Please Note: This policy is currently under review.

Patient Falls
Prevention and Management Policy

This procedural document supersedes: PAT/PS 11 v. 4 – Patients Falls Prevention and Management Policy

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Executive Sponsor(s):	Abigail Trainer, Acting Chief Nurse
Author/reviewer: (this version)	Esther Lockwood, Falls Prevention Practitioner
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Approved by:	DBTH Falls & Bone Health Group Patient Safety Committee
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Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 5	October 2022	• Added additional reference to Royal College of Physicians National Audit of Inpatient Falls Report 2020 • Changed Get Up and Go Leaflet WPR number (Page 10). • Reference to Enhanced Care Plan removed throughout. • Replaced reference to Daily Enhanced Patient Supervision and Engagement Assessment to Falls & Confusion Assessment throughout. • Replaced reference to Nurse Call, Safety Sides and low bed assessment to Safety Sides Assessment throughout. • Removed Nursing Assessment guidance linked to enhanced care plan. • Added in Box A (Page 11) consideration for fall risk factors and lying and standing blood pressure guidance. • Updated reference to 2021 version of Medicines and Healthcare Products Regulatory Agency (MHRA, 2021) • Added recommendation of crash mats and advised these will be delivered with the low beds. • Updated Daily Evaluation of Care (WPR36917). • Updated Immediate Management following an Inpatient Fall to encourage adequate Analgesia and new guidance for if the fall is unwitnessed and the patient has cognitive or communication limitations. • Added link for patient safety section on the Hive. • Section 6 – changed Patient Safety Team to Falls Practitioner under who will carry out monitoring.	Esther Lockwood

		• Updated references section with NPSA 2011 and RCP 2020. • Updated Head & Neck Guidance on Appendix 3.	
Version 4	4 March 2021	• New WPR numbers for Enhanced Care Plan and Safety Sides assessments • Update to access to low beds section • Minor wording changes • Clinical Therapies Assessments (section 4.8) updated • Management following an inpatient fall (section 4.9)updated • MHRA text updated pages13/14 • MIFIT Process added page 22 • Root Cause Analysis pages removed from Appendix (Previously Appendix 6) • Added Appendix 6 & 7.	Esther Lockwood
Version 3 (amended 31 Oct 2018)	31 October 2018	• Early Warning Score (EWS) replaced with National Early Warning Score (NEWS2) throughout.	
Version 3 (amended 17 Nov 2017)	24 November 2017	• Incorporates Safety Sides Policy and Daily Supervision and Engagement Policy (recently updated). • Contact details for Doncaster Falls Service updated. • Generic email addresses now available for enhanced care team, falls prevention team and person centred care team. • Minor wording changes (e.g. A&E replaced with ED). • Equality Impact Assessment section added.	Vicky Barradell
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	Vicky Barradell

		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.	
Version 2	10 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

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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, 2017 & 2020 for acute hospitals in

England and Wales (RCP: National Audit of Inpatient Falls, Audit Report, 2015, 2017 & 2020).

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. This policy incorporates the safe use of Safety Sides.

3 DUTIES AND RESPONSIBILITIES

3.1 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.

3.2 Chief Nurse, Deputy Directors of Nursing, Divisional Directors of Nursing, Heads of Nursing, Matrons 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.

3.3 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 management according to NICE CG161 2013:

<u>Multifactorial Risk Assessment</u>

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.

<u>Targeted Multifactorial Intervention</u>

Patients should be offered individualised interventions based upon their risk factors.

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 5).

4.2 Pathway for Patients with falls attending ED and other assessment areas

Hospital attendance with falls

→ Medical assessment for cause of fall (see Section 4.5) and Assessment for Injury

→ Medically unwell or injury requiring admission?

YES → Admit to appropriate specialty. Consider referral to Frailty Assessment Unit **(07776 242 518)** See **Inpatient pathway** Section 4.3 below.

NO → Consider mobility, walking aids, need for services input at home

→ RAPT Assessment if indicated

→ Home
Inform GP
Consider Follow Up
(see Red Box)

→ Contact Frailty Assessment Unit **(07776 242 518)** If cannot discharge or refer to medicine for frailty bed out of hours

Follow Up for Patients being Discharged

Extrinsic cause of fall & no previous falls in last 1 year. Normal Gait

→ Follow up unlikely to be necessary Provide 'Get up & Go' leaflet (WPR48620) http://www.csp.org.uk/publications/get-go-guide-staying-steady

