Rotherham Doncaster and South Humber NHS Foundation Trust

Falls Prevention & Bone Health Policy For Managing The Risks Associated With Slips, Trips And Falls (Including Falls From A Height) Involving Service Users, Staff And Others

DOCUMENT CONTROL:	
Version:	7.2
Ratified by:	Clinical Effectiveness Committee
Date ratified:	11 November 2012 (amended 01.07.2014)
Name of originator/author:	Physiotherapy Professional Lead Consultant Occupational Therapist
Name of responsible committee/individual:	Clinical Effectiveness Committee
Date issued:	26 November 2012
Review date:	November 2015
Target Audience	All Staff

CONTENTS

1. INTRODUCTION

1.1 Rationale

The management of the risk of slips, trips and falls (including falls from a height) involving patients, staff and others is especially important in health care.

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA), who recommends that each patient at risk of falling should receive multifaceted clinical and environmental interventions that could reduce the risk.

Injuries to healthcare workers and members of the public are frequent.

Slips, trips and falls involving patients, staff and others are a high cause of litigation.

1.2 Introduction

Falls prevention remains a key area with regards to patient safety and quality of care delivery. Across England and Wales, Acute hospitals report 152,000 falls every year with 26,000 reported from mental health trusts. A significant number of falls result in death or severe or moderate injury, at an estimated cost of £15 million per annum for immediate healthcare treatment alone. This is likely to be a significant underestimation of the overall cost from falls once the costs of rehabilitation and social care are taken into account e.g. up to 90% of older patients who fracture their neck of femur fail to recover their previous level of mobility or independence (NPSA 2007; 2009).

In addition to these financial costs, there are additional costs that are more difficult to quantify. The human cost of falling includes distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients, relatives, carers, staff and others.

Higher falls risk groups include:

1. Older people - those suffering from dementia are particularly vulnerable to falling because of cognitive impairment and associated difficulties such as loss of spatial awareness, side effects from medication, or problems with their balance, strength or mobility.
2. People with cardiac, neurological, muscular-skeletal conditions, continence problems, and sensory losses and difficulties.
3. People with learning disabilities who may have a combination of physical, sensory and cognitive problems.

The Health and Safety Executive (HSE) has carried out extensive research on the causes of slips and trips-particularly on floor surface friction and the negative effects of common contaminants to that friction. In 2007, case law was established regarding the standards to be applied where surfaces are expected to become contaminated.

The policy reflects national guidance as detailed in section 10`.

2. PURPOSE

The purpose of this policy is to:

- Set out the arrangements for managing risks associated with slips, trips and falls

(including falls from a height) involving patients, staff and others.

- Raise awareness about preventing and reducing the number of slips, trips and falls (amongst clinical staff this will be with particular regard to patients who are in 'high risk groups').

- Raise awareness about the need for risk assessment and risk management, post fall interventions and incident reporting.

- Reduce the risk of falls to patients by providing adequate falls risk identification and, when indicated, multi-factorial falls assessment; thus recognising factors leading to falls and implementing appropriate interventions for prevention and mitigation of injury when a likelihood of falling is present. NICE (2004) *The assessment and prevention of falls in older people CG21.*

- Raise awareness about Bone Health and about how Osteoporosis increases the risk of harmful falls *NICE (2008) TA160 Alendronate, Etidronate, Risedronate, Raloxifene and Strontium Ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women.*

- Raise awareness of environmental issues which lead to slips, trips and falls to assist staff in making the right choices when selecting floor coverings.

- Raise awareness of building design so anti slip and anti hazard features are included at the conception of new buildings and for retro installation in existing buildings.

- Set out how the organisation trains staff in line with the training needs analysis.

- Set out how the organisation monitors compliance with this policy.

3. SCOPE

3.1 This policy covers slips, trips and falls (including falls from height) involving patients, staff and others. The policy applies to all staff employed by or working for the Trust, patients and any person on Trust premises. Please note some appendices relate to specific services.

For patients, the policy focuses on the needs of those who are in the higher falls risk groups or who already have a history of falls.

The Trust has a *Policy for Safe Working at Height* (part of the Health, Safety & Security Policy suite) which sets out the Trust's arrangements under the Working at Height Regulations 2005. This should be read in conjunction with this policy where working at height is part of the work of the service.

3.2 Definitions

SLIP
A slip is to slide accidentally causing the person to lose their balance; this is either corrected or causes a person to fall.

TRIP
A trip is to stumble accidentally often over an obstacle causing an individual to lose their balance, this is either corrected or causes an individual to fall.

FALL

A fall is an event which results in the person or a body part of the person coming to rest inadvertently on the ground floor or other surface lower than the person, whether or not an injury is sustained.

FALL FROM HEIGHT
A fall from height is a fall which occurs when the person falls from anything other than ground level e.g. from a bed, chair, ladder etc, or falls from ground level to below ground level e.g. fall down a man hole or pit etc, which could cause personal injury. Under the Work at Height Regulations 2005 working at a height is a place where the person could be injured falling from it.
Slips Trips and Falls from a height should be reported as incidents under the Trust Incident Reporting Policy (using IR1 form). Some of these may come under the definition of RIDDOR.

RIDDOR
Under the Reporting of Industrial Diseases and Dangerous Occurrences
Regulations 2005, certain incidents such as major injuries that arise out of or are in connection with work are required to be reported to the Health and Safety Executive (HSE).

SERIOUS INCIDENT (SI)
Falls resulting in serious harm (e.g. hip fractures) are reportable as Serious Incidents and reporting must take place via the Assistant Director/Deputy Director within 24 hours in accordance with Trust Policy For the Management of Serious Incidents.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Trust Responsibilities

The Trust recognises its responsibilities to implement in full its duties in respect of the prevention of slips, trips and falls (including falls from height) by safe and proper means.

The Trust delegates to the Chief Executive overall responsibility for the implementation of this policy, and in turn this responsibility is delegated to the Directors and Senior Managers of the Trust.

4.2 Responsibilities of Directors and Senior Managers

Directors and Senior Managers will:

- Make arrangements for the effective implementation and monitoring of the policy.

- Produce risk assessments in their areas of responsibility as required under the Management of Health and Safety at Work Regulations 1999, where falls are identified as a hazard. The risk assessment should include environmental factors such as flooring, opening windows as well as individual capability assessments.
- Where risk assessment identifies training as a measure to support effective implementation of the policy, agree with the relevant training lead the timely delivery of suitable training.
- Make arrangements for the effective implementation and monitoring of the Trust Incident Reporting Policy, promoting a positive reporting and learning culture to facilitate continuous safety improvement with regard to slips, trips and falls (NPSA Patient Safety First Falls- How to Guide 2009).
- Influence the design of buildings so that full account can be taken of known environmental factors associated with positive risk management. This will include provision for covered areas to be provided to the external areas of access doors, to

minimise the risks from ingress of contamination from the elements.

4.3 Strategic Falls Prevention Group (see Appendix 20 for Terms of Reference)

The purpose of the group is to establish and monitor a strategic approach and action plans for falls prevention relating to service users, staff and others, based on the national guidance provided by NICE, NPSA, NHSLA, HSE etc, and to provide assurance to the Clinical Governance Group.

Key responsibilities are detailed in the Terms of Reference shown in Appendix 20.

Appendix 21 '*Get a Grip - stop slips and trips in Healthcare'* provides a range of useful information on safeguards which serve to protect patients, staff and others in the workplace.

It uses the acronym SHOES in order to aid recall the following key areas for slips, trips and falls:

- **S**pills
- **H**igh risk areas
- **O**ver used signs
- **E**nvironmental cleanliness
- **S**hoes

This will be promoted by the Strategic Falls Prevention Group and those with responsibilities as set out in this policy to increase awareness about preventing and reducing slips, trips and falls, through policy dissemination activities and training.

4.4 Falls Leads/Health and Safety Lead Duties

The Falls Leads/Health and Safety Lead will:

- Review and update the Falls Policy and associated practices and implement in line with health and safety legislation and evidence.

- Provide advice and support to Directors and Senior Managers to facilitate effective implementation and monitoring of the policy.

- Produce quarterly reports to the Strategic Falls Prevention Group which provide thematic and trend analysis of slips, trips and falls incident data, to inform practice and service development and organisational learning. The rate of harmful falls per thousand bed days is a recommended outcome measure for patient falls (NPSA Patient Safety First Falls – How to Guide 2009).

- Utilise the Slip Assessment Tool (SAT) for floor surfaces developed by the Health and Safety Executive to measure the micro surface roughness of surfaces, and make this data available to inform environmental design and safety improvements.

- Cascade lessons learnt from incidents through the Organisational Learning Forum (OLF)

4.5 Head of Estates Duties

The Head of Estates will:

- Consult with all relevant parties when replacement flooring is being specified, considering safety standards, evidence of best practice, cleaning and contamination issues.

- Facilitate the installation of suitable devices to opening windows which restrict openings to a maximum of 100mm in patient areas, which are of a type that are not easily overcome and are adequately maintained.

4.6 Service Managers/ Modern Matrons

- Ensure staff are aware of and comply with this policy.

- Ensure that staff attend slips, trips and falls training as defined in the training needs analysis
- Making arrangements for a weekly environmental Health and Safety Check of the clinical area to be undertaken, and for taking action on all identified hazards.

- Ensure post fall/head injury patient observations are recorded as required.

- Work directly with ward/departmental managers to address concerns

- Ensure reporting of all slips, trips and falls events via the Safeguard electronic incident reporting system.

- Develop and implement action plans/care plans for falls risks highlighted in any root cause analysis undertaken by Trust Falls Leads/ Senior Managers.

- Cascade lessons learnt from incidents within their areas of responsibility.

- Locally monitor falls incident trends and themes and feedback to Trust Falls Leads/Health and Safety Lead and senior managers within respective services as appropriate.

4.7 Ward Managers/Service Managers/Team Leaders have a responsibility to

- Be aware of and comply with this policy.

- Ensure post fall/head injury observations for patients are recorded as required

- Ensure all inpatients are assessed for the risk of falling in accordance with the guidance and documentation in this policy.

- Release staff to attend the slips, trips and falls training as identified in the training needs analysis.

- Implement action plans resulting from analysis of falls and incident investigation reports.

- Ensure that the above action plans are shared with ward / service area staff.

- Locally monitor falls incidents, trends and themes and feedback to line managers.

4.8 Employees will

- Be aware of their responsibilities to identify and reduce the risk of slips, trips and

falls (including falls from height).

- Be aware of patient groups who are at increased risk of falls.

- Ensure physical observations/ neuro observations for patients are completed post fall/head injury.

- Take extra caution to prevent falls from height
- RDaSH staff and contractors working at height should follow the Trust's *Safe Working at Height Policy*, this can be found in the Health and Safety section of the policies directory on the Trust intranet. In addition, guidance for preventing falls from height can be found by accessing the Health and Safety Executive website **http://www.hse.gov.uk/falls/index.htm**

- Take all reasonable precautions to prevent the possibility of patient falls from a height, and be aware of increased patient risks when they are in a situation where there is a potential for a fall from a height e.g. on stairs, close to the top of stairways/ stairwells or landings, close to areas near any sudden drop/ change in floor levels.

- Appendix 3 '*Protocol for the use of bed rails'* provides guidance about bedrail use for patients who may be at risk of falling from a bed or trolley.

- Appendix 8 provides guidance about nursing patients on the floor.

- The Trust wishes to promote a positive health and safety culture and a learning environment where staff are routinely involved in the review of incidents in order to continuously improve practice. Staff are expected to:

    - participate in the identification of environmental and clinical slip, trip and fall hazards
    - report any incidents/ concerns
    - seek advice as required and implement policies and agreed measures to manage risks.
    - Wear appropriate footwear to minimise slips, trips and falls.
    - Refer and adhere to any specific dress codes in their area of work.

4.9 Safeguarding Procedures – all employees

- The Trust works to the agreed multiagency safeguarding procedures for children and vulnerable adults in each of the geographical locations in which it provides services. All staff have a duty to report any concerns under these procedures.

- Occasionally, falls prevention interventions may raise concerns about whether service users' human rights are being affected. Where concerns arise, the relevant multi agency Safeguarding Children or Safeguarding Vulnerable Adults procedures will be sought and followed in order to provide a consistent and comprehensive response.

- Appendix 8 provides guidance regarding potential restraint related dilemmas, and specifically covers the use of wheelchair lap-belts, beanbags, nursing 'on the floor' and protective headgear. A checklist to support decision making is also included.

5. PROCEDURE/IMPLEMENTATION

5.1 How the Organisation assesses the risk of slips, trips and falls involving patients

(including falls from height)

5.1.1 In-Patient Services: Procedures

Assessment:

Mental Health Services for Older People In-Patients:
Each patient will have a Multifactorial In-Patient Falls Risk Assessment and Guidance (Mental Health Services for Older People and Learning Disability In-Patients) (Appendix 1) as part of the admission process. It will be the responsibility of the clinician co-ordinating the care to ensure that this is completed.

Doncaster Community Integrated Services (DCIS):
All In-Patients will have a falls risk assessment (Appendix 2) as part of the admission process. It will be the responsibility of the clinician co-ordinating the care to ensure that this is completed.

Adult Mental Health Services Inpatients:
The Multifactorial In-Patient Falls Risk Assessment and Guidance (Mental Health Services for Older People and Learning Disability Inpatients) (Appendix 1) must be completed for patients who have mobility problems, history of previous falls, medical or physical conditions which may predispose them to falls. It will be the responsibility of the clinician co-ordinating the care to ensure, when indicated, that the assessment is completed.

Learning Disability Inpatients/ Residential Services:
All patients within **In-P**atient settings and community homes must have a completed and up to date risk assessment with any needs identified within care plans.

