Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Patient Falls

Prevention and Management Policy

This procedural document supersedes: PAT/PS 11 v. 2 – Patients Falls – Prevention and Management Policy

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Author/reviewer: (this version)	Dr Vicky Barradell – Consultant Physician, Health Care of the Older Person
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Approved by:	DBH Falls & Bone Health Group
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Target audience:	All staff

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
PAT/PS 11 **Version 3**	6 July 2017	• Updated Specific Clinical Guidance for Post Falls Management • New guidelines-NICE Quality Standard 86:Falls in Older People, March 2015 • Specific Clinical Guidance included for Falls Assessments for all patients admitted to DBTH over 65 years or under 65 (NICE Clinical Guideline 161, Falls in Older People: Assessing risk and prevention, June 2013) • Specific Clinical Guidance for assessment of patients' needs for enhanced level of supervision (PAT/ PS 20, Enhanced Patient Supervision & Engagement Policy) • Specific Clinical Guidance for assessment of Nurse Call, Safety Sides and Low Beds for all inpatients • New National RCP Guidance on Lying and Standing Blood Pressure and Visual Assessments	Vicky Barradell
PAT/PS 11 **Version 2**	10th July 2014	• Policy transferred from 'Health, Safety, Fire and Security' (CORP/HSFS 23) section back to the 'Patient Safety' (PAT/PS 11) section. • NICE Clinical Guideline 161, Falls in Older People: Assessing risk and prevention, June 2013) • Health & Safety aspects to be considered in separate Health and Safety Policy • Renamed Patient falls prevention and management policy • Specific Clinical Guidance included for each professional group • Specific Clinical guidance included for the management following a fall	Vicky Barradell

CORP/HSFS 8 *Version 3*	*20 March 2012*	• *PAT/PS 11 v.1 transferred and incorporated into body of CORP/HSFS 8 v.3 – Slips, Trips and Falls Policy* • *# neck of femur and serious head injury now reported as a Serious Incident*	*Chris Ellingworth*
PAT/PS 11 **Version 1**	October 2009	• New guidelines – please read in full.	C M Ellingworth

Contents

1. INTRODUCTION

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and over have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year (NICE CG161).

Falls have an impact on quality of life, health and healthcare costs. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year.

Inpatient falls are common and remain a great challenge for the NHS. Falls in hospital are the most frequently reported patient safety incidents, with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day).

For those who are frail, minor injuries from a fall can affect their physical function, resulting in reduced mobility, and undermining their confidence and independence. Some falls in hospital result in serious injuries, such as hip fracture (more than 3,000 per year) and serious head injuries, and these injuries can result in death. Falls in hospitals may also result in increased length of stay and may require increased care costs upon discharge.

Patients who present to hospital following a fall or have fallen prior to admission are at high risk of falling whilst in hospital.

Tackling the problem of inpatient falls is challenging. There are no single or easily defined interventions which, when done in isolation, are shown to reduce falls. However, research has shown that a multifactorial intervention performed by the multidisciplinary team and tailored to the individual patient can reduce falls by 20–30%. These interventions are particularly important for patients with dementia or delirium, who are at high risk of falls in hospitals.

Proactive management of the hospital environment, good housekeeping and systematic and timely multidisciplinary assessment are integral to reducing this risk and subsequent harm to our patients both in hospital and following discharge.

- The policy reflects NICE clinical guideline 161 and Quality Standard 86 (NICE CG 161:2013, NICE QS 86:2015) regarding the need to take action to prevent falls and reduce injury in older people.
- The policy encompasses the key recommendations from the Royal College of Physicians National Audit of Inpatient Falls Report 2015 for acute hospitals in England and Wales (RCP: National Audit of Inpatient Falls, Audit Report, 2015).

2. PURPOSE

The purpose of this policy is to outline procedures to ensure an integrated multi-professional approach is adopted for the management of patients who have fallen or are at risk of falling.

3. DUTIES AND RESPONSIBILITIES

Chief Executive
The Chief Executive has overall responsibility for the implementation of this policy but employer's duties will be delegated down through Directors to Managers and staff as shown below.

Director of Nursing, Heads of Nursing, Matrons, General and Line Managers

- Develop infrastructure in order to safeguard patients in their area of responsibility at risk of falling.
- Support the development and delivery of training.
- Ensure that lessons are learned from incidents and relevant actions are taken and that lessons learned are disseminated throughout the Trust
- Ensure appropriate environmental risk assessments are carried out and actions taken.
- Ensure adequate housekeeping is maintained in their areas of responsibility.
- Ensure patients on wards are receiving appropriate falls assessment.
- Promote a culture within inpatient areas that reflects the individual needs of the patient striking a balance between independence and safety.
- Ensure all inpatient areas have identified at least one falls champion.

All Staff

- Ensure environment is clean and free from trip and slip hazards
- Report incident and near misses using DATIXweb
- Attend training and development as per SET and role specific requirements (see Training & Education page on intranet)
- Ensure that their specific responsibilities are carried out as per this policy

4. PROCEDURE

4.1 Falls Management Overview

Regard the following groups of patients to be at risk of falls:

- **Patients over 65 years of age**
- **Patients under 65 judged to have complex needs because of frailty or an underlying condition e.g. Parkinson's or Stroke**

Patients who are deemed to be at risk (as above) should receive (NICE CG161 2013):

- **Multifactorial risk assessment**

This aims to facilitate the recognition of a patient's individual risk factors for falling and provide a framework for addressing these both whilst in hospital and following discharge.