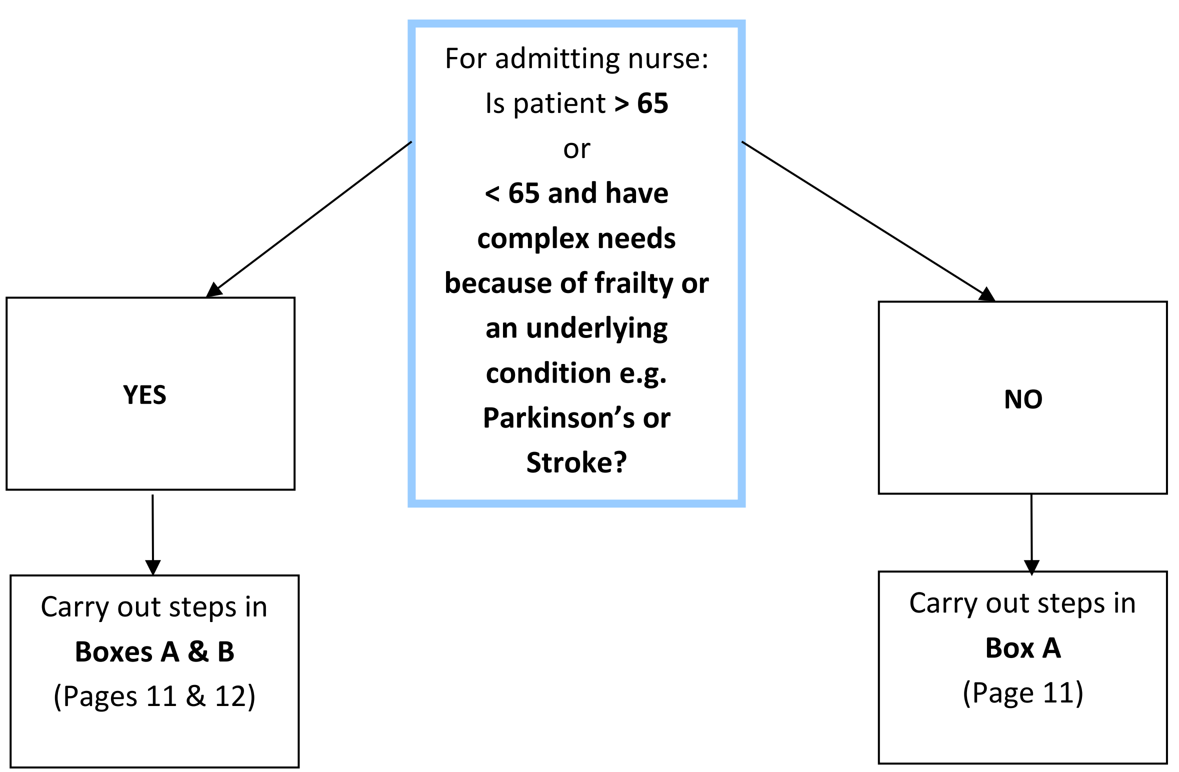
Unexplained falls requiring multifactorial assessment

→ Refer to Doncaster community services or Bassetlaw falls team (Appendix 1)

Suspected medical cause for fall (in isolation) e.g. syncope/ presyncope, Postural Hypotension/ Decreased BP

→ Refer to Care of Elderly OPD unless need for single organ specialist (e.g. TIA, seizure etc.)

4.3 Inpatient Pathway



Reassess:

The Falls & Confusion Assessment
Daily. Complete on Nervecentre under assessments.

Safety Sides Assessment
Weekly, on ward transfer, following an Inpatient fall or on change in clinical condition (a change in condition which would alter the patient's risk of falls – this is at the discretion of the nurse in charge).
Complete on Nervecentre under assessments.

<u>Box A</u>

Actions to be taken for <u>ALL</u> inpatients by all staff:

- Implement Falls & Confusion Assessment (Nervecentre).
- Implement Safety Side Assessment (Nervecentre).
- 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 2**) – 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 patients own unavailable) DRI: 7 days a week. Monday – Friday 8am – 6pm: Usual ward therapist. Weekend and Bank Holidays 8am – 6pm via bleep 1481
Bassetlaw: 7 days a week. Monday – Friday 8am – 6pm: Usual ward therapist. Weekend and Bank Holidays 8am – 6pm via Switch board
Mexborough: 6 days a week, Monday – Saturday 8am – 4pm: Usual ward therapist
- Mobility status written above bed and mobility aid, if used, is within reach of the patient.
- Ensure environment is safe:
    - Free of clutter and trip hazards
    - Bed on lowest setting
    - Brakes on beds and chairs
    - Belongings within reach

Box B

- For all patients over 65 year old or patients under 65 who have complex needs because of frailty or an underlying condition e.g. Parkinson's or Stroke, consider assessing or addressing the specific holistic needs of these patients incorporating:
    - Cognition including dementia and delirium
    - Continence
    - Mobility
    - Falls
    - Bone Health
    - Medication Review
    - Nutrition & Hydration (see Appendix 8 for further information)
- Postural Hypotension (if identified, provide the patient/carer or family with patient information leaflet WPR48510 "Postural (Orthostatic) Hypotension")
- A lying and standing blood pressure should be taken at least once (preferably 3 times) on all patients over 65 years. For RCP National guidance on lying and standing blood pressure assessments. (See **Appendix 5**).
- Avoid sedation (including night sedation) where possible.
- Avoid catheters and other devices where possible.

If a patient has a fall or near miss in hospital:

- Please reassess the following:
    - Falls & Confusion Assessment (Nervecentre)
    - Safety Sides Assessment (Nervecentre)
- Report incident and near misses using DATIXweb.
- Follow the Immediate Management Following an Inpatient Fall (Page22)

4.4 Safety Sides

The only appropriate use of Safety Sides is to reduce the risk of patients accidentally slipping or rolling out of bed. Identify the need for the use of Safety Sides, using the Safety Side Assessment (Nervecentre). It is recommended that Safety Sides should be used in the following circumstances:

- When moving a patient on an Emergency Department trolley.
- When moving a patient on a theatre trolley.
- When moving a patient between departments/areas on a bed.
  (Please refer to the Manual Handling Risk Assessment for bed/trolley movement).

