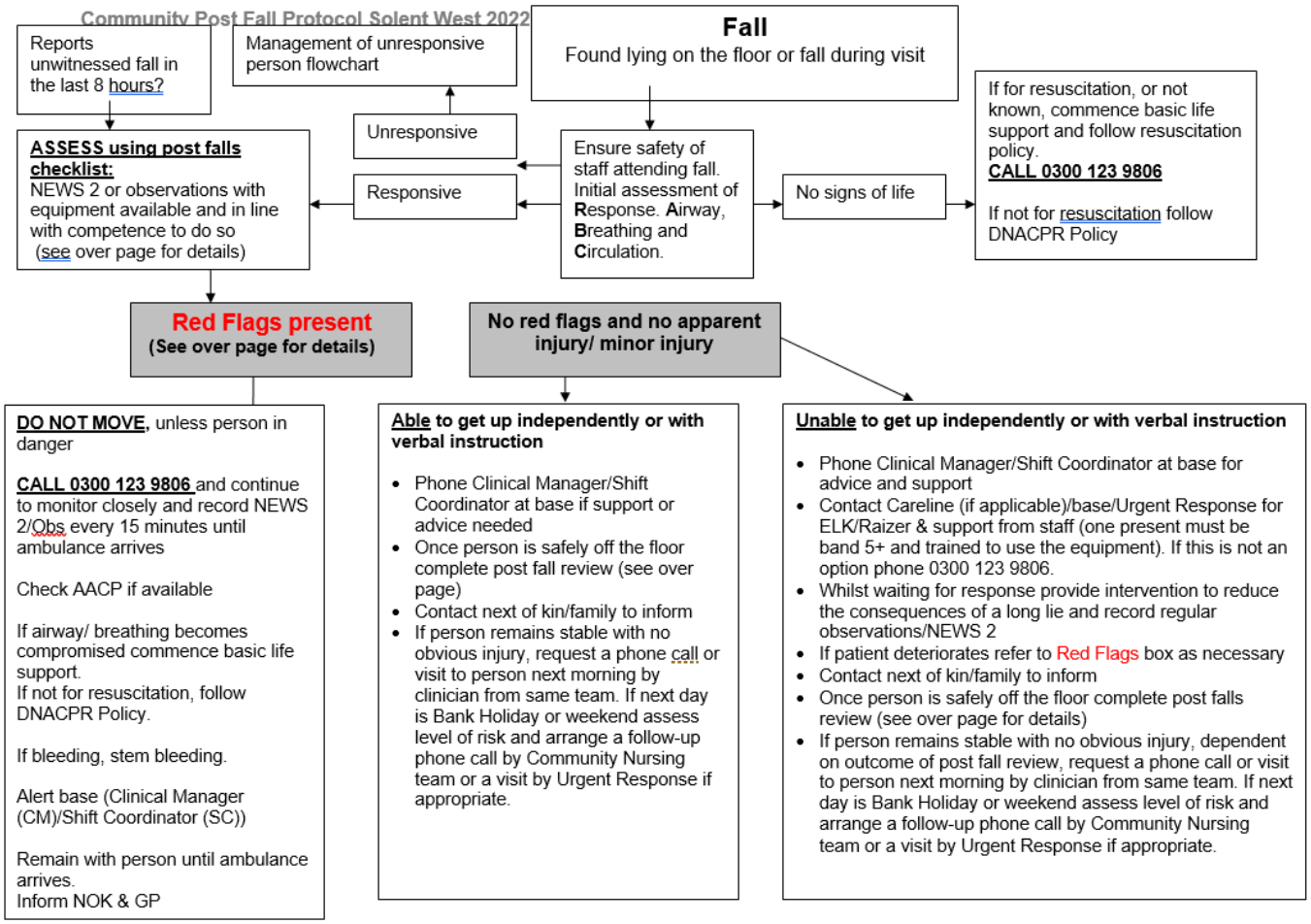
Appendix G – Outpatient Post Falls Protocol and Community Post Falls Protocol