Forensic Services
The Falls Risk Assessment (Appendix 1) will be completed for patients who have mobility problems, history of previous falls, medical or physical conditions which may predispose them to falls. It will be the responsibility of the clinician co-ordinating the care to ensure, when indicated, that the assessment is completed.

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

If unsure staff should discuss further with senior colleagues, other members of the Multidisciplinary Team (MDT) or they can contact the Trust Falls Leads for advice.

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

For patients at highest risk this may be a daily or even more often e.g per shift on a ward particularly if they have acute or fluctuating difficulties which affect their mobility, judgement and safety.

For medium to low risk reviews should occur weekly.

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

Care Planning/ Actions to take:

- Where specific risks are identified, the necessary clinical and environmental actions will be taken. Actions will be recorded in the most appropriate place e.g. on the falls

risk assessment document or as part of a separate falls care plan or within the patients overall care plan. A falls flowchart (part of Appendix 1) is provided to help guide clinical practice.

- For patients assessed as being at increased risk of falling overall, or who have had recurrent falls, individualised multi-factorial interventions should be considered to reduce risk factors and create a safer environment (as per NICE Clinical Guideline 21). These interventions may include: education and information giving; strength and balance training; exercise programmes; home hazard assessment and intervention; vision assessment and referral; medication review with modification/ withdrawal of medication implicated in falls risk (N.B. some medical and psychotropic medication is known to be strongly associated with increased falls risk); cardiac pacing – for cardio inhibitory carotid sinus hypersensitivity (this can be an undiagnosed condition in older people, who have experienced unexplained falls).

- For patients who may be at increased risk of osteoporosis a pro-active approach to osteoporosis screening and treatment is advocated (see NICE *Technical Appraisal TA160* and also information in Appendix 9).

- Patients who have fallen will require interventions to reduce their likelihood of further falls. These interventions will be decided upon during the review of the service user's care post fall, e.g. as part of care planning, Care Programme Approach (CPA) review, MDT meetings etc (see Appendix 10 for more information). Any actions taken and/or referrals made regarding such interventions will be clearly recorded in the patient's care plan.

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

5.1.2 Mental Health Community Services: Procedures (including Adult, Older People, Substance Misuse, Psychological Therapies, CAMHS)

RDaSH mental health services are provided in a range of geographical locations working in partnership with different primary care service providers. These providers have community based falls prevention services and will differ dependent on the locality.

RDaSH mental health community staff are advised to follow the Falls Assessment and Prevention Procedures in their locality/Business Division (Appendix 16).

5.1.3 Learning Disabilities: Procedures

The Learning Disabilities Community Homes Service recognises its responsibility to ensure that all reasonable precautions are taken to minimise the risks of slips, trips and falls for staff, patients, visitors and contractors.

RDaSH Learning Disability staff are advised to follow the Falls Assessment and Prevention Procedures in their locality/Business Division (Appendix 14).

5.1.4 DCIS Community Procedures

Community based staff will carry out the Falls Risk Assessment Tool (FRAT) in Appendix 2. Interventions post fall in the community will be carried out in line with the Standard Operating Procedure for DCIS.

5.2 Action following a slip, trip or fall involving patients

Please consult Appendix 10 for detailed information related to actions and interventions post fall. Appendix 10 includes advice as per NICE clinical guideline head injury, and also advises what to do if a hip fracture is suspected (it is suggested that all In-Patient/ residential units **print out and laminate Appendix 10** and ensure it can be quickly accessed by clinical staff).

5.2.1 Immediate actions

In brief, in the event of a fall, immediate response and assessment of the seriousness of the situation and of the patient's needs will take place, actions will be taken accordingly - these may include:

- In the case of suspected serious injury the fall will be treated as a medical emergency and urgent medical assistance will be summoned (via 999 if need be).

- Physical observations/Early Warning Score (EWS) should be recorded and if a head injury is present or cannot be ruled out, neuro observations should be commenced.

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

5.2.2 Follow up

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

- At the earliest opportunity following the fall the patient will be re-assessed using the Multi-factorial Falls Risk Assessment and the care plan reviewed to include any necessary changes or actions required to minimise further falls risk. (If it is suspected that medication side effects are a component in the fall then this must be brought to the attention of medical staff /GP/Prescriber immediately).

- Discussion will also be held at the review/MDT meeting and any actions identified.

- If the patient has fallen from bed then the bed rail use risk balance tool (Appendix 3) must be reviewed and actions taken accordingly.

- Referral for physiotherapy assessment/ re-assessment will follow the guidelines in place in the particular service area.

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

- In more complex cases, or where the patient has had recurrent falls, staff are also encouraged to call a multi-disciplinary case review re: falls risks and falls prevention.

- Staff will encourage patients to discuss their experiences and anxieties following falls and, where possible, develop strategies for preventing further falls collaboratively with the patient. If the patient has a fear of falling which is affecting their activities and wellbeing, then a structured approach to help them regain confidence should be considered. Other members of the Multi Disciplinary Team (MDT) e.g. Physiotherapist,

Occupational therapists, may be best placed to offer this.

5.3 How the organisation assesses the risk of slips, trips and falls involving staff and others (including falls from height)

Staff employed by or working for the Trust are required to:

- Take extra caution to prevent falls from height.
- *Follow the Trust's Safe Working at Height Policy* when working at heights (this can be found in the Health and Safety section of the policies directory on the Trust intranet). In addition guidance for preventing falls from height can be found by accessing the Health and Safety Executive website http://www.hse.gov.uk/falls/index.htm
- Take all reasonable precautions to prevent the possibility of falls from a height and be aware of increased risks when they are in a situation where there is potential for a fall from a height. e.g. on stairs, close to the top of stairways/ stairwells or landings, close to areas near any sudden drop/ change in floor levels.
- The Trust wishes to promote a positive health and safety culture and learning environment where staff are routinely involved in the review of incidents in order to continuously improve practice. Staff are expected to participate in the identification of environmental and clinical slip, trip and fall hazards. Report any incidents/ concerns, seek advice as required and implement polices and agreed measures to manage risks.
- Wear appropriate footwear to minimise slips. Staff should refer and adhere to any specific dress codes in their area of work.

5.3.1 Action following a slip, trip or fall involving staff and others

Employees will receive immediate attention if they are injured or taken ill at work and an ambulance should be called in serious cases.

All employees of the Trust are expected to assist anyone who is injured or ill in the best way they can even if all they can do is summon a more suitable person, or an ambulance.

All slip, trip and fall (including falls from a height) incidents will be reported and investigated as per the Trust Incident Reporting Policy.

Key themes/trends from slips, trips and falls incident data are reported to the Strategic Falls Prevention Group and monitored by the Falls Leads/Health and Safety Lead to inform practice development and organisational learning.

5.4 In-Patient areas/ areas accessed by patients: Environmental risk assessment

Weekly environmental Health and Safety Check

The Ward /Service Manager has the responsibility for making arrangements for a weekly environmental Health and Safety Check of the clinical area to be undertaken, and for taking action on all identified hazards.

There is no standard checklist for this purpose due to the diversity of service provided by the Trust, however with regards to falling, the following must be included as a minimum: **FLOOR COVERINGS, LIGHTING, NURSE CALL/ALARM SYSTEMS, FURNITURE, OPENING WINDOW RESTRICTORS.**

Where hazards such as spillages and/or bodily fluids are identified staff and managers must act immediately in order to maintain a safe environment for patients and staff.

6 monthly Health and Safety Check

The Ward/Service Manager is responsible for making arrangements for a full environmental risk assessment to be undertaken at least 6 monthly and for taking action on all identified hazards. For advice about procedures for this, and about the most appropriate health and safety checklists to use, further guidance can be sought from health and safety leads/ departments.

Risks associated with falling from height: environmental checks see earlier (section 4) for employee responsibilities for ensuring patients safety regarding the risks associated with falling from a height. In addition staff and managers must ensure environments and any equipment used during patient care is as safe as possible in order to prevent the likelihood of a patient or staff member falling from a height, where hazards are identified action must be taken to maintain safety. If in any doubt advice should be sought.

Advice and support can be sought from the Health and Safety Lead at any point.

5.5 Post Slip, Trip or Fall (including falls from height) Incident Reporting

- The incident will be reported as soon as possible via the Safeguard electronic incident reporting (IR1) system. If a fracture or other serious injury is confirmed the manager must contact the Assistant Director or nominated deputy in order to decide whether a Serious Incident report needs to be made on STEIS via the Deputy Director. The Safety Section should be contacted to adjust the IR1 (this may be more easily done by the manager) if the diagnosis is confirmed following the submission of the IR1. Information reported via the Safeguard electronic incident reporting system (IR1) will include:

- Time of incident.

- Place of incident, any relevant environmental factors.

- Circumstances surrounding the fall, including how the person fell if this was witnessed.

- Confirmation that EWS and/or Neuro observations have been taken and recorded.

- Staffing circumstances at time of fall.

- Fall risk category prior to fall and any relevant details from falls prevention care plan

- *Immediate actions taken/ strategies to be put in place following the fall to reduce chance of harm and any further fall occurring - *N.B this information provides assurance that the patient's immediate care and safety needs were met.

- A RIDDOR report will be completed by the Modern Matron/Service Manager if there was a serious injury as a result of an environmental factor.

- The patients' next of kin will be informed that a fall has occurred (unless the patient specifically objects).

- In order to promote learning, as an opportunity for staff support and to improve the quality of patient care, on an ongoing basis, falls incidents will be discussed in appropriate staff meetings and any immediate organisational issues/ training needs requiring action will be identified by managers.

5.6 Discharge/Follow Up Procedure

- Information regarding falls risks, falls prevention and any care plan/ interventions will be included in the patients discharge report/ letter. If necessary, the GP should be requested to review these as part of the patients follow up.

- For In-Patients who are being discharged into a care home or similar, a copy of the in-patient falls risk assessment and falls prevention care plan will be included as part of the discharge procedure.

6. TRAINING IMPLICATIONS

The Training Needs Analysis (TNA) for this policy can be found in the Training Needs Analysis document which is part of the Trust's Mandatory Risk Management Training Policy located under policy section of the Trust website

7. MONITORING ARRANGEMENTS

Area for monitoring	How	Who by	Reported to	Frequency
Duties How the Trust assesses the risk of slips, trips and falls involving patients, staff and others (including falls from height) How the Trust trains staff, in line with the training needs analysis How the Trust raises awareness about preventing and reducing the number of slips, trips and falls involving patients, staff and others	Report	Trust Falls Leads	Strategic Falls Prevention Group Lessons learnt cascaded through the Organisational Learning Forum (OLF)	Quarterly
Analysis of incidents and actions taken/learning	'Live' visual review of a sample of IR1s via on-line system. Any issues related to standard of reporting and quality of actions	Trust Falls Leads and other individuals designated by them and by Assistant Directors.	Service Managers/ Modern Matrons/ Assistant Directors Lessons learnt cascaded through the Organisational	Information received by reviewers by auto-email as it is entered on system. Review

	taken subsequently fed back verbally or via e-mail.		Learning Forum (OLF)	takes place as soon as possible but with minimum standard of fortnightly
	'Trend' Information sharing and action planning: Sample of 'Live' info analysed and where trends observed this info fed back	Trust Falls Leads	Service Managers/ Modern Matrons/ Assistant Directors	Quarterly, or sooner if issues of concern merit this

8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on the Equality and Diversity webpage of the RDaSH website click here

8.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organize care around the individual, '*not just clinically but in terms of dignity and respect'*. As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).	**Indicate how this will be met** There is no requirement for additional consideration to be given with regard to privacy, dignity or respect.

8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.	**Indicate How This Will Be Achieved.** All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)

9. LINKS TO ANY ASSOCIATED DOCUMENTS

- Incident Reporting Policy – Health and Safety Policies
- Safer Manual handling Operations – Health and Safety Policies
- Infection Control Polices - Clinical Policies
- Cleaning Polices - General Policies
- Multi agency Safeguarding Children Procedures
- Multi agency Safeguarding Adults Procedures
- Safe Working at Height Policy - Health and Safety Policies
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards Policy
- Policy for the Care of Inpatients Who are Identified as Posing a Significant Risk to Themselves of Others.
- First to Dress Initiative Policy - part of DCIS tissue viability procedures
- Trust Policy for the Management of Serious Incidents.