Beyond this, a decision with respect to Safety Sides will be based upon patient choice, risk of rolling out of bed or risk of climbing over Safety Sides. It is recommended that the patient and/or carers are asked if the patient uses safety sides at home, whilst this would not alter the risk assessment outcome of the patient in their current inpatient condition, it may be helpful in person centred care and discharge planning. It is recommended the assessment will be discussed with the patient and/or carers and the date recorded on the Nervecentre Assessment. If a patient has been assessed as having capacity, they should be included in the decision making process. For those lacking capacity, a decision made on their behalf should be done so in their best interests.

Reassessment will take place weekly, on ward transfer, following an inpatient fall or on change in clinical condition *(a change in condition which would alter the patient's risk of falling out of bed or climbing over Safety Sides – this is at the discretion of the nurse in charge).*

Cautions with Safety Sides

Safety Sides **must not** be used as a restraint: Safety Sides will be used "to help a patient avoid doing something they do not want to do (fall out of bed) and **not** to stop a patient doing something they do want to do (get out of bed)".

Where a person is at risk of climbing over safety sides the use of a low bed or additional supervision may be indicated.

Direct hazards include entrapment and entanglement either within gaps in the rails themselves, between the rails and the mattress or between the rails and the bed frame. In the most serious cases, this has led to asphyxiation and death of bed users if they have trapped their head between rails or been unable to free themselves from a position and suffered postural asphyxiation. Severe limb damage has also been reported in cases where someone has become entangled in bed rails. Indirect hazards are also present: cases have been reported where bed users have been confused or disoriented and have tried to get out of the bed by climbing over the bed rails. Users have then fallen from a greater height than would otherwise be the case, increasing the severity of injury. Bed rails are 'medical devices', which fall under the authority of the Medicines and Healthcare Products Regulatory Agency (MHRA, 2021). MHRA enforces the Medical Devices Regulations and the General Product Safety Regulations to ensure medical devices are acceptably safe.

Safety Sides

Indicated if:

Patient is Unconscious/Unresponsive

or

Patient has requested safety sides

or

Transporting a patient on the bed between wards/bays

or

Patient at risk of rolling out of bed, recent epileptic seizure, dense hemiplegia

AND

Not at risk of climbing over sides (consider air mattress risk)

Cautions:

If patient is restless, consider whether patient has sufficient 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

Consider if:

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

or

Patients unable to stand but frequently trying to mobilise

Cautions:

Very mobile patients (consider enhanced supervision).

Leaving low beds at a raised height.

Low beds as a trip hazard.

Risk of entrapment between low bed & walls/furniture.

SAFETY SIDES ASSESSMENT CAN BE COMPLETED ON NERVECENTRE UNDER ASSESSMENTS

Accessing Low Beds

All Low Beds are Bariatric Low Beds used within the Trust are now hired into DBTH. To order or return Low/Bariatric Low Beds, click on:

- Electronic Forms icon on desktop
- Medical Technical Services
- Bariatric Equipment Hire and Low Beds (Medstorm)
- Complete the request form details

It is recommended that a soft foam mattress/crash mats is used at the side of the Low Bed when in use for the patient's safety and prevention of injury if the patient rolls off the Low Bed. These will be delivered by Medstrom with the low Beds.

Falls & Confusion Assessment
Identification of Enhanced Supervision needs:

Complete the Falls & Confusion Assessment (Nervecentre) on all inpatients over age 18 – **Daily**

Implement appropriate level of supervision for patient based on outcome of Nervecentre assessment.

Implement interventions and actions appropriate to patient need.

Reassess and complete assessment on Nervecentre 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 it is appropriate and other staff are available to deal with the emergency, you must return to your patient. See Appendix 7.

Note:
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.**

Patient with escalating challenging behaviour who has been identified as at risk of falls:

- Ensure "Five for Falls" around bedside. See **Appendix 6**.
- Consider environment beyond bedside – bags on floor, wires, bins, doors.
- Purple (1:1) interventions where possible (Enhanced Supervision & Engagement Policy PAT/PS 20).
- Consider TIME AND SPACE and possible reasons why patient is behaving this way. See Appendix 7.
- Safety of other patients and staff:
  - Ensure space from patient, consider moving other patients away from them.
  - Observation from a safe distance, and attempting de-escalation techniques.
- Document that patient's behaviour is becoming more challenging and managing falls risk will increase alongside this.
- See **De-escalation: Principles and guidance including restraint PAT/PS 15.**

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, Meniere's, 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, Olanzapine	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, Enalapril	Postural Hypotension
Angiotensin Receptor Blockers	Candesartan, Losartan, Irbesartan	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 person's 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

<u>Indications for a Physiotherapy and/or Occupational Therapy Assessment</u>

- Balance or gait problems.
- New difficulty transferring (bed, chair, toilet, commode).
- Significant falls history or struggling to cope at home prior to admission.
- If circumstances around the fall highlight an environmental hazard within the home.
- Fall associated with difficulty with functional task.

<u>Assessment required by Physiotherapist and/ or Occupational Therapists for inpatients</u>

- Balance assessment.
- Gait assessment.
- Joint range of movement and muscle strength.
- Transfer ability.
- Assessment tools may include: Timed up and go test (TUAG), 180 degree turn test, Tinetti Performance Oriented Mobility Assessment (POMA), Elderly Mobility Scale.
- Check use of and / or provide appropriate mobility aid with 24 hours of admission:
  DRI: 7 days a week. Monday – Friday 8am – 6pm: Usual ward therapist. Weekend and Bank Holidays 8am – 6pm via bleep 1481
  Bassetlaw: 7 days a week. Monday – Friday 8am – 6pm: Usual ward therapist. Weekend and Bank Holidays 8am – 6pm via Switch board
  Mexborough: 6 days a week. Monday – Saturday 8am – 4pm: Usual ward therapist
- Identify need for:
  - Ongoing rehabilitation – bed base or community physiotherapy.
  - Community Physiotherapy (this may be via falls clinic or community physiotherapy services dependent on other assessment needs).
  - Provision of minor assistive equipment (such as toilet frames and commodes).
  - Referral for minor adaptations such as stair rails, and grab rails.
  - Refer to Social Service OTs for bathing assessments and major adaptations.