Red Flags	Observations	Post fall review

• Loss of consciousness
• Head Injury
  ○ Altered Consciousness
  ○ Nausea/Vomiting
  ○ Speech disturbance
  ○ Dizziness
  ○ Double vision
  ○ Headache
  ○ Patients on anticoagulants (e.g. Warfarin, Dabigatran, Rivaroxaban, Apixaban & Low molecular weight Heparin and anti-platelet meds e.g. clopidogrel)
• New onset swelling, pain, deformity or loss of use
• New loss of bladder or bowel function
• New loss of co-ordination/paralysis
• New altered sensation
• Observations indicate deteriorating person
• Uncontrolled bleeding
	• Glasgow Coma Scale (GCS)
	• Blood Pressure
	• Pulse Rate
	• Respiratory Rate
	• Patient Colour
	• Skin temperature
		• Re-do Obs
		• Full history of this fall
		• Provide post falls advice including advising person/family/carer to phone 111 if they become unwell
		• Arrange for any observations incomplete due to competency of attendee to be completed by an appropriate professional within your team
		• Consider medical assessment and urgency of this
		• Notify GP and NOK
		• Review current team input
		• Record falls and actions taken in clinical record
		• Refer to Community Independence Service for falls assessment if not known
		• Complete incident report
		• Any change in condition or person deteriorates refer to Red Flags box

Appendix G – Outpatient Post Falls Protocol and Community Post Falls Protocol



Red Flags	Observations	Post fall review

• Loss of consciousness
• Head Injury
  ○ Altered Consciousness
  ○ Nausea/Vomiting
  ○ Speech disturbance
  ○ Dizziness
  ○ Double vision
  ○ Headache
  ○ Patients on anticoagulants (e.g. Warfarin, Dabigatran, Rivaroxaban, Apixaban & Low molecular weight Heparin and anti-platelet meds e.g. clopidogrel)
• New onset swelling, pain, deformity or loss of use
• New loss of bladder or bowel function
• New loss of co-ordination/paralysis
• New altered sensation
• News 2 observations indicate deteriorating person
• Uncontrolled bleeding?
	• NEWS 2
	• Glasgow Coma Scale (GCS)
	• Blood Pressure
	• Pulse Rate
	• Respiratory Rate
	• Temperature
	• Oxygen Saturations
	• Blood Monitors
	• Patient Colour
	• Skin temperature
	• Patient reporting
		• Re-do NEWS 2/Obs
		• Full history of this fall
		• Provide post falls advice including advising person/family/carer to phone 111 if they become unwell
		• Arrange for any observations incomplete due to competency of attendee to be completed by an appropriate professional within your team
		• Consider medical assessment and urgency of this
		• Notify GP and NOK
		• Review current team input
		• Record falls and actions taken in clinical record
		• Refer to Community Independence Service for falls assessment if not known
		• Complete incident report
		• Any change in condition or person deteriorates refer to Red Flags box