10. REFERENCES

The Management of Health and Safety at Work Regulations, 1999, in line with the Health and Safety at Work etc Act 1974

Department of Health (2001) *The National Service Framework for Older People, (2001)*

NICE (2004), *Clinical Guideline 21: Falls. The assessment and prevention of falls in older people*

NPSA (2007) The third report from the Patient Safety Observatory *'Slips Trips and Falls in Hospital'*

NPSA (2009) Patient Safety First *The 'How to' Guide for Reducing Harm from Falls'*

Department of Health (2006) *Health Technical Memorandum on Flooring (HTM) 61*

NPSA (2006) *With safety in mind: mental health services and patient safety*, Patient Safety Observatory Report 2

NPSA Safer Practice Notice (2007), *Using Bedrails Safely and Effectively*
NICE (2008) *Technical Appraisal TA160 Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women*

NICE (2008) *Technical Appraisal TA161 Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women*

British Orthopaedic Association/British Geriatric Society (2007)
The Care of Patients with Fragility Fractures

NICE (2007) Clinical Guideline G56 Head Injury

Human Rights Act 1998
Social Care Institute for Excellence (SCIE) Research Briefing 1/01: Preventing Falls in Care Homes. http://www.scie-socialcareonline.org.uk

Health and Safety Executive (HSE) website provides further information on managing the risks associated with slips, trips and falls: http://www.hse.gove.uk/healthservices/

- 'Falls from Height' HSE website page
- 'Slips Resources' HSE website page
- 'Watch Your Step Campaign' HSE website page
- 'Slips Assessment Tool' Online tool
- Slips and Trips in the Health Services Health Services Sheet Number 2 (2003)

NHS Employers (2010) Health and Safety Essential Guide *NHS Employers website pages*

11. APPENDICES

Appendix 1	Multi factorial In-Patient Falls Risk Assessment and Guidance (Mental Health Services for Older People and Learning Disability Inpatients)
Appendix 2	Multifactorial In patient Falls Risk Assessment (DCIS); Community Falls Risk Assessment Tool 'FRAT' and Guidance (DCIS)
Appendix 3	Protocol for the use of Bed Rails (including examples of risk assessment tools)
Appendix 4	Bedrails: Patient Information Leaflet
Appendix 5	Protocol for the use of Hip Protectors
Appendix 6	Protocol for the use of Bed Alarms
Appendix 7	Protocol for the use of Ultra Low Beds
Appendix 8	Advice About Potential Restraint and Wheelchair Lap-belts, Bean-bags, Protective Headgear, Nursing on the floor. (including a **Checklist** which must be used if any of these items/ procedures are being considered)
Appendix 9	Osteoporosis
Appendix 10	Interventions after a patient has fallen in hospital including management of suspected head injury and possible hip fracture.
Appendix 11	Medication which may increase the risk of falls
Appendix 12	Mental Health Services for Older People: walking aid/ gait training
Appendix 13	Falls Prevention and Footwear
Appendix 14	Learning Disabilities Community Homes Services: Slips, Trips and Falls Policy
Appendix 15	Doncaster Community Integrated Services
Appendix 16	Mental Health Services Community Services
Appendix 17	Documentation Guide
Appendix 18	Flowchart for completion of inpatient documentation
Appendix 19	Inpatient Information Sheet – an example
Appendix 20	Terms of Reference strategic falls Prevention Group
Appendix 21	'*Get a Grip – stop slips and trips in Healthcare*
Appendix 22	Staff falls Information Leaflet

APPENDIX 1

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

RISK ASSESSMENT AND INTIAL ACTION PLAN

FOR THE MANAGEMENT OF SLIPS, TRIPS AND FALLS (INCLUDING FALLS FROM A HEIGHT) IN MENTAL HEALTH & LEARNING DISABILITY IN-PATIENT SERVICES

Patients name		**NHS Number**		**Ward**		**Consultant**	
DOB and Age		**Male/Female**		**Date completed**		**Completed by**	

	Yes/No	RED FLAG RATING	Details	Prompts/Strategies to consider	Action taken	Signed and date
1 History of Falls		RED		Identify any previous falls, any in last 12 months? any resulting in hospital admission?		
2 Previous fracture		RED		History of fractures including wrist/shoulder. Refer for osteoporotic assessment		
3 Medical						
Osteoporosis		RED		Check if on medication regime, if not refer to medics. Consider hip protectors		
Postural Hypotension		RED		Check lying/standing BP, discuss with medics, ensure action is taken/ care plan in place		
Dizziness		RED		Discuss with medics re cause; referral for syncope assessment if indicated		
Acute Illness		RED		Medical review		
Epilepsy		AMBER		Discuss management plan with carers and MDT		
Poor vision/hearing; not wearing glasses		RED/ AMBER		Red if glasses missing- **immediately rectify**. Amber if long standing and no prior falls; Check glasses/ hearing aids. Ophthalmology/audiology ref		
Arthritis		AMBER		Pain relief/anti inflammatory medication.		

				Physio assessment		
Numbness in feet		**AMBER**		Physio assessment/medical review		
CVA/ Cardiovascular problems		**RED**		Discuss within MDT and with carers. Physio assessment		
4 Medication						
2 medicines or more PRN medication		**RED**		Medication review/monitor side effects. Medication review/monitor side effects. If PRN psychotropic medication used for Behavioural symptoms then ensure non-pharmacological approaches been offered first. – discuss with MDT & follow BPSD NICE guideline		
Anti psychotics		**RED/ AMBER**		Amber if prescribed for some time and no prior falls. Red if recently instigated. Medication review/monitor side effects		
Heart or angina tablets		**RED/ AMBER**		Amber if prescribed for some time. Red if recently instigated nitrates or calcium channel blockers for angina		
Diuretics or Blood pressure medication		**RED/ AMBER**		Amber if BP is normal, red if BP is less than 120/80. Medication review/monitor side effects		
Anti Convulsants		**AMBER**		Medication review/monitor side effects		
Night sedation		**RED/ AMBER**		Amber if prescribed for some time and no prior falls. Red if recently instigated Medication review/monitor side effects		
Analgesia		**RED/ AMBER**		Red for Opioid based analgesia, Amber for other analgesia. Medication review/monitor side effects		
Drugs for Parkinson's		**RED**		Medication review/monitor side effects		
Sedating Antidepressants		**RED**		e.g. Mirtazapine, Trazedone. Medication review/monitor side effects		
Benzodiazepines		**RED**		Medication review/monitor sideeffects		
5 Mental Health						
Gets up frequently during the night		**AMBER**		Consider bed alarm/review observation level/sleep chart		
Responding to hallucinations		**AMBER**		Psychiatric review/frequent monitoring and observation		
Constant pacing		**RED**		Nursing observation/ pain assessment/		

				OT assessments and therapy plan		
Severe cognitive impairment/delirium/ confusion		**RED**		Frequently re orientate to surroundings/ signs/ medical review/ medication review/ nursing observation level– consider if risk indicates immediate 1:1		
6 Mobility						
Unsafe to walk alone?		**RED**		1:1 observation; agree approach; Physio assessment		
Difficulty Walking/fear of Falling		**RED**		Physio assessment/ and treatment plan OT assessment		
Stops walking to talk		**AMBER**		Physio assessment/ and treatment plan / OT assessment		
Difficulty getting out of chair/ transfer problems		**RED**		Physio assessment and treatment plan /OT assessment		
Uses walking aids		**AMBER**		Physio assessment /and treatment plan OT assessment		
Poor balance		**RED**		Physio assessment/ and treatment plan OT assessment		
Foot problems		**AMBER**		Chiropody referral/orthopaedic referral		
Urgent/frequent need for the toilet /incontinent		**AMBER/ RED**		Refer for continence assessment Medical review Check for infection; if infection present then risk level is RED		
Affected by change of flooring		**AMBER**		Display warning signs/Physio assessment		
Inadequate footwear		**RED**		Immediately rectify; proactive contact with carer; recommend appropriate footwear		
7 Physical Health						
Underweight/ Obese		**AMBER**		Dietician/ medical referral. Monitor weight weekly/ nutritional assessment or health eating plan.		
8 Environmental						
History of falls out of bed		**RED**		1:1 observation; Bed rails assessment; Consider Bed alarm Refer to Physio/OT		
Behaviour which may		**RED**		1:1 observation; MDT review		

lead to risk of fall from height				Physio/OT assessment		

Guidance: If risks are identified the related action column **MUST** be completed, include all clinical actions taken/ planned to minimise risks. Note: some risks are easily modifiable and require immediate action; immediate decisions are also required about safety precautions for patients at clear risk e.g. do they need hip protectors? bed alarms? What falls prevention observation levels are required? *Such decisions can subsequently be reviewed as the assessment process proceeds.* Any RED Flag rating indicates that the overall falls risk level is and remains **high** until the specific risk is removed, modified or managed. Further falls assessment/ care planning will therefore be required; the falls risks and the actions/ management required must also be discussed at MDT meeting/ ward round, and the discussions and plans documented accordingly.

For other patients, decide, on an individualised basis, if a specific falls care plan is required- use clinical judgement/ reasoning to make this decision and if unclear discuss with senior colleagues and other members of the MDT. Review and reassessment of the need for further actions and for an individualised care plan must take place if the patient's condition alters and the risk level or concerns increase. Falls risk factors and related care needs may alter for some patients on a day by day or even shift by shift basis, particularly if they have acute or fluctuating difficulties which affect their mobility and safety.

Summary of Plan/ Actions Taken/ Outcomes

Staff Name **Designation**

Signature **Review date**:

Falls Review Record Sheet

Clinical judgement should always guide the decision for the need for and frequency of repeat assessment and staff should take a pro-active approach to falls prevention. As a guide reviews/ repeat assessments should occur weekly for service users at high risk i.e. who have any unresolved red flag indicators, or who have multiple/ cumulative factors. Other service users should have repeat assessments undertaken monthly or as their condition alters. Repeat assessment must always take place in the event of a fall. Remember that for all patients any identified falls risk factors and care needs should be addressed and reviewed in an ongoing way as part of the continuous care planning process - for some patients this may be on a day by day or even shift by shift basis, particularly if they have acute or fluctuating difficulties which affect their mobility and safety.

Patients name		**NHS Number**		**Ward**		**Date review completed**	
DOB and Age		**Male/Female**				**Completed by**	

Grouping	**Risks: Yes/No**	**Action Taken**	**Actioned by/ signed**
1 History of Falls			
2 Previous fracture			
3 Medical			
4 Medication			
5 Mental health			
6 Mobility			
7 Physical Health			
8 Environmental			

ROTHERHAM DONCASTER AND SOUTH HUMBER MENTAL HEALTH NHS FOUNDATION TRUST

MHSOP CARE PATHWAY FOR PATIENTS IDENTIFIED AS AT RISK OF FALLING

Patient admitted onto ward

↓

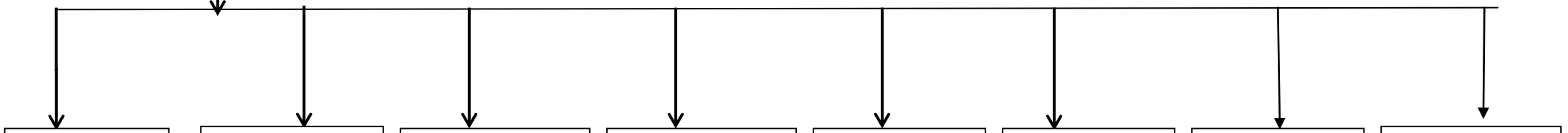
Falls risk assessment completed within 12 hours; bedrails risk balance tool to be completed for patients who are at risk of rolling/ falling from bed

↓

Create an appropriate MDT care plan and regularly review

Involving patient and carers

↓



History of Falls
Identify any previous falls; including falls from bed

Consider hip protectors, bed alarm, bed rails

Physiotherapy/ Falls prevention programme

Previous Fracture
Identify any previous fractures – discuss these with M.O or physio, re: if this is osteoporosis risk indicator?

Consider hip protectors/bed alarm/bed rails

Consider assessment and interventions for bone health

Medical
Check glasses/hearing aids
Check lying standing BP

Medical assessment to rule out physical cause
Ensure pain assessment and pain relief

Medication
Medication review

Monitor side effects of medication

Review use of PRN medication

Review prescribing following fall
Follow BPSD Nice guideline around prescribing

Mental Health
Consider hip protectors, bed alarm

Psychiatric review/ observation/ sleep chart

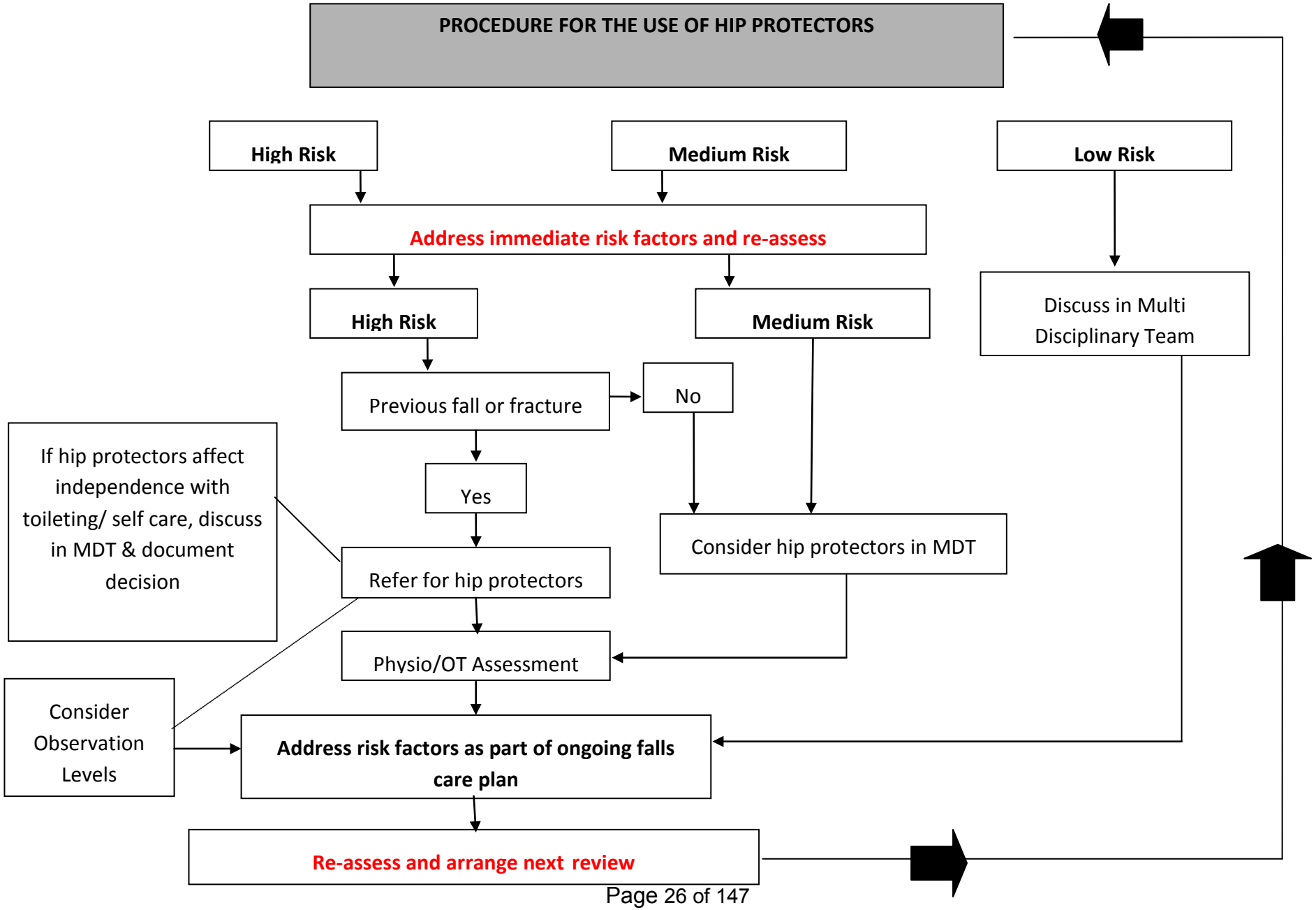
Re orientate to surroundings/ Signs/ nursing observation
Consider 1:1 if indicated

Mobility
Consider hip protectors, bed alarm
Physiotherapy assessment
Chiropody referral/ appropriate footwear
Continence assessment
Ensure clear signs

Physical Health
MUST/Dietetic referral
Medical review
Referral for alcohol counselling
Consider hip protectors, bed alarm
Health promotion advice

Environment
Identify history of falls from bed

Complete bed rails assessment
Consider bed alarm
Physiotherapy /OT assessment


PROCEDURE FOR THE USE OF HIP PROTECTORS
High Risk
Medium Risk
Low Risk
Address immediate risk factors and re-assess
High Risk
Medium Risk
Discuss in Multi Disciplinary Team
Previous fall or fracture
No
Yes
If hip protectors affect independence with toileting/ self care, discuss in MDT & document decision
Consider hip protectors in MDT
Refer for hip protectors
Physio/OT Assessment
Consider Observation Levels
Address risk factors as part of ongoing falls care plan
Re-assess and arrange next review

APPENDIX 2

ROTHERHAM, DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST
DONCASTER COMMUNITY INTEGRATED SERVICES
FALL RISK ASSESSMENT TOOL (FRAT)

Notes for users:

1) Complete the assessment form below. The more positive factors, the higher the risk for falling.