4.8 Management Following a Fall in Hospital

- Clinical assessment (See algorithm on page 23).

  If head injury present AND on anti-coagulant medication or with GCS <15 after the fall then assessment should be as quickly as possible. Escalate via bleep to the Nervecentre coordinator. Ensure clear communication is provided that the patient has had a head injury and the patients GCS score. Urgent follow up of the request is required if the patient is not seen within the 15 minutes.

  - Assessment and X-ray within 2 hours if lower limb fracture suspected or head injury with the individuals' normal conscious level and NOT on anti-coagulant medication.
  - Assessment and X-ray within 4 hours if suspicion of upper limb fracture.
  - A post fall review document (WPR 48750) must be completed immediately following the inpatient fall. The document must be jointly completed by the nursing and medical teams and filed in the patient's current episode of clinical admission notes.

- Place yellow stickers in medical notes, in Daily Evaluation of Care (WPR36917) and fold and stick one to the side of the Daily Evaluation of Care sheet to be visible from the outside of the patients file to indicate fall to medical, nursing staff and MDT.
- Reassess and update Falls & Confusion and Safety Sides Assessments and implement the appropriate actions.
- DATIXweb report (See Section 4.9).
- <u>Unwitnessed falls</u> where circumstances of the fall and injury from the fall cannot be ascertained from the patient, due to pre-existing confusion or communication limitations, please follow the post fall guidance for suspicion of hip or other lower limb fracture and suspicion of head injury until both of these injuries have been ruled out.

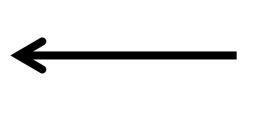
Head injuries or suspected spinal injuries

Follow NICE Head injury Guidance (Appendix 3)

Examples of Anti Coagulants (Appendix 4)

Immediate Management following an Inpatient Fall

Adverse signs
- Cardiorespiratory arrest
- Periarrest
- Unconscious



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

Call 2222 (or 999 if in MMH)

Look for injury/deformity **BEFORE MOVING PATIENT.** Ask about pain and ensure adequate Analgesia.
If fall is unwitnessed and the patient has cognitive or communication limitations, please follow the post fall guidance for suspicion of hip or other lower limb fracture and suspicion of head injury until both of these injuries have been ruled out.

Suspicion of isolated hip or other lower limb fracture
- Ensure adequate analgesia
  Move patient to bed using Hoverjack
- Commence observations as per NEWS2 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 ASAP if GCS< 15, seizure or new focal weakness (See Appendix 3&4)
- If suspected neck injury, immobilise patient and implement log roll technique
- Neuro observations every 30 mins for 2 hours, 1 hourly for 4 hours, 2 hourly for 6 hours.
  Immediately request Doctor review if GCS falls by 2 points or below 13 at any stage (See Appendix 3&4).

Suspicion of upper limb fracture/other fracture or injury
- Move patient to place of safety without using affected arm
  Adequate analgesia
- Commence observations as per NEWS2 policy & call Doctor.
  Patient needs assessment within 4 hours and X-Ray if indicated
- 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 (NEWS2), capillary blood glucose and call Doctor for review within a maximum of 12 hours.

ALL Patients post fall
DATIX form
Yellow sticker in medical & nursing notes (x2)
Review and update falls and Confusion and Safety Sides Assessments on Nervecentre
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)
- 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 (dbth.datix@nhs.net)
- Further information can be accessed here: Patient Safety – The Hive (dbth.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 (ie. Fractured skull/Neck of Femur, Grade 4 Pressure Ulcer).

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

Falls resulting in Moderate, Severe Harm or Death, or where significant learning is identified, will require a thorough investigation. The investigation will follow the MIFIT process to include interviews with staff, statements from staff, floor maps and a completed MIFIT document. The investigation content will be reviewed by the falls panel and if required the PSII Panel. The process and timescales for completion are provided within the MIFIT document which can be accessed via the documents & templates section on the Datix system.

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 strength & balance training.
- Need for Home Environmental Assessment.
- Patient education

These factors can be addressed in the Doncaster or Bassetlaw community services. For referral details see **Appendix 1**.

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 Outpatient 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
- Action for GP's to take.

4.11 Patients Lacking Mental Capacity

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking mental capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks mental capacity must be done, or made, in the persons Best Interest.

- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

5 TRAINING/SUPPORT

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

Falls Prevention and Management Training is provided as part of the Person Centred Care study day. Please contact the Education Centre to book a place for this training.

The full day is for adult ward based staff, Dementia and Falls Champions and ward based therapy staff.

The half day is for all other ward areas, outpatient staff and specialist teams that visit the wards but do not spend regular hours on the wards.