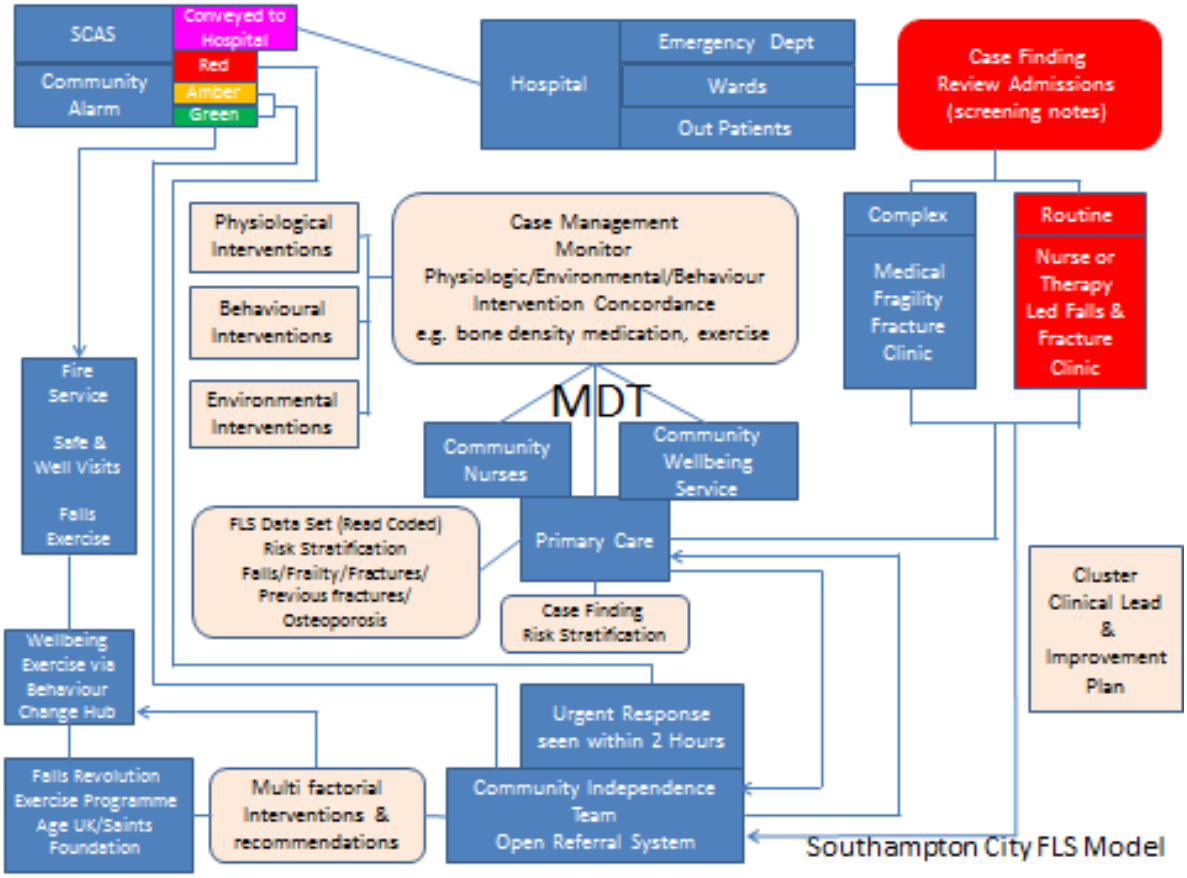
Appendix H – Equality Impact Assessment

Step 1 - Scoping identify the policies aims	**Answer**		
1.What are the main aims and objectives of the document?	To reduce the risk of patients, staff and visitors falling whilst under Solent NHS Trust care.		
2. Who will be affected by it?	Staff, patients and visitors		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	As itemised in full in section 7 of the policy		
4. What information do you already have on the equality impact of this document?	There should be no equality impact. All patients, visitors and staff groups are dealt with equally by the policy and specific clinical measures are stated for older people who are at additional risk.		
5. Are there demographic changes or trends locally to be considered?	As part of this document relates to the reduction of risk of older people falling then the rising numbers of older people will affect the resources required to ensure Solent NHS Trust implements this policy effectively.		
6. What other information do you need?	None		
Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully discriminate against any group?		No	
2. Can any group benefit or be excluded?		No	
3. Can any group be denied fair & equal access to, or, treatment as a result of this document?		No	
4. Can this actively promote good relations with and between different groups?		No	N/A
5. Have you carried out any consultation internally/externally with relevant individual groups?	Yes		With inpatient and community senior managers in services with remits for older people, with Risk team, with Health and Safety team.
6. Have you used a variety of different methods of consultation/involvement?	Yes		Discussion are relevant meetings, face to face meetings with relevant individuals/ group, email

Mental Capacity Act Implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	Yes		As itemised in section 6 of the policy.
External Considerations			
8. What external factors have been considered in the development of this policy?			National Guidelines
9. Are there any external implications in relation to this policy?		No	
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?			Patients in contact with Solent NHS Trust 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.

No negative impact.

Appendix I – Southampton Fracture Liaison Service



The Fracture Liaison Service in Portsmouth is run by Portsmouth University Hospitals NHS Trust.

Appendix J - How to measure postural blood pressure as part of a falls assessment

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

How to measure a lying and standing blood pressure (BP) as part of a falls assessment

1. Identify if you are going to need assistance to stand the patient and simultaneously record a BP.
2. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
3. Explain the procedure to the patient.

Lying

0 min

Ask the patient to lie down for **at least five minutes.**

5 mins

Measure the BP.

Standing

0 - 1 mins

Ask the patient to stand up (assist if needed).

Measure BP after standing in the **first minute.**

3 mins

Measure BP again after patient has been standing for **three minutes.**

Repeat recording if BP is still dropping.

In the instance of positive results, repeat regularly until resolved.

If symptoms change, repeat the test.

Notice and document **symptoms** of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.