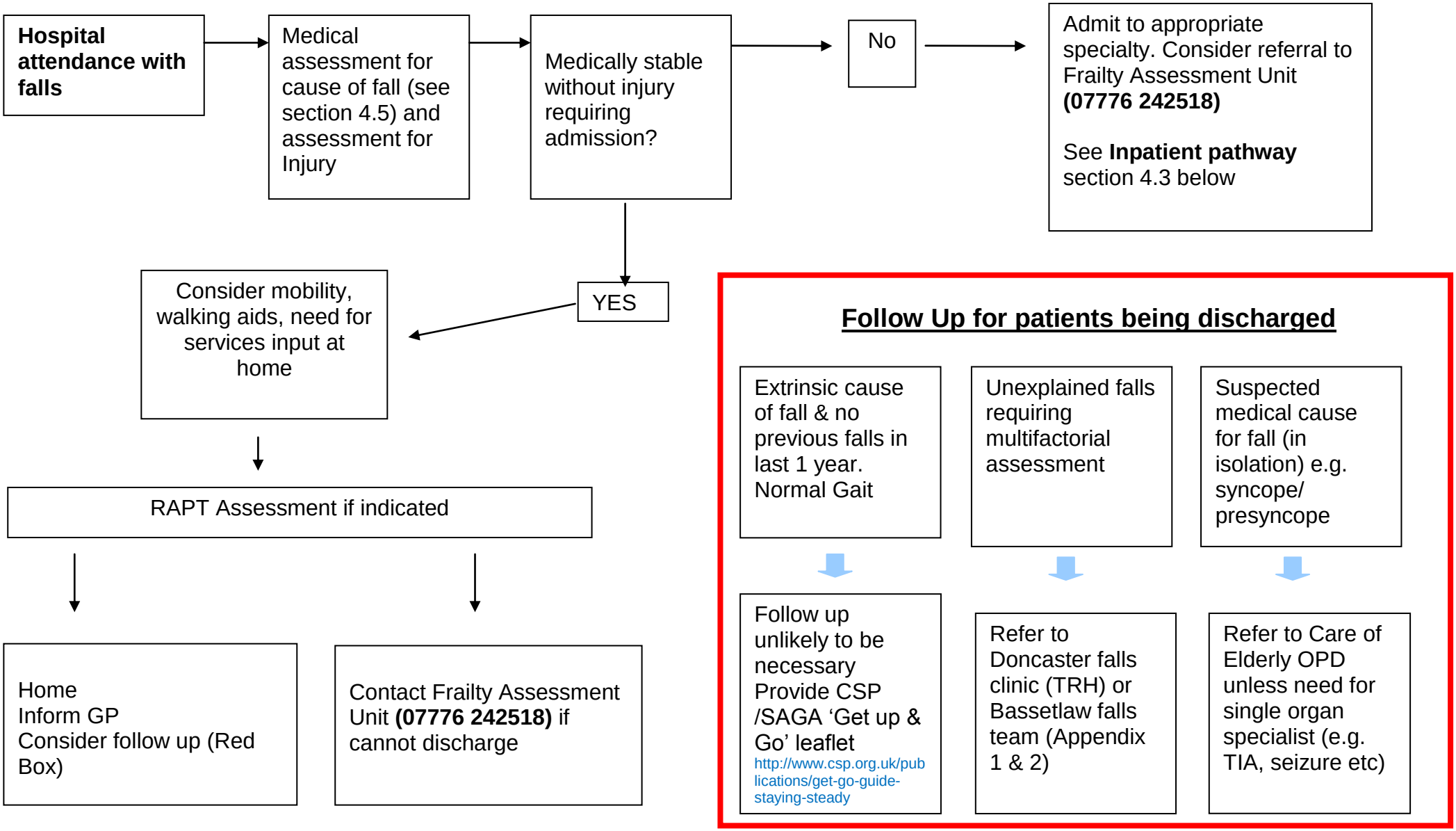
This should include assessment of:

- Falls history, including causes and consequences (such as injury and fear of falling)
- Health problems that may increase their risk of falling
- Fracture risk assessment
- Gait, balance and mobility, and muscle weakness
- Medication
- Footwear
- Cognitive impairment
- Continence problems
- Syncope syndrome
- Visual impairment.

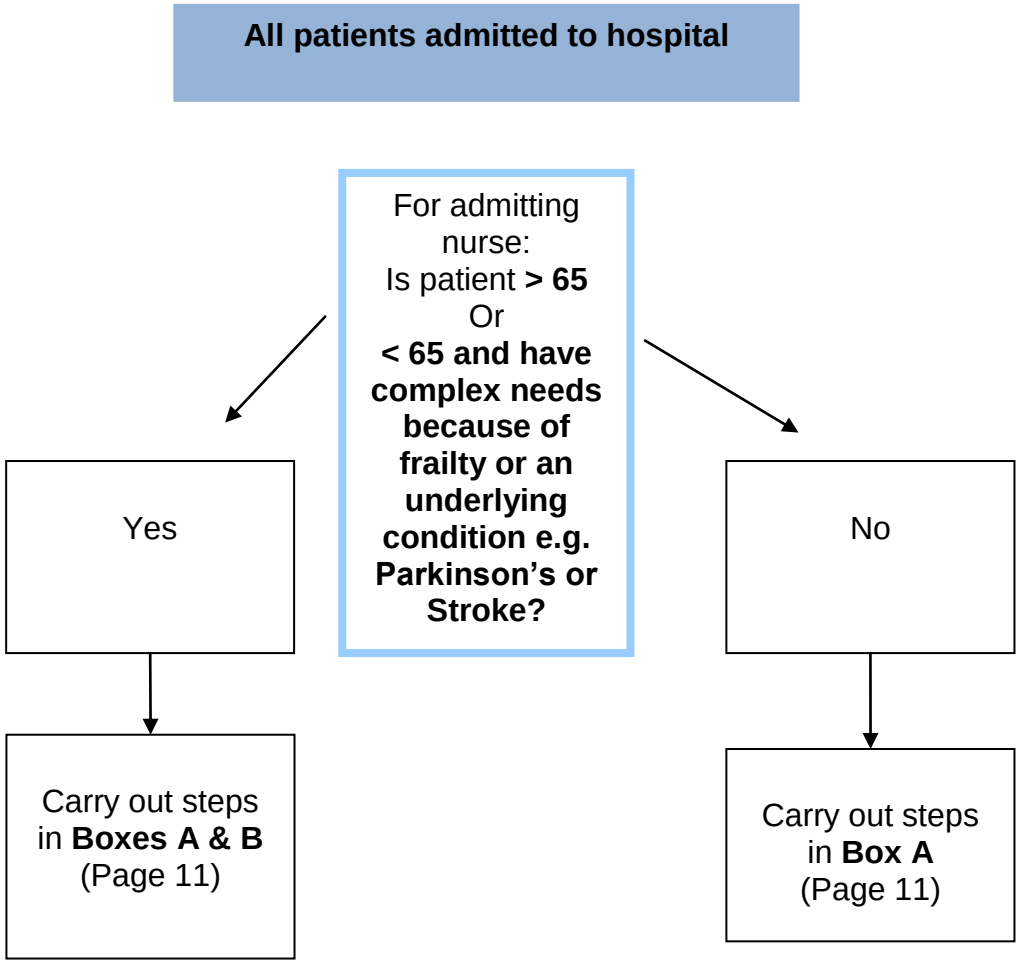
- **Targeted multifactorial intervention**
  Patients should be offered individualised interventions based upon the issues identified in the Multifactorial Risk Assessment.

This document contains a broad guide outlining how to carry out an assessment in order to target interventions.
For Royal College of Physicians (RCP) National Guidance on Bedside Visual Assessments and Lying & Standing Blood Pressure Assessments see Appendix 6.

4.2 Pathway for Patients Attending A&E/MAU with Falls



4.3 Inpatient Pathway



Reassess:

- Enhanced Care Plan **– Commence assessment on admission and complete assessment within 24-48 Hours. Ensure all relevant actions are completed during the patient's admission- Update if patient's condition changes during their inpatient stay.**
- Daily Enhanced Patient Supervision and Engagement Assessment- **Daily**
- Nurse Call, Safety Sides & Low Bed Assessment- **Weekly,** on **Ward transfer,** following an **Inpatient fall** or on **change in clinical condition**

4.4 Nursing Assessment

On admission nursing staff are expected to:

- Implement Enhanced Care Plan (WPR44090) for:
    - All patients over 65 years old
      OR
    - Patient under 65 who have complex needs because of frailty or an underlying condition e.g. Parkinson's or Stroke
    - Other examples of patients in need of Enhanced Care Plan could include:

- A 19 year with a traumatic brain injury
- A 50 year with young onset dementia
- A 60 year old with COPD, previous falls and poor mobility

The above serve only as examples. Clinical judgement should be used to identify patients with needs additional to standard care. If in doubt, discuss with Ward Manager.