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

Support is also available from:

- Area/ward Falls Champions
- Falls Practitioner

Additional information can be found:

NICE information CG161 Falls: The Assessment and Prevention of Falls in Older People (2013) https://www.nice.org.uk/guidance/cg161/evidence/full-guideline-pdf-190033741

www.netvibes.com/dbhlibrary and look for the 'Elderly Care' tab

Royal College of Physicians- Falls Prevention in hospital: a guide for patients, their families and carers https://www.rcplondon.ac.uk/projects/outputs/falls-prevention-hospital-guide-patients-their-families-and-carers

Get up & Go leaflet- https://www.csp.org.uk/publications/get-go-guide-staying-steady-english-version

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 Division	Falls Practitioner	Monthly	Report to individual Divisional Clinical Governance Meetings
Number of falls and Serious Incidents across the Trust	Falls Practitioner	Quarterly	DBTH Falls & Bone Health Group
Audit of compliance with policy	DBTH Falls and Bone Health Group	Quarterly	DBTH Falls and Bone Health Group

7 DEFINITIONS

ABCD	Airway, Breathing, Circulation, Disability. Systematic approach to the collapsed patient
AMU	Acute Medical Unit
BH	Bassetlaw Hospital
COPD	Chronic Obstructive Pulmonary Disease
CSP	Chartered Society of Physiotherapy
DBTH	Doncaster & Bassetlaw Teaching Hospitals
DOH	Department of Health
DRI	Doncaster Royal Infirmary
ED	Emergency Department
Fall	An unintentional meeting with a lower level
FAU	Frailty Assessment Unit
GCS	Glasgow Coma Scale
G&S	Group & Save
IV	Intravenous
MDT	Multi-Disciplinary Team
MIFIT	Multi-Disciplinary Inpatient Falls Investigation Tool
MMH	Mexborough Montagu Hospital
NBM	Nil by Mouth

NEWS2	National Early Warning Score (NEWS2)
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 Team
RCP	Royal College of Physicians
RDASH	Rotherham, Doncaster & South Humber Mental Health NHS Trust
Safety Sides	Rail device to prevent roll from bed also known as: Cot side, Side rails, Bed sides or Bed guards.
SET	Statutory Education & Training
SOP	Standard Operational Policy
SpR	Specialist Registrar

8 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See **Appendix 8**)

9 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

CORP/EMP 4 - Fair Treatment for All Policy
CORP/EMP 27 - Equality Analysis Policy
CORP/HSFS 1 - Health and Safety Policy
CORP/HSFS 4 - Manual Handling Policy
CORP/HSFS 23 - Care of the Larger Person Policy
CORP/RISK 33 - Incident Management Policy
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 - Enhanced Patient Supervision and Engagement Policy
PAT/PS 15 - De-escalation: Principles and Guidance including restraint

10 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

11 REFERENCES

Darowski A, Dwight J, Reynolds J (2011) Medicines and falls in hospital: guidance sheet, Royal College of Physicians available at
file:///H:/Downloads/Guidance%20sheet%20Medicines%20and%20falls%20in%20hospital%20(1).pdf

Department of Health (DOH) (2001) The National Service Framework for Older People
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Healey, F; Scobie S et al: Slips, Trips and Falls in Hospital. National Patient Safety Agency, 3rd Report (2007), London

MHRA, Medicines & Healthcare products Regulatory Agency - GOV.UK, 2020, updated January 2021

National Institute for Health & Clinical Excellence (2007-Revised September 2019) Clinical Guideline 176, Triage, Assessment, Investigation and early management of head injury in infants, children and adults. Available at https://www.nice.org.uk/guidance/cg176

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National Patient Safety Agency (NPSA) 3rd Report (2007) Slips, Trips and Falls in Hospital

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National Patient Safety Agency (NPSA) (2011) The safe use of Ultra Low beds
NPSA Safer Practice Notice 17 Using Bedrails safely and effectively

NPSA - Bedrails – Reviewing the evidence. March 2007

Oliver, D. Foot, C. Humphries, R. Making our health and social care systems fit for an ageing population. The Kings Fund. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf

Royal College of Physicians (RCP) (2006), National Audit of the Organisation of Services for Falls and Bone Health for Older People

Royal College of Physicians (RCP) (2014) National Hip Fracture Database annual Report

Royal College of Physicians (RCP) (2015), (2017) & (2020) National Audit of Inpatient Falls, Audit Report

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

NICE information CG161 Falls: The Assessment and Prevention of Falls in Older People (2013)
https://www.nice.org.uk/guidance/cg161/evidence/full-guideline-pdf-190033741

www.netvibes.com/dbhlibrary and look for the 'Elderly Care' tab

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Get up & Go leaflet- https://www.csp.org.uk/publications/get-go-guide-staying-steady-english-version

APPENDIX 1 – COMMUNITY FALLS SERVICE REFERRALS

Referral depends on location of patient's GP practice

Doncaster GP: Via single point of Access Tel: 01302 566 999

Bassetlaw GP: Via single Point of Access Tel: 01777 274 422

APPENDIX 2 – 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 must:

- 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.
- be in place prior to transferring or mobilising.

Slipper socks (Red/Beige) are stocked on all adult inpatient wards.

Bariatric Slipper socks (Grey) are also available. Available in all central stores within the Trust.