Advise patient of results and if the result is positive:

a. inform the medical and nursing team.
b. take immediate actions to prevent falls and/or unsteadiness.

A positive result is:

a. A drop in systolic BP of 20mmHg or more (with or without symptoms).
b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms).
c. A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP).

Appendix K - Home Falls Accident Screening Tool (HomeFAST)

Patient Addressograph Name:

The Home Falls & Accidents Screening Tool (HOME FAST)

Definition: Home refers to both the inside and outside of a person's residential property. As the checklist will be used for visits during the day, answers need to consider the same home environment at night.

	Circle	**Comments/Actions Taken**
FLOORS		
1. Are the walkways free of cords & other clutter?	Yes No	
2. Are the floor coverings in good condition?	Yes No	
3. Are the floor surfaces non-slip?	Yes No	
4. Are loose mats securely fixed to the floor?	Yes No NA	
FURNITURE		
5. Can the person get in & out of bed easily & safely?	Yes No NA	
6. Can the person get up from the lounge chair easily & safely?	Yes No NA	
LIGHTING		
7. Are all the lights bright enough for the person to see clearly?	Yes No	
8. Can the person switch a light on easily from his or her bed?	Yes No	
9. Are the outside paths, steps & entrances well lit at night? *no path, step or entrance – access door opens straight onto public footpath	Yes No NA	
BATHROOM		
10. Is the person able to get on & off the toilet easily & safely	Yes No NA	
11. Is the person able to get in & out of the bath easily & safely?	Yes No NA	
12. Is the person able to walk in & out of the shower	Yes No NA	
13. Is there an accessible/sturdy grab rail/s in the shower or beside the bath?	Yes No	
	Yes No	

14. Are slip resistant mats used in the bath/bathroom/ shower recess? 15. Is the toilet in close proximity to the bedroom?	Yes No	
STORAGE 16. Can the person easily reach items in the kitchen that are used regularly without climbing, bending or upsetting his or her balance? 17. Can the person carry meals easily and safely from the kitchen to the dining area?	 Yes No Yes No	
STAIRWAY/STEPS 18. Do the <u>indoor</u> steps/stairs have an accessible /sturdy grab rail extending along the full length of the steps/stairs? 19. Do the <u>outdoor</u> steps have an accessible sturdy grab rail extending along the full length of the steps/stairs? 20. Can the person easily and safely go up and down the steps/stairs, inside or outside the house? 21. Are the edges of the steps/stairs easily identified? 22. Can the person use the entrance door/s safely and easily?	 Yes No NA Yes No NA Yes No NA Yes No NA Yes No NA	
MOBILITY 23. Are the paths around the house in good repair & free of clutter? 24. Is the person wearing well fitting slippers and shoes? 25. If there are pets, can the person care for them without bending and being at risk of falling over?	 Yes No NA Yes No Yes No NA	
Notes: Consent for assessment? Yes / No Consent for intervention? Yes / No		

Guidance for Completing the Home Falls and Accidents Screening Tool (HomeFAST)

Definition: Home refers to both the inside and outside of a person's residential property. As the checklist will be used for visits during the day, answers need to consider the same home environment at night.

FLOORS	
1	**Are the walkways free of cords and other clutter?** *Definition: No cords or clutter (eg boxes, newspapers, objects) across or encroaching on walkways/doorways.* . *Includes furniture and other items which obstruct doorways, or hallways, items behind doors preventing doors opening fully, raised thresholds in doorways.*
2	**Are the floor coverings in good condition?** *Definition: Carpets/mats lay flat/no tears/not threadbare/no cracked or missing tiles – including coverings on stairs.*
3	**Are the floor surfaces non-slip?** *Definition: Score 'no' if lino or tiles are in the kitchen, bathroom or laundry in addition to any polished floor, or tiles/lino surfaces elsewhere. Can only score 'yes' if, in addition to other rooms, the kitchen, bathroom and laundry have non-slip or slip resistant floor surfaces.*
4	**Are loose mats securely fixed to the floor?** *Definition: Mats have effective slip resistant backing/are taped or nailed to the floor.*
5	**Can the person get in and out of bed easily and safely?** *Definition: Bed is of adequate height and firmness. Person does not need to pull self up on bedside furniture.*
6	**Can the person get up from the lounge chair easily and safely?** *Definition: Chair is of adequate height, chair arms are accessible to push up from, seat cushion is not too soft or deep.*
7	**Are all the lights bright enough for the person to see clearly?** *Definition: No globes to be less than 75w, no shadows thrown across rooms, no excess glare.*
8	**Can the person switch a light on easily from his or her bed?** *Definition: Person does not have to get out of bed to switch a light on at night – has a torch or bedside lamp.*