2) If there is a **positive response to three or more of the questions on the form,** then please see the guidance for further assessment, referral options and interventions for the different risk factors. If trained and competent complete the falls template on SystmOne.

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

Name:	Date of Birth
NHS Number:	

		YES	NO
1	Is there a history of any fall in the previous year? **How assessed?** Ask the person.		
2	Is the patient / client on four or more medications per day? **How assessed?** Identify number of prescribed medications.		
3	Does the patient / client have a diagnosis of stroke or Parkinson's Disease? **How assessed?** Ask the person.		
4	Does the patient / client report any problems with his/ her balance? **How assessed?** Ask the person.		
5	Is the patient/client **unable** to rise from a chair of knee height? **How assessed?** Ask the person to stand up from a chair of knee height without using their arms.		

Guidance for further assessment, referral options and interventions

Risk factor present	Further assessment	Referral Options	Interventions
1) History of falling in the previous year	Review incident(s), identify factors which may have caused or contributed to the fall. Check medical records, ask relatives if present.	Occupational Therapy Physiotherapy Falls Clinic/CICT	Discuss fear of falling and realistic preventative measures.
2) Four or more medications per day	Identify types of Medication prescribed – ask patient, check actual medication if patient has them present, check medical records, ask GP. Ask about symptoms of dizziness.	General Practitioner Falls Clinic Pharmacist	Review medications, particularly sleeping tablets (see www.bhps.org.uk/falls for more information on medication and falls). Discuss changes in sleep patterns which could be normal with ageing.
3) Stroke or Parkinson's disease	Recent/old stroke? Functional decline? Medically stable? Confusion?	Occupational Therapy Physiotherapy Falls Clinic/CICT	Review medications, particularly Parkinson's medication.
4) Balance and gait problems	Can they talk while walking? Do they sway significantly on standing?	Occupational Therapy Physiotherapy Falls Clinic/CICT	Teach about risk. And how to manouvere safely, effectively and efficiently. Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises. Transfer exercises. Evaluate for assistive devices. Consider environmental modifications to compensate for disability and to maximize safety, so that daily activities do not require stooping or reaching overhead.
5) Is the patient/client **unable** to rise from a chair of knee height?	If not, can they rise using hands?	Physiotherapy. Falls clinic. GP	Discuss why they cannot rise

Postural hypotension (low blood pressure)	Three readings taken 1) After rest five minutes supine (laying down, or sitting if this cannot be done) 2) 1 minutes later Standing 3) 3 minutes after standing Drop in systolic BP greater than 20mmHg and or drop in diastolic greater than 10mmgHg	District Nurse Practice nurse General Practitioner Falls Clinic	Offer extra pillows or consider raising head of bed if severe. Review medications. Teach to stabilize self after changing position and before walking. Avoid dehydration

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

DCIS INPATIENT RISK ASSESSMENT AND INITIAL ACTION PLAN

FOR THE MANAGEMENT OF SLIPS, TRIPS AND FALLS (INCLUDING FALLS FROM A HEIGHT)

Patients name		**NHS Number**		**Ward**		**Consultant**	
DOB and Age		**Male/Female**		**Date completed**		**Completed by**	

	Yes/ No	RED FLAG RATING	Details	Prompts/Strategies to consider	Action taken	Signed and date
1 History of Falls		RED		Identify any previous falls – why did they fall? How many in last 12 months? Any resulting in hospital admission?		
2 Previous fracture		RED		History of fractures including wrist/shoulder. Refer for osteoporotic assessment		
3 Medical						
Osteoporosis		RED		Check if receiving medication regime if not refer to medics (calcium? biphosphonates?). Check for risk factors.		
Postural Hypotension		RED		Check lying/standing BP, discuss with medics if available, systolic >20, symptomatic? Refer for medical review?		
Dizziness		RED		Check postural BP. Discuss with medics re cause; referral for syncope/medical assessment if		

				indicated		
Acute Illness		**RED**		Medical review		
Epilepsy		**AMBER**		Discuss management plan with carers and MDT		
Poor vision/hearing; not wearing glasses		**RED/ AMBER**		Red if glasses missing- **immediately rectify**. Amber if long standing and no prior falls; Check glasses/ hearing aids. Ophthalmology/audiology referral		
Arthritis		**AMBER**		Pain relief/anti inflammatory medication. Check functional ability. Physio/OT assessment		
Numbness in feet		**AMBER**		Physio assessment/medical review. Check BM? Diabetic? Neuropathy?		
CVA/ Cardiovascular problems		**RED**		Discuss within MDT and with carers. Physio/OT assessment. Medical review?		
Parkinson's Disease		**RED**		Discuss within MDT and with carers. Physio/OT assessment. Medical review?		
Pain		**RED/ AMBER**		Red if pain is severe and/or mobility affected/ contributes to falls. Refer for medical review, analgesia.		
Respiratory		**RED/ AMBER**		Amber if stable otherwise RED. Consider if short of breath on exertion, COPD, asthma. Consider referral to medic, physiotherapist, respiratory nurse specialist. Chest infection – refer to medic.		
Diabetes		**RED/ AMBER**		Amber if stable otherwise RED. Medical review if unstable.		
4 Medication						
2 medicines or more		**RED**		Medication review/monitor side		

PRN medication				effects. Medication review/monitor side effects. If PRN psychotropic medication used for Behavioral symptoms then ensure non-pharmacological approaches been offered first. – discuss with MDT & follow BPSD NICE guideline		
Anti psychotics		**RED/ AMBER**		Amber if prescribed for some time and no prior falls. Medication review/monitor side effects		
Heart or angina tablets		**RED/ AMBER**		Amber if prescribed for some time and no falls. Red if recently instigated nitrates or calcium channel blockers for angina. Consider medication review, especially if fallen and cause uncertain		
Diuretics or Blood pressure medication		**RED/ AMBER**		Amber if BP is normal, Red if BP is less than 120/80 Medication review/monitor side effects		
Anti Convulsants		**AMBER**		Medication review/monitor side effects		
Night sedation		**RED**		Medication review/monitor side effects.		
Analgesia		**RED/ AMBER**		Red for Opioid based analgesia, Amber for other analgesia. Medication review/monitor side effects		
Drugs for Parkinson's disease		**RED**		Medication review/monitor side effects. Especially dopaminergic ones such as sinemet, madopar.		
Sedating Antidepressants		**RED**		e.g. Mirtazapine, Trazodone. Medication review/monitor side effects		

Benzodiazepines		**RED**		Medication review/monitor side effects		
5 Mental Health						
Gets up frequently during the night		**RED/ AMBER**		Consider bed alarm/review observation level/sleep chart		
Responding to hallucinations		**AMBER**		Medical/Psychiatric review/frequent monitoring and observation		
Constant pacing		**RED**		Nursing observation/ pain assessment/ OT assessments and therapy plan		
Severe cognitive impairment/delirium/ confusion		**RED**		Frequently re orientate to surroundings/ signs/ medical review/ medication review/ nursing observation level– consider if risk indicates immediate 1:1		
6 Mobility						
Unsafe to walk alone?		**RED**		Consider need for 1:1 observation; agree approach; Physio assessment		
Difficulty Walking		**RED**		Physio assessment/ and treatment plan OT assessment. Medical review		
Fear of Falling		**RED**		Physio assessment/ and treatment plan OT assessment.		
Stops walking to talk		**AMBER**		Physio assessment/ and treatment plan / OT assessment		
Difficulty getting out of chair/ transfer problems		**RED**		Physio assessment and treatment plan /OT assessment		
Uses walking aids		**AMBER**		Physio assessment /and treatment plan OT assessment		
Poor balance		**RED**		Physio assessment/ and treatment plan OT assessment		
Foot problems		**AMBER**		Chiropody referral/orthopaedic		

				referral		
Urgent/frequent need for the toilet /incontinent		**RED**		Refer for continence assessment Medical review Check for infection		
Affected by change of flooring		**AMBER**		Display warning signs/Physio assessment		
Inadequate footwear		**RED**		Immediately rectify; proactive contact with carer; recommend appropriate footwear		
7 Physical Health						
Underweight/ Obese		**AMBER**		Dietician/ medical referral. Monitor weight weekly/ nutritional assessment or health eating plan.		
8 Environmental						
History of falls out of bed		**RED**		1:1 observation; Bed rails assessment; Consider Bed alarm Refer to Physio/OT		
Behavior which may lead to risk of fall from height		**RED**		1:1 observation; MDT review Physio/OT assessment		

Guidance: If risks are identified the action column MUST be completed, include all clinical actions taken/ planned to minimize risks.
Note: some risks are easily modifiable and require immediate action; immediate decisions are also required about safety precautions for patients at clear risk e.g. do they need hip protectors? bed alarms? What about falls prevention observation levels? Such decisions can subsequently be reviewed as the assessment process proceeds.

Any RED Flag rating indicates that further falls assessment and falls prevention MDT actions/ care plan will be required; the patient's falls risks and actions required must also be discussed at MDT meeting/ ward round, and documented accordingly.

For other patients, decide, on an individualized basis, if a specific falls care plan is required- use clinical judgment/ reasoning to make this decision and if unclear discuss with senior colleagues and other members of the MDT.

Review and reassessment of the need for an individualized care plan must take place if the patient's condition alters and the risk level or concerns increase indicators, or who have multiple/ cumulative factors. Other service users should have repeat assessments undertaken monthly or as their condition alters. Repeat assessment must always take place in the event of a fall. Remember that for all patients any identified falls risk factors and care needs should be addressed and reviewed in an ongoing way as part of the continuous care planning process - for some patients this may be on a day by day or even shift by shift basis, particularly if they have acute or fluctuating difficulties which affect their mobility and safety.

Summary of Plan/ Actions Taken/ Outcomes

Staff Name **Designation**

Signature **Review date**:

Falls Review Record Sheet

Clinical judgment should always guide the decision for the need for and frequency of repeat assessment and staff should take a pro-active approach to falls prevention. As a guide reviews/ repeat assessments should occur weekly for service users who have any unresolved red flag

Patients name		**NHS Number**		**Ward**		**Date review completed**	
DOB and Age		**Male/Female**				**Completed by**	

Grouping	**Risks: Yes/No**	**Action Taken**	**Actioned by/ signed**
1 History of Falls			
2 Previous fracture			
3 Medical			
4 Medication			
5 Mental health			
6 Mobility			
7 Physical Health			
8 Environmental			

If additional review is done such as after each fall and there are no changes to the risk assessment already completed, then this page may be used to document it.

APPENDIX 3

PROTOCOL FOR THE USE OF BED RAILS & BED BUMPERS

SCOPE
This protocol covers the use of bed rails and bed bumpers within RDaSH services

PURPOSE
The purpose of this protocol is to:

- Support patients and staff to make individual decisions around the risks of using and not using bed rails, and to use them safely and correctly
- Ensure compliance with Medicines and Healthcare products Regulatory Agency (MHRA) and National patient safety Agency (NPSA) advice.

DEFINITIONS

Bed Rails	Also known as bedside–rails, cot-sides, safety sides and bed guards; used in the health and social care sectors to protect vulnerable people from falling out of bed.
Integral Bed Rails	These are incorporated into the bed design and supplied with it, or are offered as an optional accessory by the bed manufacturer
Bed Rail Bumpers	These are a padded air- permeable accessory or enveloping cover, used to prevent impact injuries and also reduce the potential for limb entrapment. In some instances these themselves can become a hazard and introduce entrapment risks if they are able to move or compress.
Inflatable Bed Sides	These are air filled bed rails. For some children's systems some inflatable bed sides house the mattress in its own pocket or compartment, a feature which reduces entrapment risk between parts.