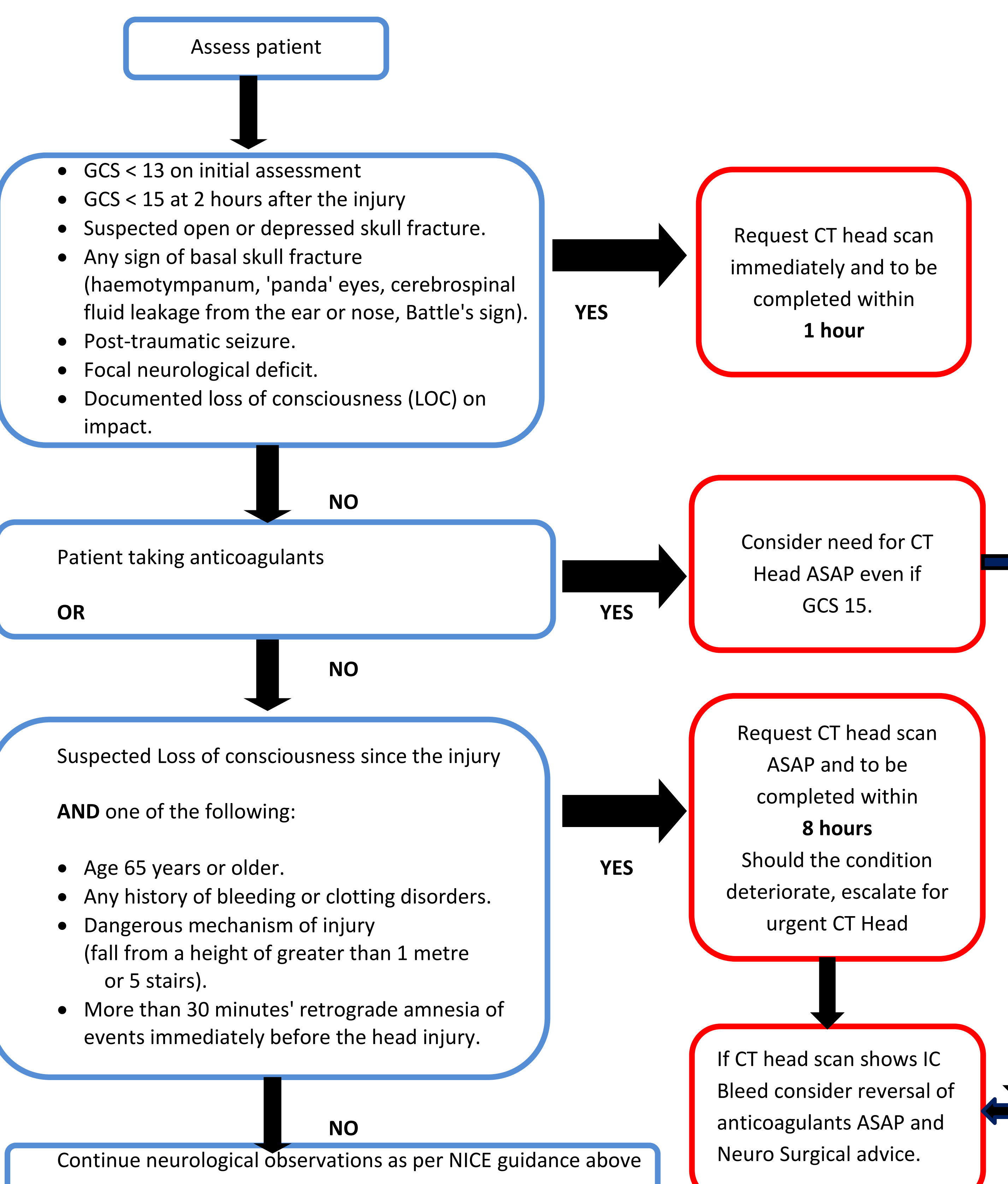
Patients with long term medical foot problems should be assessed by an Orthotist (use Clinical Therapies Referral Form).

For patients with short term medical foot problems e.g. oedema, gout etc. soft Velcro top shoes can be accessed from the Orthopaedic wards or ordered via Procurement Department (Small ERP084 medium ERP085 and Large ERP086).

Slipper socks can also be used if required over TED stockings/dressings.

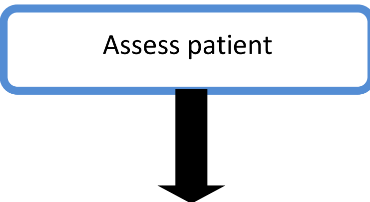
APPENDIX 3 – NICE HEAD INJURY GUIDANCE

Indications for Urgent Brain Imaging (NICE CG176) (Edited by Trust Trauma Lead)