The Enhanced Care Plan provides a framework to assess and address the specific holistic needs of these patients (Including a Multifactorial Falls Assessment as per NICE CG161, 2013) incorporating:

- Cognition including dementia and delirium
- Continence
- Mobility
- Falls
- Bone Health
- Medication review
- Nutrition
- Postural Hypotension

A Lying and Standing Blood Pressure should be taken at least once (preferably three times) on all patients on the Enhanced Care Plan.
For RCP National Guidance on Lying and Standing Blood Pressure Assessments please see Appendix 6.

Box A

Actions to be taken for ALL inpatients by all staff

- Implement Daily Enhanced Patient Supervision and Engagement Assessment (WPR44100)
- Implement Nurse Call, Safety Side and Low Bed Assessment (WPR44040)
- Call bell in sight and in reach and patient shown how to use it
- Glasses and hearing aids in place (If worn)
- Appropriate footwear (see Appendix 3) – Slipper socks may be used on admission as an interim measure for those with no appropriate footwear. Please ask relative to bring own footwear in as soon as possible.
- Ensure appropriate mobility aid is available (via physiotherapy if patient's own unavailable)
- Mobility status written above bed
- Ensure environment is safe:
    - Free of clutter and trip hazards
    - Bed on lowest setting
    - Brakes on beds and chairs
    - Belongings within reach

It is the responsibility of all staff on leaving a patient to ensure that the above measures are implemented to keep patient safe

Box B

- Implement Enhanced Care Plan (WPR44090)

Commence assessment on admission and complete assessment within 24-48 Hours. Ensure all relevant actions are completed during the patient's admission- Update if patient's condition changes during their inpatient stay.

- Avoid sedation (including night sedation) where possible
- Avoid catheters and other devices where possible

If a patient has a fall in hospital, please update the following documents and implement the relevant actions:

- **Daily Enhanced Patient Supervision and Engagement Policy**
- **Nurse Call, Safety Sides and Low Bed Assessment**
- **Enhanced Care Plan**

Safety Sides (NPSA 2007) - Assessment Document (WPR 44040)

Indicated if:

Patient is Unconscious/Unresponsive
Or
Patient has requested safety sides
Or
Patient is likely to roll out of bed (Consider air mattress risk)
Or
Patient at risk of rolling out of bed, recent epileptic seizure, dense hemiplegia
AND
Not at risk of climbing over sides

Cautions:

If patient is restless – consider use with safety bumper

If patient has sufficient level of cognition to understand the purpose and risk of safety sides

Risk of patient climbing over safety sides

Fluctuating levels of consciousness or confusion

Low beds (NPSA 2011)

Consider if:

Patient is restless/agitated or likely to climb over safety sides

Patients likely to roll out of bed

Or

Patients unable to stand but frequently trying to mobilise

Cautions:

Very mobile patients

Leaving low beds at a raised height

Low beds as a trip hazard

Risk of entrapment between low bed & walls/furniture

Accessing Low Beds

In hours - Low beds are available from Medical Technical Services via the Bariatric online request form and can be transferred between sites if requested before 13:00 Monday- Friday. Bariatric Low Beds are ordered via the Bariatric online request form & supplied by an external company supplied within 4hrs.

Out of Hours - escalate Low Bed Requests to Clinical Site Manager (Attempts will be made to locate one on site, if unavailable a bed will be ordered from external contracted company & supplied within 4hrs)

Enhanced Supervision:

Complete the Daily Enhanced Patient Supervision and Engagement Assessment on all inpatients over age 18 - **– Daily**

Implement appropriate level of supervision for patient based on overall highest risk identified

Implement interventions and actions appropriate to patient need

Update as required during the day/night or shift if the patient's condition changes, if a fall has occurred or on ward transfer

If you are responsible for providing dedicated supervision to a patient you must not leave that patient unless you have handed over the responsibility to a colleague or it is an emergency situation. In an emergency situation, as soon as appropriate staff are available to deal with the emergency you must return to your patient.

N.B The need to reduce the risk of patients falling in hospital needs to be balanced with the rehabilitation needs of patients and their right to make decisions about the risks they are prepared to take.

If there is inadequate staffing to provide the required level of supervision to a patient at risk of falls this is **a patient safety issue and must be escalated- See DBTH Enhanced Patient Supervision and Engagement Policy- PAT/ PS 20**

4.5 Medical Assessment

Most falls are caused by more than one issue. It is important to identify all precipitating factors and address them in turn. In the majority of falls, particularly in older populations there are medical causes or medications that contribute to the risk of falling:

Medical Assessment	
Falls history	Previous falls including injuries
Assessment for medical causes of falls (History & Examination)	Lying & Standing Blood Pressure Syncope/Presyncope Structural cardiac causes (e.g. valvular disease) Neurological (e.g.Stroke, Peripheral Neuropathy, Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease, Spinal Cord Disease etc) Musculoskeletal causes ENT causes (BPPV, menieres, labyrinthitis, vestibular migraine etc) Delirium & Dementia Continence assessment Visual assessment
Medication review	See advice sheet re: medicines and falls
Bone Health	History of previous fractures (fragility & non fragility) Any female over 75 years of age with fragility fracture should be commenced on treatment for osteoporosis if no contraindication is present Osteoporosis risk assessment. Consider using FRAX tool www.shef.ac.uk/FRAX

Should you require advice regarding the management of a patient with a fall or recurrent falls consider referral to a Care of the Older People Physician.

4.6 Medication Guide

- Older people are at increased risk from the adverse effects of medication due to altered pharmacokinetics, pharmacodynamics, inappropriate prescribing and non-compliance.
- Most drugs lack a sound evidence base proving efficacy in older frailer people, those with multiple comorbidities and in those on multiple medications
- When prescribing any drug it is important to weigh up risks and benefits to the individual involving them in any decision and considering any impact on quality of life

Outlined below are some of the more commonly prescribed drugs that may increase a person's risk of falling (Darowski (2011))

Drug Group	Examples	
Benzodiazepines	Temazepam, Diazepam, Nitrazepam, Chlordiazepoxide,	Sedation, Drowsiness Avoid abrupt withdrawal in those on long term
Z drugs	Zopiclone, Zolpidem	Drowsiness, impaired balance
Sedating antidepressants (Tricyclics)	Amitriptyline, Imipramine, Dosulepin, Lofepramine Mirtazepine, Trazodone	Postural hypotension Drowsiness & impaired balance
Drugs for psychosis & agitation	Chlorpromazine, Haloperidol, Risperidone, Olanzepine	Sedation, poor balance Postural Hypotension
Opioid Analgesics	All opioid analgesics e.g. Morphine, Codeine, Tramadol, Buprenorphine	Cause delirium, slow, sedate, impair balance
Anti- epileptics	Phenytoin, Carbamazepine, Phenobarbitone,	Sedation, slow reactions, unsteadiness, ataxia. Phenytoin can cause permanent cerebellar damage
Muscle relaxants	Baclofen	Sedation, reduced muscle tone
Vestibular Sedatives	Betahistine, Cinnarizine, Prochlorperazine	Sedating. Prochlorperazine causes parkinsonism