9	**Are the outside paths, steps and entrances well lit at night?** *Definition: Lights exist over back and front doors, globes at least 75w, walkways used exposed to light – including communal lobbies.*
10	**Is the person able to get on and off the toilet easily and safely?** *Definition: Toilet is of adequate height, person does not need to hold on to sink/towel rail/toilet roll holder to get up, rail exists beside toilet, if needed.*
11	**Is the person able to get in and out of the bath easily and safely?** *Definition: Person is able to step over the edge of the bath without risk, and can lower himself/herself into the bath and get up again without needing to grab onto furniture (or uses bathboard, or stands to use shower over bath without risk).*
12	**Is the person able to walk in and out of the shower recess easily and safely?** *Definition: Person can step over shower hob, or screen tracks without risk and without having to hold onto anything for support.*
13	**Is there an accessible/sturdy grab rail/s in the shower or beside the bath?** *Definition: Rails which are fixed securely to the wall, which are not towel rails, and which can be reached without leaning enough to lose balance.*
14	**Are slip resistant mats used in the bath/bathroom/shower recess?** *Definition: Well-maintained slip resistant rubber mats, on non-slip strips in the base of the bath or shower recess.*
15	**Is the toilet in close proximity to the bedroom?** *Definition: No more than 2 doorways away (including the bedroom door) – does not involve going outside or unlocking doors to reach it.*
16	**Can the person easily reach items in the kitchen that are used regularly without climbing, bending or upsetting his or her balance?** *Definition: Cupboards are accessible between shoulder and knee height – no chairs/stepladders are required to reach things.*
17	**Can the person carry meals easily and safely from the kitchen to the dining area?** *Definition: Meals can be carried safely or transported using a trolley to wherever the person usually eats.*
18	**Do the <u>indoor</u> steps/stairs have an accessible/sturdy grab rail extending along the full length of the steps/stairs?** *Definition: Grab rail must be easily gripped, firmly fixed, sufficiently robust and available for the full length of the steps or stairs.*
19	**Do the <u>outdoor</u> steps have an accessible, sturdy grab rail extending along the full length of the steps/stairs?**

	Definition: Steps = more than 2 consecutive steps (changes in floor level). Grab rail must be easily gripped, firmly fixed, sufficiently robust and available for the full length of the steps.
20	**Can the person easily and safely go up and down the steps/stairs, inside or outside the house?** *Definition: Steps are not too high, too narrow or too uneven for feet to be firmly placed on the steps (indoor and outdoor), person is not likely to become tired or breathless using the steps/stairs and has no medical factor likely to impact on safety on the stairs, eg foot-drop, loss of sensation in feet, impaired control of movement etc.*
21	**Are the edges of the steps/stairs easily identified?** *Definition: No patterned floor coverings, tiles or painting which could obscure the edge of the step.*
22	**Can the person use the entrance door/s safely and easily?** *Definition: Locks and bolts can be used without bending or over-reaching, there is a landing so thee person does not have to balance on steps to open the door and/or screen door.*
23	**Are the paths around the house in good repair, and free of clutter?** *Definition: No cracked/loose pathways, over growing plants/weeds, overhanging trees, garden hoses encroaching on walkways.*
24	**Is the person wearing well-fitting slippers and shoes?** *Definition: Person currently wearing supportive, firmly fitting shoes with low heels and non-slip soles or slippers which have not worn and support the foot in a good position.*
25	**If there are pets, can the person care for them without bending and being at risk of falling over?** *Definition: Pets = any animals that the person has responsibility for. Person does not have to feed pets when pets are jumping up or getting underfoot, person does not have to bend to the floor without available support to feed or clean pets, pets do not require a lot of exercise.*

Reference: Mackenzie L, Byles J, Higginbotham N (2000) 'Designing the Home falls and Accidents Screening Tool (HOMEFAST); Selecting the items'. *British Journal of Occupational Therapy* 63 (6) 280-269 THE HOME FALLS AND ACCIDENTS SCREENING TOOL

Appendix L - Falls prevention in hospital: a guide for patients, their families and carers

This is leaflet.