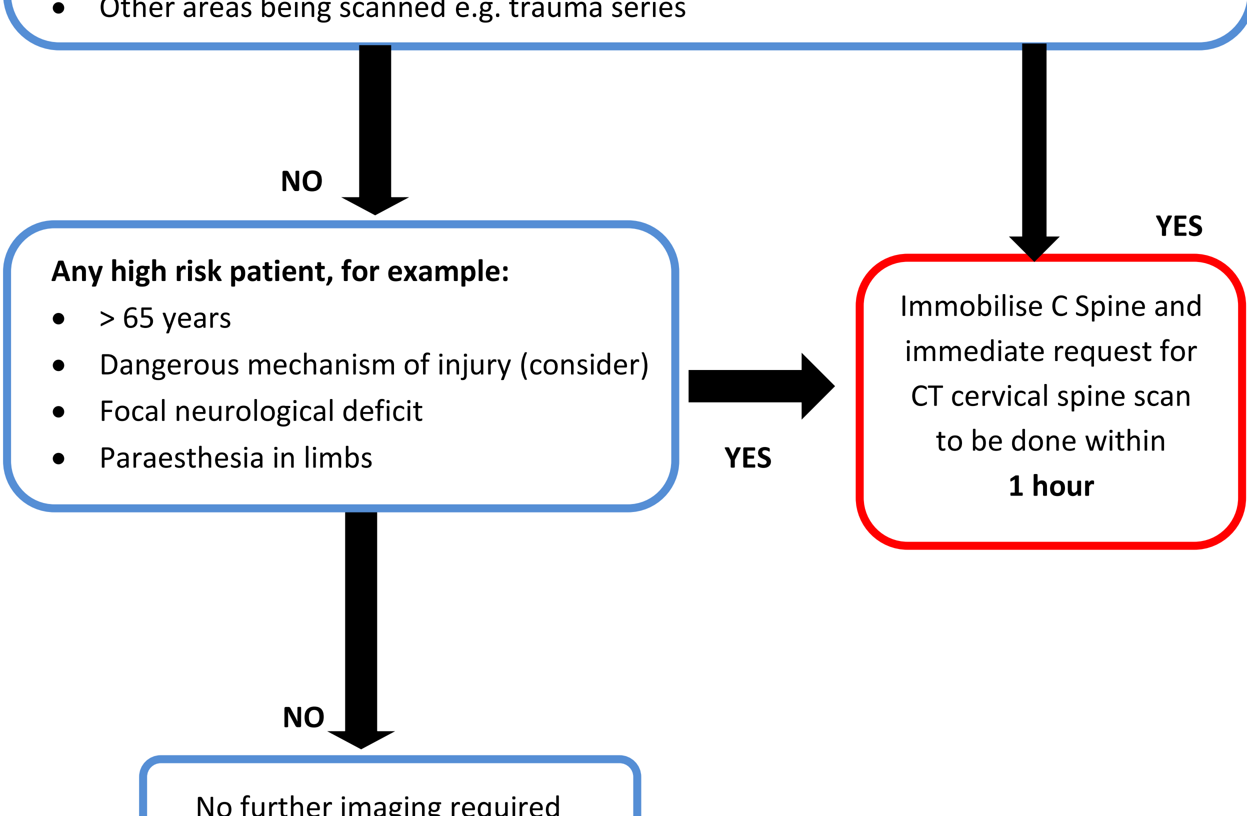


<u>Indications for urgent cervical spine imaging (NICE CG176)</u>

(Edited by Trust Trauma Lead)



- GCS < 15 or intubated
- Inability to concentrate (drugs, alcohol)
- Patients GCS 15 but clinical suspicion of C Spine injury (Presence of midline neck pain or tenderness or inability to rotate neck to 45 degrees to left and right without increasing pain or neurology
- Presence of distracting injuries
- Other areas being scanned e.g. trauma series



No further imaging required

APPENDIX 4 – 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 5 – 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 6 – 'FIVE FOR FALLS'

Preventing Inpatient Falls at DBH

'Five for Falls' Promotion

Improving patient care with regular safety checks

1. Nurse call buzzer within reach
2. Hazard free environments
3. Appropriate footwear
4. Access to mobility aids and mobility status above beds
5. Glasses/Hearing aids (if worn)

Key Considerations

in all patients over 65 years

- Postural Hypotension
- Delirium and Dementia
- Medications causing falls
- Continence
- Visual impairment

Doncaster and Bassetlaw Hospitals supports

and

APPENDIX 7 – ENHANCED CARE & TIME AND SPACE

Enhanced Care

If you are asked to provide 'enhanced care' this means the registered nurse looking after this patient has deemed there to be an increased risk of them coming to harm without your supervision.

This could be because your patient is at an increased risk of falling or has dementia or delirium and is unable to follow instructions from the nursing staff to keep themselves safe.

Please make sure the patient has a completed the 'This is me' form and feel free to add to it. This will give you an insight to the person you are supervising and enable you to provide person centred care.

Purple level of supervision

1:1 Supervision

This means you must be with the patient at all times unless a visitor is present.

If a visitor is present, you must still keep the patient within continual eyesight at all times and explain this is to maintain patient safety.

At the discretion of the ward manager/ sister or nurse in charge there may be occasion for the staff member to discontinue the supervision whilst the visitor is present with the patient.

Red level of supervision

Cohort supervision

This means no more than 4 patients to 1 member of staff, within continual eyesight at all times.

Cohort supervision should be maintained even when the patient is asleep as they can wake up suddenly and may fall.

At times you may need to leave /lose eyesight of some of the cohorted patients to attend to one of the cohorted patients individually. In such circumstances you will need to request assistance of your colleagues to cohort the remaining patients for the period of time you are with one of the patients.

What we expect from you

Patients requiring supervision can often get bored. By using This is Me, you can engage with your patients and find out what matters to them. This includes providing personal hygiene care, getting patients out of bed and into day clothes (where appropriate), ensuring glasses, hearing aids and dentures are in good working order and being used by the patient, drinking, eating, toileting, performing observations, going for a walk, watching TV, reading or even being able to complete activities, if they are available, on your ward area.