Sedating antihistamines	Chlorphenamine, Hydroxyzine	Sedation
Anticholinergics	Oxybutinin, Trospium, Tolterodine	Delirium, sedation, postural hypotension
Alpha blockers	Doxazosin, Tamsulosin	Postural hypotension
Thiazide diuretics	Bendroflumethiazide, Metolazone	Postural hypotension Weakness secondary to hyponatraemia & hypokalaemia
Loop diuretics	Furosemide, Bumetanide	Dehydration causing hypotension
ACE inhibitors	Lisinopril, Ramipril	Postural Hypotension
Angiotension Receptor Blockers	Candesartan, Losartan	Postural Hypotension (maybe less so than ACE inhibitors)
Beta Blockers	Atenolol, Bisoprolol	Bradycardia, Hypotension, Postural Hypotension
Calcium Channel Blockers	Amlodipine, Felodipine Diltiazem, Verapamil	Postural Hypotension Postural Hypotension, Bradycardia

If it is identified that certain medications may be contributing to a persons risk of falling but the parent team do not have the expertise or confidence to review that medication then please consider highlighting this to the GP on the discharge summary or involving hospital pharmacist for advice.

4.7 Clinical Therapies Assessment

Physiotherapy

Indications for a Physiotherapy assessment

- Balance or gait problems
- New difficulty transferring

Assessment required by Physiotherapist for inpatients

- Balance assessment
- Gait assessment
- Transfer ability
- Identify need for:
    - Ongoing rehabilitation
    - Outpatient physiotherapy (this may be via falls clinic or DBTH physiotherapy services dependent on other assessment needs)
    - Occupational Therapy

Occupational Therapy

Indications for Occupational Therapy assessment for inpatients

- If circumstances around the fall highlight an environmental hazard within the home
- Fall associated with difficulty with functional task
- Need for pendant alarm or tele-monitoring

This should not routinely be performed as an inpatient unless essential for discharge.

An outpatient referral to occupational therapy or to Falls Clinic may be indicated if history of the home environment suggests environment is contributing to falls.

4.8 Management following A Fall In Hospital

Actions following an inpatient fall

- Clinical assessment (See algorithm below)
    - If head injury present AND on warfarin or with GCS<14 then assessment should be within 30 minutes
    - Assessment and X-ray within 2 hours if lower limb fracture suspected or head injury with normal conscious level and NOT on warfarin
    - Assessment and X-ray within 4 hours if suspicion of upper limb fracture
- Place yellow sticker in medical notes and in Daily Evaluation of Care (WPR36915) to indicate fall to medical, nursing staff and MDT
- Implement Enhanced Care Plan (WPR44090) if not already in place
- Update Falls section of Enhanced Care Plan (WPR44090) if indicated
- Update Enhanced Patient Supervision assessment and implement the appropriate level of supervision
- DATIXweb report (See section 4.9)

Head injuries or suspected spinal injuries

Follow NICE Head injury Guidance (Appendix 4)

Immediate Management following an Inpatient Fall

Adverse signs
- **Cardiorespiratory arrest**
- **Periarrest**
- **Unconscious**

Call 2222 (or 999 if in MMH)

PRIOR TO MOVING PATIENT
Ensure staff safety
ABCD
Perform observations
Check conscious level

Ask about pain. Look for injury/deformity **BEFORE MOVING PATIENT**

Suspicion of hip or other lower limb fracture

Ensure adequate analgesia
Move patient to bed using Hoveriack

Commence observations as per EWS policy & call Doctor
Patient needs assessment and X-Ray within 2 hours

IV access, IV fluids, NBM
Give opioid analgesia, take bloods including G &S & clotting
If fracture confirmed contact Orthopaedic SpR via switchboard & inform Ward Manager/Matron

Head injury – if accompanied by new neck pain **do not move until Dr arrived**. Obtain hard collar & spinal board from A&E

Commence half hourly neuro obs & call Doctor
Patient needs assessment within 30 minutes if GCS< 14, seizure or new focal weakness (See Appendix 4)

If suspected neck injury log roll patient if competent

Neuro observations every 30 mins for 2 hours, 1 hourly for 4 hours, 2 hourly for 6 hours.
Doctor review if GCS falls by 2 points (See Appendix 4)

Suspicion of upper limb fracture

Move patient to place of safety without using affected arm
Adequate analgesia

Commence observations as per EWS policy & call Doctor.

Patient needs assessment and X-Ray within 4 hours

If fractured confirmed contact orthopaedic SpR via switchboard

Patient is conscious and able to move all limbs normally

Move patient to place where observations can be recorded

Perform observations, blood sugar and call Doctor for review within a maximum of 12 hours.

ALL Patients post fall
DATIX form
Yellow sticker in medical & nursing notes
Senior review of enhanced supervision needs
Inform NOK (immediately if serious injury, daylight hours if not)

4.9 Incident Reporting and Serious Incidents

Incident Reporting

- All falls should be reported via the DATIXweb system (DOH 2001) http://intranet/Corporate-Directorates/Medical-Director/Integrated_Risk_Management_System_Datix.aspx
- Please give as much factual information as you can. Consider the circumstances of the fall and any potential contributory factors.
- If you require training for this please contact DATIX Administrator IRMS.Datix@dbh.nhs.uk
-

How to identify the degree of harm – NPSA Guidance

No Harm (impact prevented) any incident that had the potential to cause harm but was prevented, resulting in no harm (Near Miss)

No Harm (impact not prevented) an incident that happened but no harm occurred

Low – an incident that required extra observation or minor treatment and caused minimal harm (i.e. cuts, bruises, fractured fingers / toes, some skin tears, Grade 2 Pressure Ulcers)

Moderate – an incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment (due to incident) or transfer to another area which caused significant but not permanent harm (i.e. Grade 3 Pressure Ulcers, Fractured arm / leg, unintended injury during surgical procedure). Ask yourself: "If this had happened at home, would you have had to come into hospital for treatment?" If you answer "Yes" then the harm is considered "Moderate" in the first instance.

Severe – an incident that appears to have resulted in permanent harm (i.e. Fractured skull / Neck of Femur, Grade 4 Pressure Ulcer)

Death – an incident that directly resulted in the death of a person

Serious Incidents

- Examples of Serious Incidents resulting from a fall include:
  - Fractured Neck of Femur
  - Skull Fracture
  - Intracranial Haemorrhage

- Any Serious Incident relating to falls **MUST** be reported within 24 hours (or 1 working day)

- A Root Cause Analysis must be completed within 2 weeks (Root Cause Analysis Tool documentation available in Appendix 7)

- The outcome of the Root Cause Analysis should be fed back to the Clinical Falls Lead

4.10 Discharge from Hospital and Follow Up

The indications for follow up include:

- Ongoing medical assessment/treatment (e.g. further investigations, management of postural hypotension, medication review).
- Requirement for Falls physiotherapy programme
- Need for Home Environmental Assessment
- Patient education

These factors can be addressed in the Doncaster Falls Clinic (RDASH at Tickhill Road Hospital) or through the Bassetlaw Falls Team. For referral details see Appendix 1 & 2.