NAIF patient guide.pdf

Appendix M - What to do if you fall. Information for Patients

This is fact sheet.

Falls%20Service%20What%20To%20Do%

Appendix N - Stay safe at home. Information for Patients

This is fact sheet.

Staying%20Safe%20at%20Home.docx

Staying Safe at home Easy read vers

Appendix O - Advice to patients with dizziness due to postural hypotension

This is fact sheet.

Postural%20Hypotension%20patient%2

Appendix P - Health bones. Caring for your bones. Information for patients

This is fact sheet

Healthy%20Bones%202021.docx

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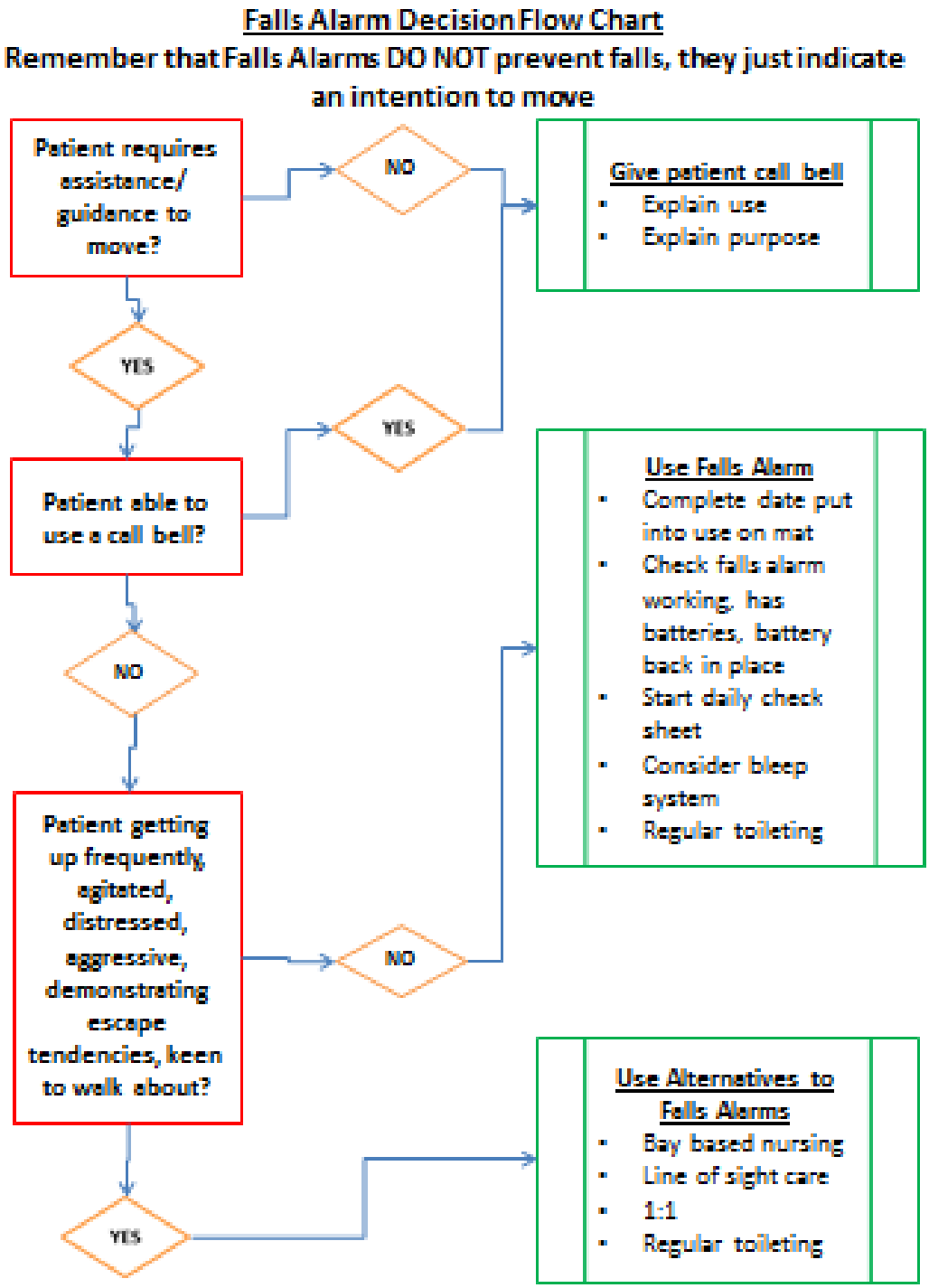
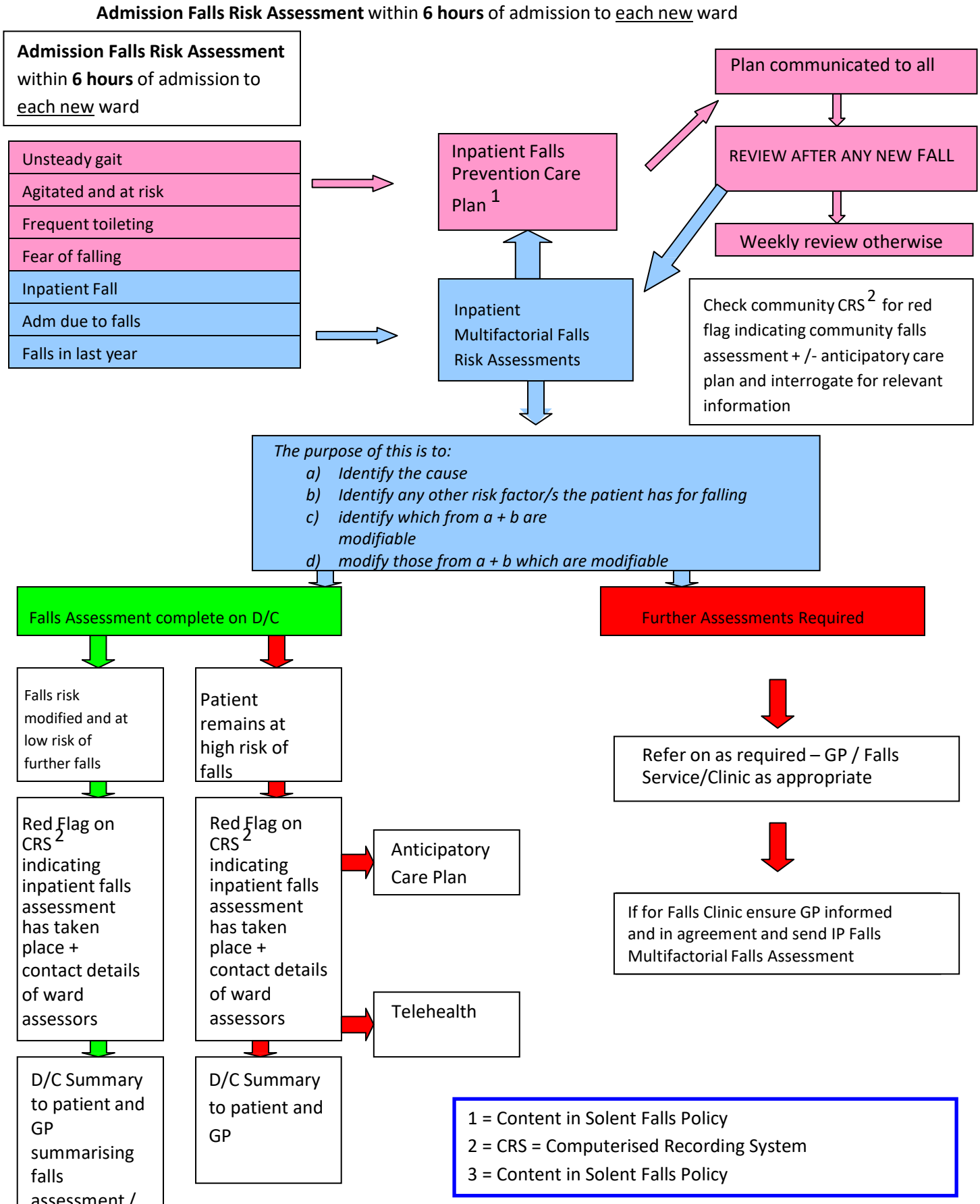
Appendix Q - Falls Alarm Decision Flow Chart



Appendix R - Diagrammatic Representation of Inpatient Falls Pathway



Appendix S - Southampton Community Falls Pathway (Portsmouth under development)