INTRODUCTION

- Bed rails are designed to prevent occupants falling from bed and being injured. They are not intended to prevent people from getting out of bed or to restrain people whose condition disposes them to erratic or repetitive movement

- Patients in hospital may be at risk of falling from bed for many reasons including poor mobility, dementia or delirium, visual impairment, and the effects of treatment or medication. In England and Wales, over a single year there were 44,000 reports of patients falling from bed. This included eleven deaths and around 90 fractured neck of femurs, although most falls resulted in no harm/ minimal injury. Patients who fell from beds without bed rails were significantly more likely to be injured and to suffer head injuries. A review of published bedrail studies suggests falls from beds with bed rails are usually associated with lower rates of injury; initiatives aimed at reducing bedrail use can increase falls.

- Bed rails are not appropriate for all patients, and using bed rails also involves risks. National data suggests around 1,250 patients injure themselves on bed rails each year, usually in a minor way (e.g. scrapes and bruises to lower legs).

- Based on national NHS reports deaths from bed rail entrapment in hospital settings in England and Wales occur less often than one in every two years and could probably have been avoided if safety advice had been followed. **Staff should continue to take great care to avoid bedrail entrapment, <u>but need to be aware</u> that in hospital settings there is a greater risk of harm to patients from falling from beds than there is from using bedrails.**

- Incorrect use of bed rails might themselves constitute a hazard and using bed rails to prevent the patient from leaving their bed could be considered as a restraint. (NPSA 2007) (MHRA 2006) (MDA 2001)

- National guidance acknowledges that bed rails may need to be used to protect patients who are restless or agitated. Such behaviour may result in harm if the patient is left unprotected or unobserved whilst confined to bed, so decisions about observation levels and the use of additional safeguards for protection (such as bumpers) will need to be made.

- Bed rails are not intended as a moving or handling aid

- Most bed rails are designed to be used only with adults or adolescents over 12 years old. If bed rails are intended for use by children staff must undertake a risk assessment involving the parent (s). Any use of bed rails (and associated products) for children must comply with the manufacturers instructions and with Medical Devices Agency requirements.

- Patients and their relatives sometimes welcome the use of bed rails to reassure them that they are safe in their environment.

ASSESSMENT & USE OF BED RAILS & BED BUMPERS

1. Assessment Procedures

There are different types of beds, mattresses and bed rails available and each patient is an individual with different needs. Most decisions about bed rails are a balance between competing risks. Staff should use professional judgement and clinical reasoning to consider the risks and make decisions for individual patients

- If the patient has the potential to fall from the bed consideration must be given to the causes of risk and ways these may be minimised e.g. different position in the ward, regular toileting, observing patient regularly, night lights, medication review with medical staff (such as reducing diuretics)

- For patients identified as potentially at risk of rolling/ falling out of bed, a bed rail 'risk balance assessment tool and checklist' shall be completed or an equivalent clinical process followed. Note risk balance tools are an aid to making professional judgements but not a substitute for them

- Any decision to implement or not implement the use of bed rails will be discussed with the patient, relative/ carer (if appropriate) and multi-disciplinary team. If an immediate decision is required and MDT members are not available (e.g. at night; at weekends) then the nurse in charge/ senior nurse will make the decision at that time.

- Consider mental capacity and best interest decision making in accordance with the Mental Capacity Act 2005.

- Information about bed rails use and falls prevention should be routinely provided to patients and carers (e.g. bed rails information leaflet).

- If a patient or relative request the use of bed rails the same risk assessment and decision making procedures should be followed

- Using bed alarms, or nursing the patient on a low bed if available, may also be considered. The use of a "crash mat" at the side of the bed could also be considered but an assessment must take place due to the risk of a trip hazard

- The following should be documented in the care plan/ patient record;
    - Rationale for use of bed rails or for not using bed rails
    - Plans for review
    - Whether bed rail bumpers are required
    - Discussion with patient (and/or relative as appropriate)

- Decisions about bed rails should be reviewed immediately whenever a patient's condition or wishes change. If they are removed, details of this decision shall be documented.

- Bed rails should not be used in place of supervision, and consideration must be given to the patient's need for observations with relation to their continued safety and needs, particularly for patients' who are agitated/ unsettled

- If a patient is found in positions which could lead to entrapment (e.g. limbs through gaps in rails/ between split rails) or is attempting to climb over the rail this is a clear indication that they may be at risk of injury from entrapment or falling. **Immediate changes must therefore be made to the care plan** e.g. possibly a change to a different type of bedrail, or decision made not to use bed rails as risks may now outweigh benefits.

- Safety of patients using bed rails is enhanced by frequent checking that they are safe and comfortable and that they have everything they need, including toilet needs. The safety needs of patients who are vulnerable to falls without bed rails are very similar. Observing patients with bed rails (e.g. for pain, discomfort, anxiety, breathlessness, medical needs) should therefore be part of routine good practice on the ward. Standard practices and policies for observation and observation levels should be followed.

- In some situations bedrail use is standard (e.g. when transporting patients, when patient unconscious, after anaesthetic)

2. Safe Fitting and Operation of Bed Rails: Integral and Detachable

- All staff should ensure that they are aware of how to use a piece of equipment prior to caring for the patient

- All staff using bed rails should be competent to fit them correctly and safely

- The following dimensions must be ensured:
  - The distance between the head panel or foot panel and bed rail must be less than 60mm or greater than 250mm. This ensures the gap is either too small or too large to enable a patient to trap their head or neck
  - The height of the top edge of the bed rail above the mattress without compression should be greater than 220mm

- If the patient is an unusual body size e.g. emaciated, hydrocephalic, micro cephalic, small - check for any bedrail gaps which would allow head, body or neck to become entrapped.

- All staff must inspect each bed rail for defects before use to ensure that it is in safe working order, each member of staff has a responsibility to remove and report unsafe equipment

- Staff must ensure that bed rails are compatible to the bed they are used with.

- Care must be taken to ensure that anything such as bed clothes, giving sets, catheter tubes, cables or mattress covers are not trapped in the bed rails. Things trapped in the rails or hinges can prevent bed rails from safely locking.

- Once raised and clicked into place the security of the bed rail must be double-checked.

- Beds should usually be kept at the lowest possible height to reduce the likelihood of injury in the event of a fall, whether or not bed rails are used. The exception to this is where patients are independently mobile and the bed needs to be at a certain height for safe transfers/ standing

- Beds need to be raised when direct care is being provided. Patients who are on bed rest and receiving frequent interventions may prefer their bed to be left raised, rather than it being constantly raised and lowered

3. Removal and Cleaning of Bed Rails

- Removable bed rails should be removed from the side of the bed when they are not required, as they create an additional risk of injury to patients, staff and relatives or may be raised accidentally

- Ensure the bed rails are cleaned during and after use as per infection control procedures.

4. Bed Rail Bumpers

- If there is a risk of the patient trapping their head, body or limbs between the bed rails then specifically designed padded accessories must be used.

- Bed rails bumpers must be cleaned during and after use as per infection control procedures.

5. Request for Items to Facilitate Hospital Discharge

- When bed rails are requested for a patient on discharge**,** local community equipment procedures for this shall be followed.

6. Pressure Relief Equipment

Before and during the use of pressure relief equipment, mattress replacement system & overlay with bed rails, consider and seek advice as appropriate regarding:

- The hazard of entrapment between the side of the mattress & bed rail may be exacerbated due to the soft, easily compressed nature of the mattress and /or overlay edge.

- The reduction in the effective height of the bed rail relative to the top of the mattress and /or overlay as it may allow the patient to roll over the top of the bed rail; **extra height bed rails or side rail extensions may be required**

- If the standard divan mattress is replaced with a pressure relief system, the whole bed rail assembly may require additional securing straps because the bed rail assembly rely on the weight of the traditional divan mattress to hold the assembly securely in place.

7. Children's Bed Rails

- Most bed rails are designed to be used with adults and adolescents over 12 years of age. Additional risk assessment should be carried out on the suitability of the bed rail for the individual child or small adult, as bar spacing and other gaps will need to be reduced.

- There are no published standards on bed rails for children; guidance that is available does not indicate that it was completed with a particular age group in mind. A risk assessment shall be undertaken which will involve the parent(s). The assessment must consider the mobility of the child and whether they will be likely to climb over the bed rail.

- Bed rails are designed to help stop children rolling out of bed accidentally. They are not designed or intended to limit the freedom of children by preventing them from intentionally leaving their beds or are they intended to restrain children. It is essential that bed rails are suitable for the children using them and compatible with the particular bed being used.

MAINTENANCE

- In many serious or fatal incidents involving bed rails, the cause has been a lack of maintenance. If a bed rail is faulty it should not be used– for in-patient areas follow local procedures; for community the Integrated Community Equipment Service (or equivalent provider) must be contacted to rectify.

- Routine inspection and maintenance of bed rails will be carried out in line with Trust medical devices procedures

TRAINING

Matrons, ward managers and service managers have a responsibility to ensure that staff carry out their duties as required and are competent to do so.

Staff responsible for assessment, fitting and use of bed rails must be competent to:

- Understand the rationale for use of bed rails and bed rail bumpers

- Carry out risk assessment for use competently and be able to fit correctly; be able to show the patient/carer how to use safely; follow procedures for cleaning and storing (ward staff); follow locality procedures for issue and use (community staff).

A range of falls training sessions are delivered in the Trust If over and above there are any specific training requirements with regards to bed rail use please liaise with line managers, falls prevention leads or colleagues in learning and development.

The HSE (Health and Safety Executive) in conjunction with BUPA have produced a bed rail training package. Ward managers, deputies and clinical leads who work in areas where bed rails are in use are advised to complete this, see link below:
http://www.hse.gov.uk/healthservices/bedrails/

LEGISLATION & REFERENCES

- Medicines and Healthcare products Regulatory Agency (2006) Device Bulletin Safe Use of Bed Rails DB2006(06) December 2006 ISBN 1-90-073159-2
- National Patient Safety Agency (2007) Using bed rails safely and effectively in hospital 26 February 2007
- Medical Devices Agency (1999): Bed Side Rails (Cot Sides) Fitted with Telescoping Crossbars – Risk of Movement and Subsequent Patient Injury Safety Notice MDA SN1999(36), October 1999 - London HMSO
- Medical Devices Agency (2000): Bed Side Rails (Cot sides) – Risk of Entrapment and Asphyxiation; (2001): Bed rails (Cot sides) – Risk of Entrapment and Asphyxiation Supplement to HN2000(10) - London HMSO
- Medical Devices Agency (2001): Advice on the Safe Use of Bed rails Device Bulletin MDA DB2001(04), July 2001 - London HMSO
- Medical Devices Agency (2002): Bed Safety Equipment – An evaluation London HMSO ISBN1–84182–568-9

- Medicines and Healthcare products Regulatory Agency (2004): Reporting Adverse Incidents and Disseminating Medical Device Alerts MDA/2004/001, 01 January 2004 - London, HMSO

BEDRAILS RISK BALANCE ASSESSMENT TOOL & CHECKLIST: In Patient Services

Patient name: NHS No: Ward:

D.O.B: Date of Assessment:

Consider bedrail use if patient has: history of falls at night, a history of falls out of bed, if they have poor sitting balance, if they are immobile, if they have a fear of falling out of bed, if any members of the MDT or family members identify concerns about the risk of falls from bed, or if the overall falls risk assessment / falls care plan indicates bedrails are to be considered.

Section A: **If bedrails are <u>not used</u> how likely is it that the patient will come to harm?** Ask the following questions (please tick if applicable/ likely)	***Section B:*** **If bedrails are <u>used</u> how likely is it that the patient will come to harm?** Ask the following questions (please tick if applicable/ likely)
1. How likely is it that the patient will fall out of bed? Patients may be more likely to slip, roll, slide or fall out of bed if they: • Have fallen from bed before • Have been assessed as having a high risk of falling • Are very overweight • Have a visual impairment • Have a partial paralysis • Have seizures or spasms • Are sedated, drowsy from strong painkillers, or prn medication • Are delirious or confused • Are affected by alcohol or street drugs • Are on a pressure – relieving mattress which 'gives' at the sides • Use bedrails at home; **2. How likely is it that the patient will be injured in a fall from bed?** Injury from falls from bed are more likely and may be more serious if the patient: • Has osteoporosis • Takes anticoagulants • Has fragile skin • Has a vascular disease • Is critically ill;/has long-term health problems • Is malnourished **3. Will the patient feel anxious if the bedrails are not in place?** • Some patients may be afraid of falling out of bed even though their actual risk is low	**1. Will bedrails stop the patient from being independent?** • Bedrails can be a barrier to independence for patients who otherwise could leave their bed safely without help. **2. Is the patient likely to climb over the bedrails?** • An injury's severity can be increased if the patient climbs over the bedrail/ footboard and falls from a greater height. It is patients who are significantly confused and have enough strength and mobility to clamber over bedrails that are most vulnerable **3. Is the patient likely to injure themselves on the bedrails?** Bedrails can cause injury if the patient knocks themselves on them or traps their legs or arms between them. The most vulnerable patients are those: • With uncontrolled limb movements • Who are restless and significantly confused • With fragile skin Bedrails, even when correctly fitted, carry a very rare risk of postural asphyxiation. Patients who are very confused, frail and restless are more likely to be at risk. Remember fitting additional equipment (e.g. Bed rail covers/bumpers, mesh bedrails, inflatable bedrails, integral bedrails) may minimise the risk of injury. **4. Is the patient likely to become trapped in the bedrails?** • Note you can use bedrail bumpers to minimise this risk **5. Is using bedrails likely to cause the patient distress?** • Bedrails may distress some patients who feel trapped by them

Now make your decision based on a <u>balance of risks</u> NOTE: BEDRAIL USE **<u>IS</u>** RECOMMENDED IF THE RISKS IN *SECTION A* ARE GREATER THAN THE RISKS IN *SECTION B.*
Record the decision made:

Signed: Designation: Date & Time

CHECKLIST If using bedrails: give patient and family members information about bedrails and their use; if patient unable to consent follow usual procedures for assessing capacity and decision making; **discuss decisions within MDT**; ensure an appropriate falls prevention care plan in place; ensure bedrails in good repair, work correctly, match and fit the bed; ensure gap between the top end of the bedrail and the head of the bed is less than 6cm or more than 25cm; If a pressure relief mattress is in use check if extendable bed rails are needed and if so ensure they used; If the patient at risk of striking their limbs on bedrails ensure equipment is used to minimise risk of injury e.g. padded bed rail covers/ bumpers, mesh bedrails, integral bedrails, inflatable bedrails. Please remember bedrails are to be used on both sides of the bed, when the use of bedrails is no longer clinically indicated they should be removed and the decision to do so recorded in the clinical record

REVIEW: <u>Immediately review</u> the decision to use bedrails if the patient has been found in positions which could lead to entrapment, has become trapped or if the balance of risks changes in other ways. Otherwise review as part of usual care plan review procedures

Doncaster Community Integrated Services
Risk Assessment Tool for the Use of Bed Rails

This assessment must be completed in all cases where Bed Rails are being considered for use. Please use the flow chart overleaf to complete your assessment.