It may be that some of these factors have been addressed during an inpatient stay and therefore a Falls Clinic referral may not be necessary. In this situation consider referral on to individual specialties:

- OPD Physiotherapy
- OT for Home Environmental Assessment
- Care of Older People Clinic
- Specialty medical clinics (Cardiology, Neurology)
- General medical follow up

Discharge letters should include:

- Diagnoses
- Results of relevant investigations
- Changes to medications
- Inpatient falls
- Follow up details
- Interventions completed on the Enhanced Care Plan during inpatient admission and any outstanding actions required on discharge
- Action for GP's to take.

5. TRAINING/ SUPPORT

Increasing knowledge and awareness through information provision and training is a vital part of falls prevention.

Work is in progress to develop profession-specific training programmes for all staff.

Tier 2 training for all clinical staff is available as part of the Person Centred Care Training days. Please contact the Education Centre to book on to these.

Support is available from:

- Area/ward Falls Champions
- DBTH Falls Prevention Practitioner: Esther Lockwood. esther.lockwood@dbh.nhs.uk OR Debbie Searson Deborah.Searson@dbh.nhs.uk
- DBTH Falls Lead Consultant Geriatrician: Dr Victoria Barradell. Victoria.barradell@dbh.nhs.uk

Information in the mean time is available through:

- NICE information CG161 Falls: The Assessment and Prevention of Falls in Older People (2013) http://www.nice.org.uk/nicemedia/pdf/CG021publicinfoenglish.pdf
- http://www.rcplondon.ac.uk/projects/fallsafe
- www.netvibes.com/dbhlibrary and look for the falls tab
- Royal College of Physicians- Falls Prevention in hospital: a guide for patients, their families and carers www.rcplondon.co.uk/fffap
- Get up & Go leaflet- http://www.csp.org.uk/publications/get-go-guide-staying-steady

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Number of falls and Serious Incidents within each Care Group	Care Group Matrons and Clinical Directors	Monthly	Report to individual Care Group Clinical Governance Meetings
Number of falls and Serious Incidents across the Trust	Diane Crozier, Clinical Risk Department	Monthly	DBH Falls & Bone Health Group
Audit of compliance with policy	DBH Falls and Bone Health Group	Periodically	DBH Falls and Bone Health Group

7. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- CORP/HSFS 1 - Health and Safety Policy
- CORP/HSFS 4 - Manual Handling Policy
- CORP/HSFS 23 - Care of the Larger Person Policy
- CORP/ RISK 13 – Policy for the Reporting and \management of Incidents and Near Misses
- CORP/RISK 15 - Serious Incidents (SI) Policy
- PAT/PA 19 - Mental Capacity Act 2005 - Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- PAT/PA 28 - Privacy and Dignity Policy
- PAT/PS 20 v 1- Enhanced Patient Supervision and Engagement Policy

8. DEFINITIONS

ABCD	Airway, Breathing, Circulation, Disability. Systematic approach to the collapsed patient
A&E	Accident & Emergency
AMU	Acute Medical Unit
BDGH	Bassetlaw District General Hospital
CG	Care Group
CSP	Chartered Society of Physiotherapy
DBTH	Doncaster & Bassetlaw Teaching Hospitals
DOH	Department of Health
DRI	Doncaster Royal Infirmary
EWS	Early Warning Score
Fall	An event which results in a person coming to rest inadvertently on the ground or floor or other lower level
FAU	Frailty Assessment Unit
GCS	Glasgow Coma Scale
G&S	Group & Save
IV	Intravenous
MDT	Multi-Disciplinary Team
MMH	Mexborough Montagu Hospital
NBM	Nil by Mouth
NHS	National Health Service
NICE	National Institute for Health & Care Excellence
NOK	Next of Kin
NPSA	National Patient Safety Agency
OPD	Outpatient department
OT	Occupational Therapist
QS	Quality Standard
RAPT	Rapid Assessment Physiotherapy
RCP	Royal College of Physicians
RDASH	Rotherham, Doncaster & South Humber Mental Health NHS Trust
SET	Statutory Education & Training
SOP	Standard Operational Policy
SpR	Specialist Registrar
TRH	Tickhill Road Hospital

9. REFERENCES

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Department of Health (DOH) (2012) Better Care to prevent falls and fractures will improve lives and save the NHS billions

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust, Enhanced Care Plan, WPR44090

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust, Enhanced Patient Supervision & Engagement Assessment Record, WPR44100

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust, Nurse Call, Safety Sides & Low Bed Assessment, WPR44040

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Royal College of Physicians (RCP) (2015) National Audit of Inpatient Falls, Audit Report

APPENDIX 1 – TICKHILL ROAD FALLS CLINIC REFERRAL FORM

ROTHERHAM DONCASTER and SOUTH HUMBER NHS Foundation Trust
DONCASTER COMMUNITY INTEGRATED SERVICES

DAY SERVICES REFERRAL FORM
TICKHILL ROAD HOSPTIAL, WESTON ROAD, DONCASTER DN4 8QL
TELEPHONE: 01302 796456 – FAX: 01302 796112

Failure to complete this form fully may result in it being returned.

PATIENT DETAILS	**GP DETAILS**
NHS No.	GP: GP/Clinician
Surname:	Surgery:
Forename:	Telephone:
Date of Birth:	**NEXT OF KIN**
Address:	Name:
	Telephone:
Telephone No:	Relationship:

FALLS RISK ASSESSMENT TOOL (FRAT)

- **Is there a history of any fall in the previous year? YES/NO**
- **Is the patient on four or more medications per day? YES/NO**
- **Does the patient have a diagnosis of Stroke or Parkinsons Disease? YES?NO**
- **Does the patient report any problems with their balance? YES/NO**
- **Is the patient unable to rise from a chair of knee height? YES?NO**
  (Ask the person to stand up from a chair of knee height without using their arms)

If there is a positive response to three or more of the above questions? Please refer.

INVESTIGATIONS, RESULTS AND TREATMENT TO DATE (please attach documentation)
If not completed this referral will be returned.