'Time and space' is a useful tool to identify common reasons for patients needing enhanced care:

Remember TIME AND SPACE

	Do...	Don't...
T Toilet **I** Infection **M** Medication **E** Electrolytes **A** Anxiety/Depression **N** Nutrition/Hydration **D** Disorientation **S** Sleep **P** Pain **A** Alcohol/ Drugs **C** Constipation **E** Environment	• Follow Delirium Guidelines. • Re-orientate frequently. • Use calming speech. Involve family/friends. • Walk to toilet frequently. • Be kind, calm and mindful of emotional needs.	• Change bed/ward. • Argue/confront. • Catheterise – unless essential. • Restrain – do allow to walk with supervision. • Sedate unless part of treatment plan.

If you notice any of the 'time and space' reasons which may be causing a problem for your patient, let the nurse in charge know your concerns immediately and try to help your patient now. Here are some suggestions of how you can help:

- When providing enhanced care, please try to establish if your patient is in pain and unable to communicate this to the nursing staff. Are they having regular pain relief and have they taken their medication?
- Please also perform a bladder scan on your patient and record the results
- Please also establish when your patient last had their bowels open as this can often cause confusion.
- Patients who have been RAG as Purple also need a behaviour chart as this helps us understand the person more.

What you should expect from the ward team

A good handover including: level of supervision and why they need it, any information that will support you to engage patients in meaningful activity.

If you need a comfort break, let a member of the ward team know and they will provide cover for you at this time.

If you feel you are struggling to maintain patient safety, or feel you are at risk, escalate this to the nurse in charge immediately

You will be given regular breaks, for example, swap with another member of staff to work on the ward whilst someone else supervises the patient(s). A plan will be made at the beginning of your shift to rotate staff providing supervision at least every two hours. Please let a member of staff know if you need more regular breaks, for example if the patient(s) is/are particularly challenging.

If you experience any problems with receiving breaks or rotation of staff to provide supervision inform the nurse in charge at the time and inform your line manager if you still have concerns following the shift.

APPENDIX 8 – NUTRITION & HYDRATION

Nutrition is important for older people and can contribute to minimize the risk of falls.

Nutritional status in elderly individuals is a key predictor of both frailty and sarcopenia[1].

Nutrition related indicators of falls risks [3]:

- Malnutrition and/or at risk of malnutrition (see NICE CG32)
- Reduced muscle mass and strength
- Low vitamin D status
- Dehydration
- Hypoglycaemia

A healthy balance diet with adequate energy, protein, calcium and Vit D are essential to optimize muscle, bone and functional outcomes [1].

Energy – although energy expenditure is decreased due to reduced muscle mass and physical activity, it is important that older people still eat regular nutritious meals and small snacks throughout the day. Protein – adequate amount of protein is needed for preservation of muscle mass. Sarcopenia, the decline in skeletal muscle mass associated with aging, is a key contributor to frailty and is often associated with decreases in energy (calorie) intake [2].

Protein requirements for older people [3,4]:

	Protein requirements per kg body weight per day	Daily protein requirements based on average weight of a male and female	
		70kg male	55kg female
Healthy older people	1.0-1.2g	70-84 g	55-66g
Older people who are malnourished or have an acute/chronic condition	1.2 – 1.5g	84-105g	66-83g
Those with severe illness/injury	>1.5g	>105g	>83g

Source: ESPEN guideline on clinical nutrition and hydration in geriatrics 2019.

Fibre – constipation is very common due many factors associated with ageing (e.g. chronic disease, immobility, medication). Therefore, adequate amounts of dietary fibre (30g/day) are needed from source such as, fruits, vegetables, grains and legumes.
Vitamin D and calcium – deficiencies/low levels should be corrected with supplementation and according to local/national guidance.

Hydration
Consequences of dehydration: low blood pressure, weakness, dizziness, impaired mental performance, increased risk of developing pressure ulcers, risk of urinary tract infections, constipation. Refer to

Nutrition and Hydration policy (PAT T 43 v 3) for guidance on how to ensure adequate and monitoring of fluid intake.

Common Vitamin and mineral deficiencies

Vitamin D due to inadequate exposure to sun. Vitamin B12, and iron due to inadequate absorption

Inpatient nutritional assessment.

Ward to screen patients for Malnutrition using the Malnutrition Universal Screening Tool (MUST), on admission, weekly and every time the patient changes wards.

1. Esquivel, Monica K. "Nutritional Assessment and Intervention to Prevent and Treat Malnutrition for Fall Risk Reduction in Elderly Populations." *American journal of lifestyle medicine* vol. 12,2 107-112. 28 Nov. 2017, doi:10.1177/1559827617742847
2. Marty E, Liu Y, Samuel A, Or O, Lane J. A review of sarcopenia: Enhancing awareness of an increasingly prevalent disease. Bone. 2017 Dec;105:276-286. doi: 10.1016/j.bone.2017.09.008. Epub 2017 Sep 18. PMID: 28931495.
3. https://www.malnutritionpathway.co.uk/falls.pdf
4. Dorothee Volkert et al. ESPEN guideline on clinical nutrition and hydration in geriatrics

Recommended Supportive resources:

https://www.fote.org.uk/wp-content/uploads/2017/03/Five-tips-to-boost-nutrition-hydration-poster.pdf

https://www.malnutritionpathway.co.uk/library/proteinideas.pdf

APPENDIX 9 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT?PS 11 v 4	Corporate	Esther Lockwood	Existing	May 2022

1) **Who is responsible for this policy?** DBTH 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?** Details: [see Equality Impact Assessment Guidance] - 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 – see CORP/EMP 27.

Date for next review:	**January 2024**		
Checked by:	**Marie Hardacre**	**Date:**	**May 2022**