IF THERE ARE CHANGES MADE TO THE BED OR MATTRESS ANOTHER RISK ASSESSMENT MUST BE CARRIED OUT

Client Name: _____

Address: _____

_____

_____

Assessor Name: _____

_____

Base: _____

Results of Assessment:

Bed Rail Sides	***Recommended***	❑
	Not Recommended	❑

Reason for Decision:

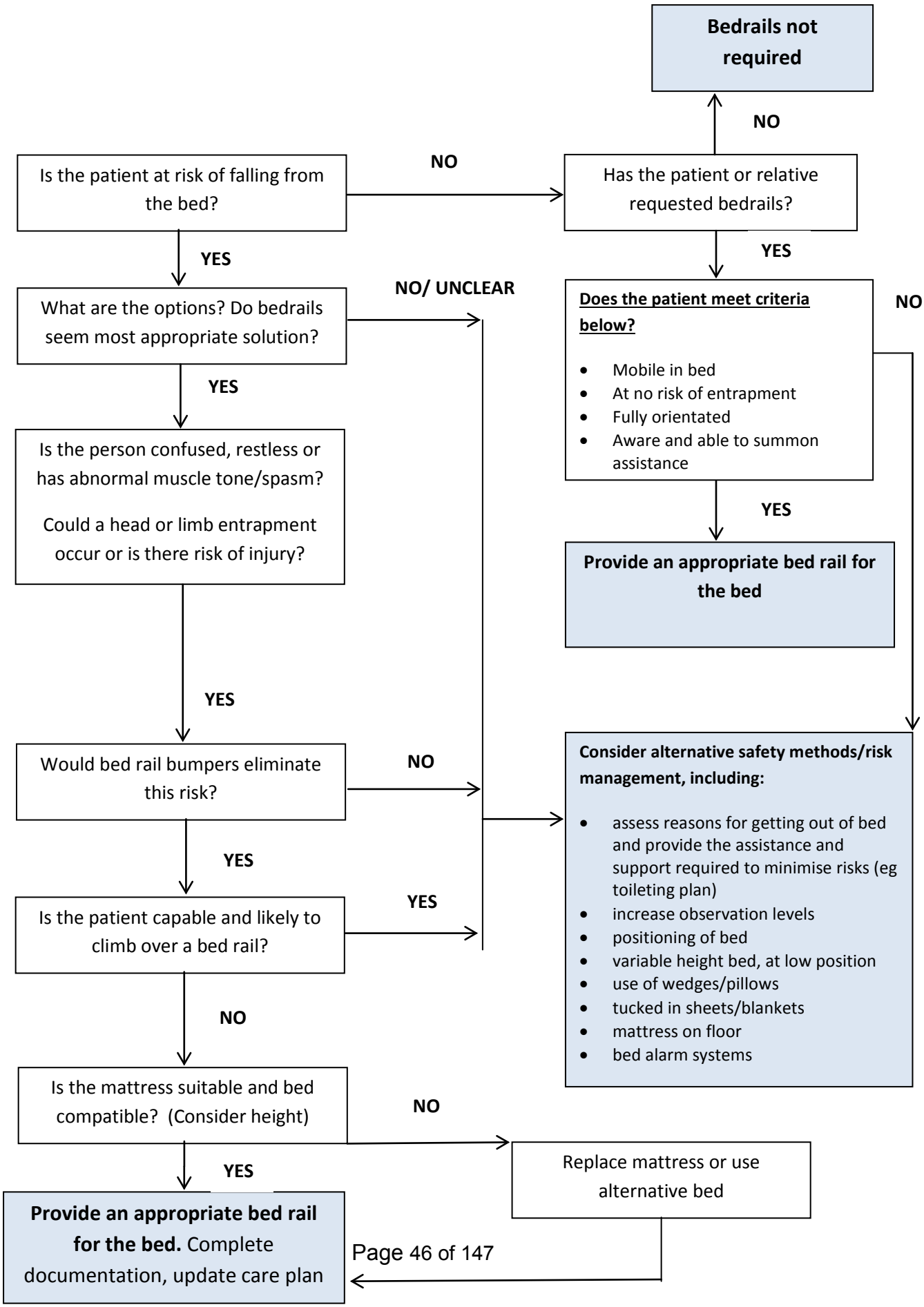
Special Considerations/Instruction:

Date of Requisition: _____

Date Fitted: _____

Fitted By: _____

Use of Bedrails Assessment FLOW CHART



MHRA Bed Rails Poster

Safe use of bed rails

MHRA

Bed rails successfully prevent many falls, but their incorrect use has resulted in the deaths of bed occupants by asphyxiation through entrapment in gaps.

Risk assessment is **key** to ensure safe use. It should start with the bed occupant and include the combination of the proposed equipment, the bed and the mattress.

Issues to consider

- If the person is likely to fall from their bed, are bed rails an appropriate solution?
- Does the person's physical size or behaviour present a risk?
- Is the bed rail height appropriate for the bed occupant?
- Can the person's head, neck, chest or body become trapped between:
  - > the bars of the bed rails?
  - > other gaps created by the bed, rail, mattress and head/footboard combination?
- Is the bed rail fitted correctly – does it seem likely that it will move away from the side of the mattress or bed during use and so creating a hazard?
- Bed rails designed for adults should not be used for children.

If either the bed, mattress, bed rail or condition of the occupant changes then the risk assessment should be carried out again.

Our publication 'Safe use of bed rails' DB 2006(06) has more detailed information and is available on our website: www.mhra.gov.uk
Report problems with assistive technology products online, via the MHRA website www.mhra.gov.uk or email: aic@mhra.gsi.gov.uk
For advice email dts@mhra.gsi.gov.uk

'Third party' bed rails, as photographed below, are not model specific and fit a wide range of beds. The principles set out below apply to all types of bed rails.

Design safety

Bed rails should be fitted so that the gap between their end and the headboard is less than 60mm or greater than 250mm.

All gaps between the rail bars for adults must be 120mm or less and for children 60mm or less.




Hazards

Most of the deaths caused by bed rails could have been avoided if thorough risk assessments of the bed occupant, the bed and the bed rail combination had been carried out.

MHRA investigations have also shown that many serious and fatal incidents with bed rails have been caused by a lack of maintenance.

Bed rails must be inspected on a regular basis to ensure they are in good condition.




Things to avoid

- Gaps that could cause head, neck or chest entrapment when the mattress is compressed or between the end of the bed rail and the headboard or footboard.
- Using bed rails which are not compatible with the bed base.
- Using insecure fittings that let the bed rail drop down or move away from the side of the bed.
- Using bed rails that have not been maintained regularly.
- Bed rails with parts missing.

APPENDIX 4

BEDRAILS: PATIENT INFORMATION LEAFLET

How bedrails are used

Bedrails are attached to the sides of hospital beds to reduce the risks of patients rolling, slipping, sliding or falling out of bed. They cannot be used to stop patients getting out of bed, even if they might be at risk of falling when they walk.

Who decides when to use bedrails?

If patients are well enough, they can decide. If they are too ill to decide for themselves, hospital staff will decide after first talking to their relatives or carers. Bedrails are used if the benefits are greater than the risks.

The benefits

Some patients fall out of bed because their illness affects their balance, or their treatment makes them very drowsy. Some patients need special air-filled mattresses to reduce the risk of pressure sores, which can be easier to roll off accidentally. Some patients have electric beds with controls they use to move from lying down to sitting up. These beds can be very comfortable, but some patients are at risk of falling when they use the controls to change their position. Most patients who fall out of bed receive only small bumps or bruises, but some patients are seriously injured. Bedrails can prevent such accidents.

The risks

Some illnesses can make patients so confused that they might try to climb over a bedrail and injure themselves. If there is a possibility that a patient will try to climb over a bedrail, it is safer not to use them.

If patients are independent, bedrails would get in their way.

If patients are very restless in bed, they can knock their legs on a bedrail or get their legs stuck between the bars. Padded covers and special soft bedrails can reduce this risk.

In this hospital, all bedrails have been checked to reduce the small risk of patients getting trapped between the bed and the bedrail.

Alternatives to bedrails

There are many ways to reduce the risk of patients falling (see fall prevention booklets/ information). If you have any questions about bedrails or preventing falls, please ask the staff.

APPENDIX 5

PROTOCOL FOR THE USE OF HIP PROTECTORS

A. Scope

Hip protectors are generally only used in older people's services and most often used in older people's mental health services. However they may be provided in other service areas (DCIS, Learning Disabilities, Adult Mental Health) on an individual patient basis based on presenting needs, risks and associated medical conditions.

B. Background

Hip fractures in the elderly after a fall are a major cause of morbidity and mortality. They can result in complications, infections, blood clot in the legs and failure to regain mobility. Hip fractures have a serious impact on a person's life. Many older people lose independence and have to rely on help from family or need care in a nursing home.

Hip fracture carries high morbidity and mortality. Amongst patients with dementia, incidence is higher and recovery poorer. There are around 75,000 hip fractures in the UK annually. This is expected to increase to 101,000 by 2020 with an estimated cost of £2.2 billion. Average cost in dementia is greater due to higher complication rates. Dementia has been demonstrated to be an independent risk factor for sustaining a hip fracture with studies showing up to 50% of hip fracture patients to have dementia.

C. Patients at Risk of Harm from Falls

A number of factors can increase the risk of a hip fracture, including osteoporosis, falling on a hard surface, falling directly onto the hip and a person's age. *Osteoporosis is a condition that affects the bones, causing them to become weak and fragile and more likely to break (fracture). These fractures most commonly occur in the spine, wrist and hips but can affect other bones such as the arm or pelvis.*

Women and men are at a greater risk of falling when they become older due to a loss in muscle size and strength, poor balance and co-ordination.

Risk Factors for harm from falls are:

- Have had a previous fragility fracture
- Are currently using steroid tablets or injections or have used them frequently
- Have a history of falling have a family member who has had a hip fracture
- Have another condition known to cause osteoporosis
- Have a low body mass index
- Smoke, drink more than 14 units of alcohol a week for women and 21 units a week for men.
- Low levels of the sex hormone oestrogen in women as a result of early menopause, having a hysterectomy with removal of ovaries (before the age of 45), anorexia nervosa or Turners syndrome.
- Low levels of the sex hormone, testosterone, in men following surgery for some cancers.
- Hyperthyroidism when levels of thyroid hormone are abnormally high

- Conditions that cause long periods of immobility

D. What are Hip Protectors?

A hip protector is a specialised form of pants or underwear containing pads (either hard or soft) along the outside of each hip/leg, designed to prevent hip fractures following a fall. Most hip fractures follow an impact due to a lateral fall. The pads are located over the trochanters, the bony extrusions of the hip region. Hip protectors are either of the "crash helmet type" or "energy-absorbing type". The "crash helmet type" distributes impacts into the surrounding soft tissue, while the "energy-absorbing type" is made of a compressible material and diminishes the force of impact.

E. How might hip protectors prevent hip fractures

Hip protectors may be most useful for people who are confused or have dementia, are falling often or for those frailer individuals in residential care type environments whose bones are very fragile, especially if they have previously suffered a fracture.

F. Current Evidence

*NICE guidance Falls: Assessment and Prevention of Falls in Older People June 201*3 states that 'Reported trials that have used individual patient randomisation have provided no evidence for the effectiveness of hip protectors to prevent fractures when offered to older people living in extended care settings or in their own homes. Data from cluster randomised trials provide some evidence that hip protectors are effective in the prevention of hip fractures in older people living in extended care settings who are considered at high risk'

The report concludes that the benefit from using hip-protectors is inconclusive and there is ambiguity with relation to falls and the protection that hip protectors offer. However, there are many types of hip-protector and many types of person who may benefit. The evidence remains inconclusive however there is suggestion within evidence that if a person is wearing a hip protector and has a fall, it may reduce the chance of a hip fracture. The greatest issue with hip-protectors appears to be compliance.

None of the reports suggest that hip protectors should be used independently, only as part of wider falls prevention intervention.

A review in the Journal of Clinical Nursing *Hip protectors: are they beneficial in protecting older people from fall-related injuries? Journal of Clinical Nursing Volume 23, Issue 1-2, pages 13–23, January 2014* reviewed six articles.

The report states that the methodological quality of the research publications collated varied, and the use of hip protectors was deemed inconclusive. Compliance was raised as a prevailing issue. However the report concluded that the problem of fall-related injuries was significant. Whilst some evidence was inconclusive, it stated that the use of hip protectors for high risk patients was recommended as best practice

G. Provision of Hip Protectors

- **Older People's Mental Health Services**

On admission hip protectors are offered to patients who:

- Have a diagnosis of Osteoporosis
- Are being treated with bone health medication
- In patients who are over 90 years of age will be offered hip protectors

Within 48 hours the Physiotherapist will carry out a comprehensive patient assessment which will include mobility, strength, balance and falls history. The Physiotherapist will also carry out the FRAX assessment.