Recent blood results YES/NO U & E's ☐ FBC☐ Bone ☐ LFT☐ TFT ☐
B12 ☐ Folate ☐ Glucose ☐

Recent ECG YES/NO Relevant X-Ray results YES/NO Other (please state)

MMSE (Mini mental status examination) done? Score = (out of 30)

REASON FOR REFERRAL .
IS THE PATIENT AWARE OF AND CONSENTS TO THE REFERRAL? YES/NO
Does the patient have the ability to engage in rehabilitation? YES/NO

Rehabilitation YES/NO Medical Review YES/NO Other (please state)

PAST MEDICAL HISTORY

PTO

ANY SENSORY OR COGNITIVE IMPAIRMENT: (please state)
OTHER AGENCIES INVOLVED/REFERRED TO:
HOME SITUATION (delete) HOUSE **YES/NO** FLAT **YES/NO** BUNGALOW **YES/NO** LIVES ALONE **YES/NO** WITH RELATIVE/CARER **YES/NO** RESIDENTIAL/NURSING HOME **YES/NO** CARERS(INC. NUMBER OF CALLS) **YES/NO**
MOBILITY (delete) NO AID **YES/NO** STICKS **YES/NO** CRUTCHES **YES/NO** FRAME **YES/NO** **TRANSFERS** INDEPENDENT **YES/NO** ASSISTANCE (HOW MANY) **YES/NO** USE OF HOIST **YES/NO**
Has the patient got their own transport **YES/NO** Would they be willing to come in at short notice **YES/NO** Would they be happy to receive a text message to come in following a cancellation **YES/NO**
Referred By: Occupation Place of work/Telephone Number Date and Time referred:

APPENDIX 2 – BASSETLAW FALLS TEAM REFERRAL

Patients with a Bassetlaw GP can be referred to the Bassetlaw falls team

Referrals can be made through **Single Point of Access**

Tel: 01777 274422

APPENDIX 3 – FOOTWEAR GUIDANCE

Guidance for assessing in-patient footwear

- Patients should provide their own footwear.
- If they have none with them please ask a relative to supply
- In the short term slipper socks with gripped soles can be used until safe footwear is available

Footwear should….
• Be the correct size • Have fastenings that work and secure the shoe to the foot • Have a gripped sole • Not have a worn down or uneven sole • Not have had the 'uppers' cut away

Staff should ensure
Appropriate footwear is in use prior to mobilising Slipper socks can be obtained via procurement Red- Medium- Order Number:CVW044 Beige-Large- Order Number:CVW032 Bariatric Slipper socks are also available. Contact Procurement Department on a specific patient need basis. Patients with long term medical foot problems should be assessed by an Orthotist (use Clinical Therapies Referral Form) For patients with short term medical foot problems e.g. oedema, gout etc. soft Velcro top shoes can be ordered via Procurement Department (Small ERP084 medium ERP085 and Large ERP086, these are £41 for a pack of 5 and come as singles (NS).

APPENDIX 4 – NICE HEAD INJURY GUIDANCE

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Fall with head injury / suspected head injury - Inpatients

Head Injury: Any trauma to the head, other than superficial injuries to the face

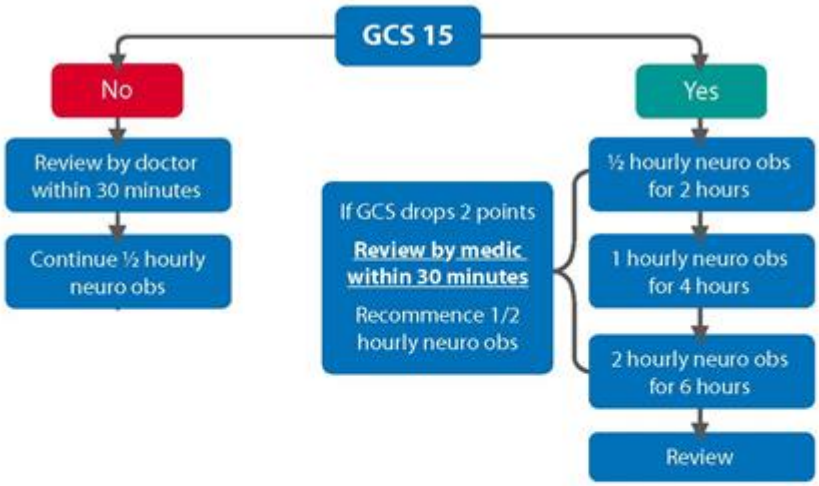
Doctors' Responsibilities:
Assess patient with suspected head injury and perform neurological examination

Nurses' Responsibilities:
Monitor level of consciousness for potential deterioration

Neurological observations **MUST** be commenced on any patient following a fall if any of the following signs / symptoms apply:

- Witnessed head injury
- External bruising, swelling or laceration to the head
- New onset of symptoms suggestive of brain injury: Vomiting, headache, altered consciousness, dizziness
- On anticoagulant therapy (not DVT prophylaxis)
- Pain or tenderness on head

Patient must be commenced on a neurological observation chart and have neurological observations recorded half-hourly (overnight the patient **MUST** be woken up) until Glasgow Coma Scale (GCS) is **15.**

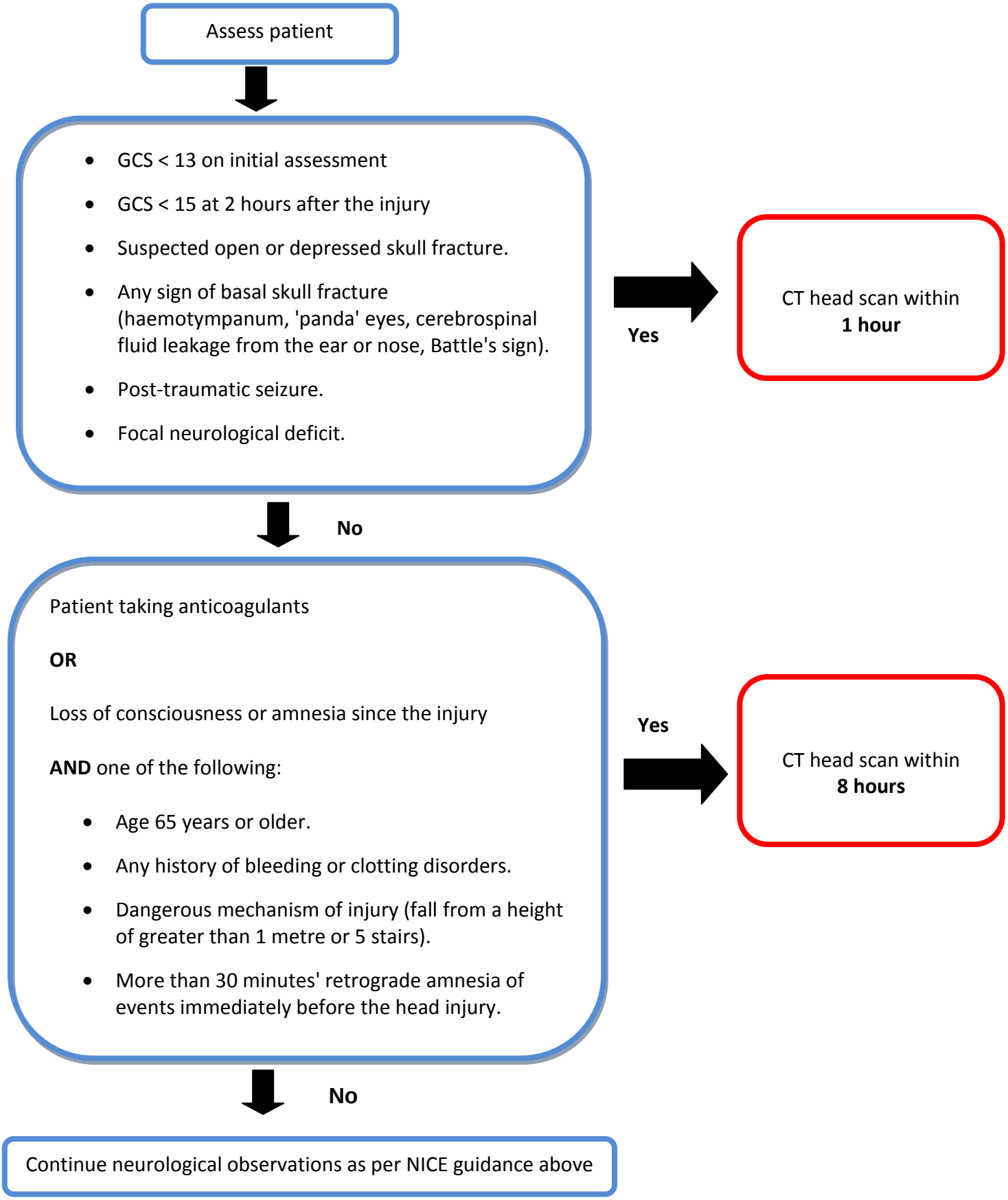


Note
Patients with cognitive decline or dementia may not present in the same way.
As well as above, distinct changes in usual behaviour / level of agitation, restlessness or listlessness will require immediate review.

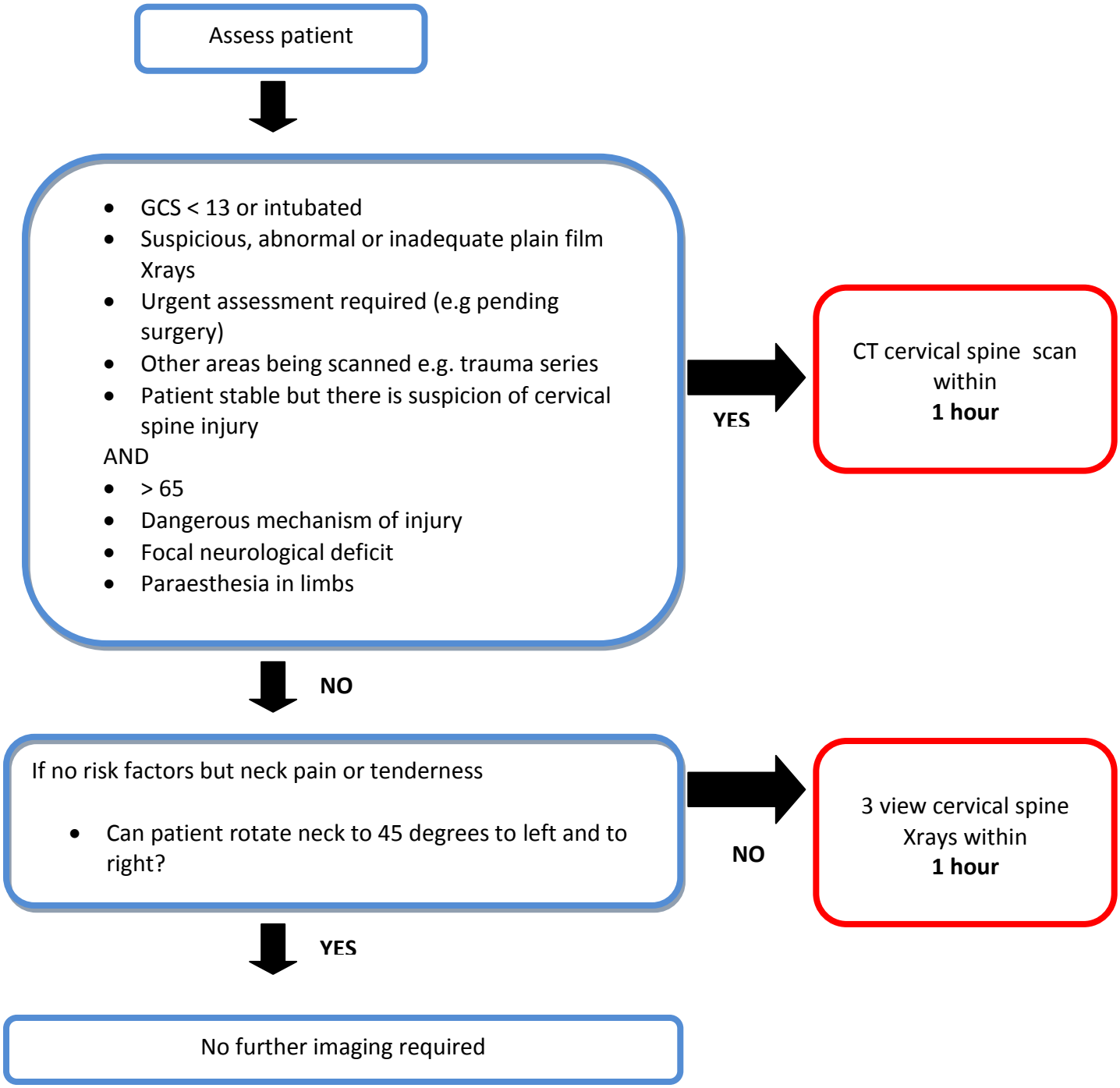
All other post-fall care should continue in line with the falls policy

WPR36290 Dec 2011 WHITE

Indications for urgent brain imaging (NICE CG176)



Indications for urgent cervical spine imaging (NICE CG176)



APPENDIX 5 – EXAMPLES OF ANTICOAGULANTS

Serious Head Injury in patients taking anticoagulants

If a patient has a head injury with evidence of intracranial haemorrhage on brain imaging then the case **MUST BE** discussed with the consultant haematologist on call for consideration of urgent reversal (unless deemed clinically inappropriate by a senior clinician)

Traditional Anticoagulants

- Warfarin
- Acenocoumarol (Sinthrome)
- Phenindione

Unfractionated Heparin

Low Molecular Weight Heparins (prophylactic dalteparin need not be included in this guidance)

- Dalteparin
- Enoxaparin
- Tinzaparin

Newer Oral Anticoagulants

- Rivaroxaban
- Apixaban
- Dabigatran

APPENDIX 6: RCP LYING & STANDING BLOOD PRESSURE ASSESSMENT GUIDANCE & VISION ASSESSMENT GUIDANCE

Measurement of lying and standing blood pressure as part of a multi-factorial falls risk assessment

Procedure:

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

1. Explain procedure to the patient.
2. The first BP should be taken after lying for at **least five minutes.**
3. The second BP should be taken after standing in the first minute
4. A third BP should be taken after standing for three minutes
5. This recording can be repeated if the BP is still falling
6. Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.
7. 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 much less significant than a drop in systolic BP)

8. 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.