The FRAX assessment tool has been developed by World Health Organisation to evaluate fracture risk of patients. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as bone mineral density (BMD) at the femoral neck. The FRAX algorithms gives a probability of a major osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture).

If the patient scores 'high' and falls in the RED category 'to treat'. Hip Protectors will be issued.

For other patients the Physiotherapist/MDT may make a clinical recommendation for hip protectors (along with other considered interventions) based on presenting needs, risks and associated medical conditions

The outcome of the FRAX assessment will be included in the patient's discharge letter to the GP for further action dependent on the results.

- **DCIS, Learning Disabilities, Adult Mental Health**

Hip protectors will be considered on an individual patient basis if indicated; based on presenting needs, risks and associated medical conditions. It is suggested that clinicians in these services follow the same risk assessment and clinical reasoning processes as described for older people's mental health services to guide their decision making

H. Guidance for Use

1 Hip protectors must be considered as a **part** of the falls management plan/ intervention, and must not be seen as a standalone solution. All other aspects of falls prevention, other risks identified must be addressed in addition to the provision of the hip protectors.

4 If hip protectors are likely to limit independence in toileting, self-care or well-being then discussion about their appropriateness and the balance of overall risks should occur – involving other members of the MDT as appropriate. These discussions and decisions made must be clearly documented.

5 It is important to include the patient in the decision making process if possible and consent obtained and documented in notes. Carers/family may also be consulted especially if the patient is unable to provide consent.

6 Hip protectors should not be provided unless a falls risk assessment and care plan has been completed

7 For patients suffering from pressure sores, or who have other tissue viability problems – then further advice should be sought from the tissue viability nurse before the use of hip protectors. Advice should also be sought and multi-disciplinary discussion occurs if the patient is confined to bed for 24 hours or more.

8 Only the soft shell hip protectors are suitable for wearing in bed.

I. Ordering of Garments

When a patient has been identified as requiring hip protectors an RDC request can be completed (or local procedures for ordering may have been agreed, in which case these should be followed – if in doubt seek advice from modern matron). Some wards

may keep a limited stock to ensure that all identified patients receive the garments immediately.
Measurements must be taken and care to ensure the correct size garment is issued.

J. Providing Garments to Patients

Once the garments have been given to the patient they are deemed to belong to that patient.
Care must be taken that they are washed and dried in line with manufacturer's instructions.
Patient's name clearly marked inside the garments.

K. Aftercare

Once out of the care of the ward future use of hip protectors and issues related to this becomes the responsibility of the GP, (and the care home). If the patient is discharged to a care home, a copy of the falls risk assessment and associated care plan should be sent with the patient to ensure continuity of care and to alert the home to potential falls risks, and also the use of hip protectors.

PROTOCOL FOR THE USE OF BED ALARMS / SENSORS

INTRODUCTION

The use of bed alarms / sensors can reduce the number of falls by up to 54%, according to research (*Dept of Elderly Medicine, 2004*). While they cannot in themselves prevent falls, they can alert staff that someone who is at risk of falling is about to get out of bed.

CRITERIA FOR USE

- Bed alarms are to be considered for patients who are at risk of falling through the night
- For patients under 6 stone in weight bed alarms are ineffective, as they do not activate. They are also unsuitable for patients who are using a pressure relief overlay mattress.
- If bed alarms are thought to be reducing the amount of quality sleep that a patient has, alternatives will need to be considered.

Key Points

- The falls risk assessment and care planning procedures must have been followed and the use of a bed alarm must be part of a falls management plan.
- When portable bed alarms are used consideration should also be given to the location of the patients' bedroom. The patient's should be allocated a room as close to the main observation area of the ward as possible.
- Any shortage of bed alarms to meet patient needs must be reported to the ward manager.

MAINTENANCE AND CHECKING

1 Bed alarms must be checked on a weekly basis for faults and ward areas must have an identified process for the changing of batteries

2 All identified faults must be reported as agreed locally.

3 Bed alarms must be recorded within the locality medical devices register

4 Modern Matrons to monitor and report when integrated bed alarms fail to function

REFERENCES

Department of Elderly Medicine 2004. *Bed Sensors Reduce In-Patient Falls*. University Hospital Nottingham

Guidance on the Use of Ultra-low Beds

Ultra low beds can help to prevent harm from falls particularly for patients who are at risk of falling out of bed

Some patients are at risk of falls from their bed. Agitation and confusion combined with limited mobility or acute illness are particular risk factors. To prevent injuries to such patients when the use of bed rails is deemed inappropriate, consideration should be given to the use of ultra-low beds.

Patients must be assessed individually to ensure that this is the most appropriate method of preventing potential falls from bed.

When considering the use of an ultra-low bed:

- Physical illness – some essential medical and nursing interventions may be difficult or impractical when using an ultra-low bed.
- Psychological illness or distress – the unusual position may aggravate distress, confusion and/or agitation.
- Discomfort or pain – any unsettling stimuli such as pain can aggravate confusion and/or agitation.
- Disabilities/capabilities – the use of an ultra-low bed may affect the patients capabilities e.g. transfers and mobility.
- The wishes of Patients and/or relatives/carers.
- Previous accidents/injuries.
- Any variation in status over a 24 hour period e.g. nocturnal confusion.
- Consider mental capacity and best interest decision making in accordance with the Mental Capacity Act 2005

Key points

- The decision to use an ultra-low bed must be recorded in the nursing notes and discussed with and communicated to all members of the ward (multidisciplinary) team
- The patient's family and/or carers should also be informed of the decision.
- The use of ultra low beds must be reviewed and documented as part of care planning review process
- Care must be taken to ensure beds not near to floor level furniture or fittings such as radiators, pipes or lockers as risk of injury to the patient

- Consider risk of potential asphyxia entrapment if patient slipped between side of mattress and wall if bed placed against the wall

- Consider risk of patient tripping over crash mat placed next to bed

Ultra Low Bed Assessment Guide

If an ultra low bed **is not used** how likely is it that the patient will come to harm? Ask the following questions	If an ultra low bed **is used** how likely is it that the patient will come to harm? Ask the following questions
• How likely is it that the patient will roll out of bed? • How likely is it that the patient would be injured if they rolled out of bed? • Will the patient feel anxious if they are not near the floor?	• Will an ultra low bed stop the patient from being independent? • Could the patient stand up unaided from an ultra low bed? • Could the patient become trapped under the carriage of an ultra low bed? • Could using an ultra low bed cause the patient distress?
Consider using ultra low bed if bed rails are not suitable and benefits outweigh the risks. Ultra low beds can be used alone of in conjunction with other falls prevention measures	

APPENDIX 8

ISSUES ABOUT RESTRAINT

Bed Rails, Bean bags, Lap Straps, Nursing on the Floor

People have a right within the law to do what they want and to go where they want unless limited by legislative action. Respecting people's basic human rights to dignity, freedom and respect underpins good quality care. Whilst some people may need support in making choices and decisions they have the right to make choices about their lives and to take risks

It is important for staff to understand their role within 'duty of care'

It distinguishes between putting people at risk and enabling them to choose to (if they have capacity) to take reasonable risks – duty of care does not mean people have to be kept safe from every eventual risk. No environment is entirely risk-free.

Rights, risks and restraints. An exploration into the use of restraint in the care of older people. November 2007 Commission for Social Care Inspection (CSCI)

"Physical intervention is only used as a last resort, in accordance with Department of Health guidance and protects the rights and best interests of the service user, including people with special needs, and is the minimum necessary consistent with safety" –

Domiciliary Care National Minimum Standard 14.6.DOH

Definition of Restraint

The Mental Capacity Act 2005 states *Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm."* Department for Constitutional Affairs (2007). *Mental Capacity Act 2005. Code of practice*.

Physical restraint**:** a physical restriction to moving around as one wishes.

This might be by using belts or cords, sheets or blankets to tie or secure someone to a place such as a chair or a bed; chairs or beds from which someone is unable to move; bed or side rails; or chair or lap tables.
Commission for Social Care Inspection Rights, risks and restraints

When it is appropriate to use restraint

The main reason usually for the restraint (of older people) is for their personal safety, to prevent them from harm in particular from falling
Black K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute; Karlsson S, Bucht G, Eriksson S and Sandman P. (1996). Physical restraints in geriatric care in Sweden: prevalence and patient characteristics. *Journal of the American Geriatric Society*, 44 (11): 1348-54

Key points

- Should never be used unless no other options can be found and the practice is within the law.
- Where there is an immediate risk of harm to the individual or others,
- Other methods to control the situation have been tried, found to be unsuitable or failed

Circumstances when restraint may be allowed

No service user is subject to physical restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other service user and there are exceptional circumstances.

Legal Implications

The inappropriate use of restraint is against the law. Restraint can constitute assault, battery or false imprisonment and can lead to criminal prosecution. Certain criteria need to be met for restraint to legally occur:

- the person lacks capacity and it will be in the person's best interests
- it is necessary to restrain the person to prevent harm to them
- restraint is a proportionate response to the likelihood of the person *suffering* harm and the seriousness of that harm.
- restraint must be the minimum amount of force for the shortest time possible *Commission for Social Care Inspection Rights, risks and restraints*

If it is used in an inappropriate situation the restraint may constitute abuse and may be subject to Safeguarding Adults legislation

Risks

Restraint may have repercussions on the health and wellbeing of a person e.g.

- Walk less - mobility deteriorates
- Greater risks of pressure sores, may possibly cause other injuries
- Depression/cognitive decline,
- DVT
- Respiratory problems
- Poor posture – back pain

Interventions

- Minimise risk by the use of other falls prevention methods such as increased staff support/ supervision, hip protectors, knee and shoulder pads.

- Always consider if there are other options and exhaust these first. Then consider what is the least restrictive for the individual e.g A 'bean bag' type chair might be better than a recliner; and a mattress on the floor might be better than bed rails however undignified this might seem.

Decision making process

- Decisions should be made within the MDT with the RMO at the lead. Expert advice of other professionals should also be sought if necessary. e.g **Safeguarding Leads,** Moving and Handling key trainers. In exceptional circumstances (e.g. in emergency situations where immediate action is needed) agreement/ concurrence by the MDT to the decision, may occur retrospectively.

- Risk assessments and care planning must be undertaken and decisions recorded.
- The relative risk of doing something versus not doing something should be risk assessed and decisions related to this recorded
- Wishes of the patient must be sought and recorded along with views of relatives and advocates
- When a decision is made that using restraint is necessary, consent must be obtained unless the service user lacks capacity. In these cases procedures under the mental capacity act must be followed
- Consent must be informed i.e. steps must be taken to ensure that the service user has understood the pros and cons of the restraint, and considered other options
- Staff need to take into account how the person can themselves end the restraint, if they wish to withdraw consent.
- The decisions should justify that any restraint used is the least restrictive method, and that it is in line with the level of risk
- Care plans**:** plans drawn up should specify what is to be done and include time limits for use of restraint and frequency of reviews. (Decisions must be reviewed frequently). Care plans must also specify any actions required to comply with tissue viability and with any other care needs arising from the use of restraint. If mobility or movement is restricted by the restraint then the care plan must also include actions to provide adequate range of motion interventions to maintain health, independence and well-being. <u>These care plans and records related to them should be subject to regular review by ward managers.</u>

Clarke A. with Bright L. (2002). *Showing restraint. Challenging the use of restraint in care homes*. London:

Counsel and Care (2001). *Residents taking risks. Minimizing the use of restraint – a guide for care homes*.

Royal College of Nursing (2004). *Restraint revisited – rights, risk and responsibility. Guidance for nursing staff*. London: Royal College of Nursing.

Department of Health Guidelines *" Guidance for Restrictive Physical Interventions 2002"*

K. and Haralambous B. (2005). *Barriers to implementing 'restraint free care' policies*. Melbourne: National Ageing Research Institute

Guidelines for the use of Wheelchair Lap-belts

Introduction

There are a number of concerns regarding the use of wheelchair lap-belts, particularly with people who have been identified as having an increased risk of falls. These concerns relate to the difficult decisions that may have to be made regarding balancing risks with safe and lawful practice

The use of Wheelchair Lap-belts

- Wheelchair lap-belts are intended as a safety device to be used during transportation only.
- There may be other occasions when their use is required as part of an overall falls risk management plan e.g if the patient needs to spend time in a wheelchair and there is a risk of the patient slipping out of the chair.
- Wheelchair lap-belts may also be used at the request of patients - occasionally patients themselves feel safer wearing them- e.g. if they have some balance problems or are anxious about falling out of a chair

Implementation

- Decisions should be made within the MDT.
- Rationale for use of lap-belts will be clearly documented within patient record with evidence of MDT discussion, risk, clinical reasoning; least-restrictive methods; protection of the patient's rights, dignity and well-being
- Decisions must be documented in the patient record
- Advice/ input from the Safeguarding Leads may be sought
- Decisions should be reviewed on every occasion that the lap-belt is used
- Measures in place to meet a patients needs (e.g. toileting, nutrition) during use
- Patient to be regularly monitored for signs of distress

Key points

- Patients should only be sitting in a wheelchair (with cushion) for short periods of time for transit purposes. The only exception to this is for patients who are long-term wheelchair users/ dependent, these patients should be using their own bespoke chair complete with their own pressure care cushion or customised seating system or when a clinical need is identified.
- Wheelchair lap-belts should never routinely be used as a falls prevention method, evidence suggests that restraining people in a wheelchair with a lap-belt can **increase the risk** of falls (i.e. it leads to decreased mobility, a loss of muscle strength and increased distress/ agitation).
- Consider consent, capacity and best interest decision making in line with Mental Capacity Act 2005.
- Consent must be informed and steps must be taken to ensure that the service user has understood the pros and cons of using the lap-belt