9. In the instance of positive results, repeat regularly until resolved.
10. If symptoms change, repeat the test.

https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff

Access RCP Bedside Visual Assessment via:

https://www.rcplondon.ac.uk/projects/outputs/bedside-vision-check-falls-prevention-assessment-tool

APPENDIX 7 – ROOT CAUSE ANALYSIS FORM

To be undertaken for patients who fall & sustain # Neck of Femur or Serious Head Injury

Day	Action	Responsibility
1	Complete adverse incident form. Attach copy with RCA.	Ward Manager / Nurse in charge
	↓	
	RCA tool to be completed on ward.	Ward Manager / Nurse in charge
	↓	
	Inform next of kin or relatives Obtain statements from staff	Ward Manager / Nurse in charge
	↓	
1- 2	Completed RCA to be sent to Matron.	Ward Staff
	↓	
	Contact to be made with family and advise of investigatory process	Matron
	↓	
3 – 9	RCA meeting to be arranged and taken place. Attendees should include: • Consultant/Doctor • Member of falls steering group • Dr who examined post fall • Matron • Physiotherapy • Occupational Therapist (if applicable) • Ward Sister/relevant ward staff If any are unable to attend, a representative must attend in their place.	Matron Please ensure that all attendees have a copy of completed RCA tool before the meeting
	↓	
10	RCA summary and concluding report and action plan to be sent to: • Patients Consultant • Head of Risk • Clinical governance Lead • Divisional Nurse Manager • Chair of falls steering group	Matron
	↓	
4 weeks		Discuss at next Clinical Governance meeting ward manager and matron to present.
	↓	
	Consider appropriate timescales to feedback to family.	Matron
	↓	
		Action plans should be reviewed at Care Group Clinical Governance meetings until all actions complete.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Fall Root Cause Analysis Protocol

District No:……. DoB:…… **Adverse Incident No:** …….

Ward: ……. Care Group: …… NHS No. ……....

Consultant: ……. Injury Sustained: …….....

Admission

Date of admission : ……..

Reason for admission: ……

Admitted from: Home ☐ Nursing Home ☐ Another Hospital (state) ……

Clinical Management: (brief summary) ……

……..

Ward transfers during this admission:

Ward: …….. Date Admission: …….. Date Transfer: ……

Ward: …….. Date Admission: …….. Date Transfer: ……

Ward: …….. Date Admission: …….. Date Transfer: ……

Details of fall:

Date of fall: …… Time of fall: ……

Description of fall:……

Location of fall: ……

Name of staff member who witnessed/found patient: ……

Admission Assessments

Was a moving and handling assessment completed? Yes □ No □

Was a safety side & low bed assessment completed? Yes □ No □

Was a full assessment of the patient's abilities to perform activities of daily living completed? Yes □ No □

Was the enhanced supervision assessment completed on a daily basis? Yes □ No □

Was the patient on the Enhanced Care Plan? Yes □ No □

Comments

……

……

History of previous falls

This admission ……

……

Were staff informed of a risk of the patient falling during handover Yes □ No □

Previous admissions (last 12 months - Information from HMR1/PAS)……

……..

……..

……

Other MDT involvement:

Physiotherapy Yes ☐ No ☐ Date of referral …….

Occupational Therapy Yes ☐ No ☐ Date of referral…….

Speech & Language Therapy Yes ☐ No ☐ Date of referral ……..

Dietician Yes ☐ No ☐ Date of referral …….

Infection Prevention & Control Yes ☐ No ☐ Date of referral …….

List of all staff on duty:

Name	Band / Role	Date statement obtained
LIST ANY WORKFORCE	**DEFICITS AND GIVE REASON**	**FOR DEFECIT**.

Ward Environment Factors (Describe)

Level of Light: ……. Noise: ……..

Floor Texture: ……Was flooring damaged/ripped/lifting?.....

Trip Hazards (e.g. cables) ……..Was any equipment involved: ……

Was the patient being nursed on a low bed: ……..
Was the appropriate level of supervision in place as per daily assessment?.....

Contributory Factors:

Was the patient confused before the fall?		Yes □	No □
Did the patient have safety sides in-situ?		Yes □	No □
Could the patient reach the nurse call buzzer?		Yes □	No □
Did the patient have other means of summoning help?		Yes □	No □
Does the patient have any sight problems?		Yes □	No □
Does the patient wear glasses?	Yes □	No □	N/A □
Was the patient wearing them?	Yes □	No □	N/A □
Does the patient have hearing problems?	Yes □	No □	N/A □
Does the patient use of any hearing aids?	Yes □	No □	N/A □
Was the patient using the hearing aid?	Yes □	No □	N/A □
Is it in full working order?	Yes □	No □	N/A □
Was the patient wearing appropriate footwear?	Yes □	No □	N/A □
Was the patient wearing appropriate clothing?	Yes □	No □	N/A □

Patients continence status before fall……

Ward Management Persons informed of fall and injury:

Ward Staff…….. Date……. Time reviewed…….

Medical Team …… Date……. Time reviewed…….

Patients relatives informed (date/time/designation)……

Matron informed (date/time/designation)……..……

Head of Risk: (date/time/designation) .....

Falls team: (date/time/designation).....

Specific actions following a fall

Following the fall was the Enhanced Supervision Assessment reviewed? Yes ☐ No ☐

Was the appropriate level of supervision implemented? Yes ☐ No ☐

Patient seen by Medical Staff: ……

……

Investigations requested post medical review: ……

……

Has the initial care plan been reviewed: Yes ☐ No ☐

Patient placed on appropriate observations: Yes ☐ No ☐
e.g. Neurological-observations (Head Injuries)

Summary of observations post fall ……
complete ward location map, including where nursing staff were during fall.
(Attach to RCA paperwork).
Has the nurse call, safety sides & low bed assessment been reassessed and actions updated?
Has the Enhanced Care Plan been implemented or updated and the relevant actions implemented?
Have the relevant actions to communicate risk within the team been implemented ?(Patient status at a glance board/ Safety Huddle/ Handover Documentation)

Contributory factors: e.g. skill mix, bed occupancy, ward dependency, medication.

……

……

……

……

……

……

Summary of events

.
Summary of events cont'd……..

Form completed by……Date……

Compliant by RCA Protocol: Yes ☐ No ☐

Falls RCA Meeting

Date …… Time……

Present:

-
-
-
-
-
-
-

Patient Hospital No……..……..Date of Birth ……

Date of Admission ……..……Speciality …….

Ward ……..…...Site……

Findings/conclusions

Inc -- events/contributor factors/was the correct assessments made/was the plan appropriate/was the plan reviewed

Action Plan – to be agreed at the meeting by the team present.

Recommendation	Action	Timescale	By who	Updated progress

Copies to:

Summary completed by: ……

Designation:……

Date:……..

Notes page inc list of documents used during investigation.

APPENDIX 8 : EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/PS 11 v.3	Medical Directors Office	Vicky Barradell	Existing Policy	March 2017

1) Who is responsible for this policy? DBH Falls & Bone Health Group

2) Describe the purpose of the service / function / policy / project/ strategy?

The aim of the policy is to provide specific guidance about the prevention and management of falls for patients in hospital and discharged from hospital.

3) Are there any associated objectives? This policy is in line with the National Service Framework for the Elderly and NICE Clinical Guideline 161

4) What factors contribute or detract from achieving intended outcomes? – This policy will be widely available and will be supported by an education programme

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? No

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: March 2020

Checked by: Vicky Barradell **Date: March 2017**