GUIDELINES FOR NURSING PATIENTS ON THE FLOOR

Introduction

Nursing patients on a mattress on the floor is occasionally used in the management of patients who are at risk of falling out of bed. Nursing patients on the floor should only be considered to reduce the risk of potential injury or distress as a result of current mental / physical condition; it should only be considered when other alternatives have been explored/ tried and deemed unsuitable (e.g use of adjustable high/ low bed). Staff are advised to use procedures for Safeguarding (child and adult protection procedures) to help inform their decisions; direct advice and support in individual cases/ situations can be sought from RDaSH 'Safeguarding Leads/Managers'

Benefits

- Minimise risks/ potential injury associated with falling from a bed at height
- May minimise fear/ distress related to feeling unsafe and at risk of falling out of a bed

Implementation

- Decisions should be made within the MDT
- Rationale to nurse a patient on the floor will be clearly documented within patient record with evidence of MDT discussion, risk, clinical reasoning; least-restrictive methods; protection of the patient's rights, dignity and well-being and must only be considered when other alternatives have been tried and deemed unsuitable

- Service user consent must be obtained unless the service user lacks capacity. In the event of the service user not having capacity an MDT decision would be made based on the best interests of the patient
- Decisions should be reviewed, on every occasion that care is delivered in this way

- Ensure changes of position and monitoring with regards to tissue viability in line with trust polices and guidance.
- Advice/ input from the Safeguarding Leads may be sought
- Measures in place to meet a patients needs (e.g. toileting, nutrition) during use ppatient to be regularly monitored for signs of distress

Key points

- Ensure manual handling risk assessment completed, ensure environment risk assessment completed (of immediate environment where the bed is)
- Ensure staff trained and competent to ensure safe movement of patient from the floor/low level
- Ensure staff trained and competent to use any equipment and that relevant manual handling equipment is available e.g. hoist
- Consider patient's privacy and dignity needs
- Consider impact on mobility/ physical health of the patient
- Consider emergency evacuation procedures

- Consider consent, capacity and best interest decision making in line with Mental Capacity Act 2005. Consent must be informed and steps must be taken to ensure that the service user has understood the pros and cons of being nursed on the floor
- Ensure area can be cleaned in line with infection control measures
- Ensure no hazards within reach e.g. things that may fall on top of the patient

GUIDELINES FOR THE USE OF BEAN BAG SEATING

Introduction

Bean Bags may occasionally be used in the care and management of patients who are at risk of falling, falling out of a chair, or where the use of bean bags has been identified as an effective therapeutic intervention e.g for relaxation.

Implementation

- Decisions should be made within the MDT
- Rationale to use a bean bag will be clearly documented within patient record with evidence of MDT discussion, risk, clinical reasoning; least-restrictive methods; protection of the patient's rights, dignity and well-being and must only be considered when other alternatives have been tried and deemed unsuitable
- Service user consent must be obtained unless the service user lacks capacity. In the event of the service user not having capacity an MDT decision would be made based on the best interests of the patient.

- Decisions should be reviewed, on every occasion that care is delivered in this way
- Ensure changes of position and monitoring with regards to tissue viability in line with trust polices and guidance.
- Advice/ input from the Safeguarding Leads may be sought
- Measures in place to meet a patients needs (e.g. toileting, nutrition) during use
- Patient to be regularly monitored for signs of distress
- Ensure that bean bag cannot be unzipped as contents may pose a choking or inhalation risk in confused patients/ patients lacking in capacity

Key points

- Ensure manual handling risk assessment completed, ensure environment risk assessment completed (of immediate environment where the bean bag is)
- Ensure staff trained and competent to ensure safe movement of patient from the floor/low level
- Ensure staff trained and competent to use any equipment and that relevant manual handling equipment is available e.g. hoist
- Consider patient's privacy and dignity needs
- Consider impact on mobility/ physical health of the patient
- Consider emergency evacuation procedures
- Consider consent, capacity and best interest decision making in line with Mental Capacity Act 2005. Consent must be informed.
- Ensure area can be cleaned in line with infection control measures

- Ensure no hazards within reach e.g things that may fall on top of the patient

GUIDELINES FOR THE USE OF PATIENT HEAD PROTECTION / HELMETS

Introduction

Head Protection is occasionally used in the management of patients who are at risk of falling, or occasionally chosen to be worn by the patient/ service user to increase their confidence in their own safety.

Head protection may be used to reduce the risk of patient injury as result of current mental / physical condition; longer term use must always be justified in that the risks remain or are recurrent/ ongoing. Staff are advised to use procedures for Safeguarding (Child and Adult) to help inform their decisions; direct advice can sought from 'Safeguarding Leads/Managers'.

The use of head protection may be part of a risk management plan whereby wearing the head protection enables the patient/ service user to choose to participate in activities and routines which they otherwise may be unable to do as safely.

Implementation

- Decisions should be made within the MDT
- Rationale to use head protection will be clearly documented within patient record with evidence of MDT discussion, risk, clinical reasoning; least-restrictive methods; protection of the patient's rights, dignity and well-being and must only be considered <u>when other alternatives have been tried and deemed unsuitable.</u> Documentation must include plans for review
- Service user consent must be obtained unless the service user lacks capacity. In the event of the service user not having capacity an MDT decision would be made based on the best interests of the patient.
- Patient to be regularly monitored for signs of distress as a result of appearance and comfort,
- Head protection/ helmets must be individually prescribed/ fitted for use; instructions for correct daily fitting and wearing should be followed
- All staff who fit or assist the patient/ service user in the putting on of the head protection/ helmet should ensure it is fitted correctly

Key Points

- Consider that use of head protection may affect hair growth and cause hair loss
- Consider risk of scalp problems/ rubbing to pressure areas/ infection – particularly if not fitted correctly or not maintained properly
- Consider risk of stigma and patient's privacy and dignity needs
- Monitor with regards to possible pressure areas in accordance with trust pressure care management policy
- Ensure head protection can be cleaned in line with infection control measures
- Consider patient's privacy and dignity needs

CHECKLIST

(RE: USE OF WHEELCHAIR LAP-BELTS/ BEANBAGS/ HEAD PROTECTION/ NURSING ON THE FLOOR)

This checklist provides a tool for clinical reasoning and decision making in relation to falls and the use of wheelchair lap belts, beanbags, head protection and nursing on the floor as part of an overall falls management plan...

- Has a falls risk assessment been carried within the previous 24 hours?
- Is a falls prevention care plan in place?
- Have all other alternatives for falls management been considered?
- Has an MDT discussion taken place about the use of the item/ procedure, potential risks/ issues related to restraint?
- Has a discussion taken place with the patient and/ or family about the use of the item/ procedure?
- If restraint is a concern have ***safeguarding procedures*** been followed?
- Have implications for moving and handling (moving and handling assessment must have been completed)?
- Has tissue viability and infection control been considered and any necessary actions taken to ensure that these are not compromised?

All discussions and decisions made must be fully documented in the patient's clinical records. This checklist may also be put into the notes to evidence the reasoning process.

Osteoporosis

Osteoporosis is defined as a progressive systemic skeletal disease characterised by low bone mass and deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture

- In the UK, **one in two women and one in five men** over the age of 50 will break a bone mainly because of poor bone health.
- Osteoporosis costs the NHS and government £2.3 billion a year – that's **£6 million a day**.
- There are about **230,000 osteoporotic fractures** every year.
- **1,150 people are dying every month** in the UK as a result of hip fractures

Approaches to the prevention and treatment of osteoporosis include measures to reduce fracture risk in the general population include increasing the level of physical activity undertaken, reducing the prevalence of smoking, and increasing dietary calcium intake. Epidemiological studies have shown, with varying degrees of certainty, that these risk factors are associated with osteoporosis

Up to 20% of symptomatic vertebral fractures and 30% of hip fractures occur in men

The two major risk factors are being female and elderly. In addition, there are a number of other well established risk factors listed below:

• Early menopause (age <45)

• Hypogonadism

• Physical inactivity

• Thin body type

• Major gynaecological surgery e.g. hysterectomy

• Amenorrhea

• Anorexia

• Heredity

• Rheumatological conditions e.g. rheumatoid arthritis, ankylosing spondylitis

• Lifestyle factors: Smoking, alcohol; high caffeine intake

• Insufficient dietary calcium and Vitamin D.

Secondary osteoporosis accounts for 20% of cases in women and 40% of cases in men and may occur as a result of:

• Endocrine disorders - including thyrotoxicosis, primary hyperparathyroidism, Cushing's syndrome`

• Gastro-intestinal disorders (malabsorption, partial gastrectomy, liver disease)

• Malignancy (multiple myeloma, metastastic carcinoma)

• Certain drugs (corticosteroids, heparin).

Interventions and Screening

Bone Mineral Density (BMD)

Measurements of BMD are widely recognised as being effective at identifying patients who are at a higher than average risk of fracture

Exercise

Physical activity can delay the progression of osteoporosis by slowing the rate at which bone mineral density is reduced from the late 20's onwards

Nutrition

□A balanced diet provides all the vitamins and minerals required to develop and maintain strong bones. The recommended daily intake (RDI) for calcium in adults is 700 mg although more may be required for people with osteoporosis

Fractures

Adults who sustain a fracture are over 50 % more likely to have another one of a different type

Alcohol and Smoking

An alcohol intake of more than 2 units per day increases the risk of an osteoporotic Fracture, a history of smoking also increases risk

Bone density is most commonly measured by dual energy x-ray absorptiometry (DXA) scan

Reference;

NICE TA160 Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women

Post Fall Protocol

Background

Each year around 282,000 patient falls are reported to the NPSA from hospitals and mental health units. A significant number of these falls result in death, severe or moderate injury including around 840 fractured hips, 550 other types of fracture, and 30 intracranial injuries

Reducing the risk of harm

When a serious injury occurs as a result of an inpatient fall, safe manual handling and prompt assessment and treatment is critical to the patient's chances of making a full recovery.

Aim

- Identification and treatment of any injury, including comfort, reassurance and pain relief where necessary.
- Recognition and track and trigger/signpost of any physical deterioration using Early Warning Score (EWS) /Neurological (Neuro) obs.
- Taking and documenting appropriate observations to identify injury, including observations to assess for medical causes of the fall (for example, increased confusion, hypotension, hypoglycaemia etc.).
- Making safe any obvious environmental hazard that contributed to the fall.
- Informing relatives as soon as possible and involving (where appropriate) in any actions planned to reduce the risk of further falls.
- Completing an incident form even if the service user suffered no physical harm, including all the key information for learning.
- If there is serious injury e.g hip fracture, Assistant Director to initiate investigation under the SI policy and initiating a full root cause analysis.
- Reassessment of falls risk and review /development of a plan of care to reduce the likelihood of risk or harm from falls
- Taking action to reduce the likelihood of further falls incidents or risk of harm from falls; this may include use of additional equipment or referral to specialist services.

Spinal Injury

It has been estimated that in Europe 20% of women aged over fifty will suffer a Vertebral Compression Fracture (VCF) and although there has been shown to be a similar prevalence in men, it is thought that, as their fractures present at an earlier age, aetiology may be traumatic

Moving a patient with potential for spinal injury or suspected fracture before their injury has been appropriately immobilised can cause severe harm. An initial brief assessment can identify if there is any pain, loss of sensation, visible injury or limb deformity that could indicate a fracture

If a hoist and a fabric sling are used for a patient with spinal fracture, the spinal cord can be damaged.

Spinal Injury may be a fracture, dislocation, or spinal shock. Which ever, the initial emergency treatment is the same.

Signs and Symptoms

- History of traumatic event – blow to head/neck, fall, accident involving speed, crushed
- Unnatural posture/ position
- Pain in neck or back
- Step or twist in curve of spine
- Pale, cool, clammy skin
- Often a slow pulse
- Absence of feeling and / or movement in part of the body
- Loss of bladder or bowel control
- Difficulty breathing

Treatment

- **D**anger
- **R**esponse
- **A**irway
- **B**reathing
- **C**ompressions (if needed)

If the person is conscious,

- Reassure the person whilst telling them not to move – ensure you are in their eye line, if not they will move to see where the voice is coming from.
- **Ensure ambulance is on the way**
- Keep the person in the position you found them in.
- Hold their head still with your hands, keep the head and neck in line with the upper body.
- Treat any other injuries, bleeding etc.

- Physical observations, EWS. Continue to monitor response, airway and breathing.

- Have handover ready for ambulance service.

If person is unconscious,

- If the person is breathing normally in the position you found them, their airway must be clear at that present time therefore there is no need to tilt the head back. If not breathing start Cardio Pulmonary Resuscitation (CPR), this becomes the most important issue at that time; the airway must be opened to provide adequate breathes, so use head tilt chin lift.

- **Ensure ambulance is on the way**

- Remain with the person holding their head with your hands, keeping the head and neck in line with the upper body. Monitoring their breathing.

- **If you have to leave the person, you become concerned about their airway or they begin to vomit, you must put them in the recovery position.** Using as many people as possible use the log role to keep the head and neck in line with the spine whilst turning.

- Continue to monitor the breathing, treat any other injuries and take physical observations and EWS.

- Have handover ready for the ambulance service.

Hip Fracture

All patients with hip fracture should be admitted to an acute orthopaedic ward **within 4 hours of presentation.**

All patients with hip fracture who are medically fit should have surgery **within 48 hours of admission, and during normal working hours.**

The Care of Patients with Fragility Fracture, published in 2007 by the British Orthopaedic Association and British Geriatrics Society

Risks

Unnecessary delay can present risks to the patient of possible blood loss due to fracture, increased risk of pressure sores if the patient is immobilized for long period, confusion and pain.

Signs and Symptoms

The key presenting symptoms of a suspected hip fracture are:

- Shortening and rotation of the limb, pain,
- Difficulty moving the limb and Difficulty weight bearing.
- Difficulty mobilizing
- Pain

*** However approximately 15% of fractures are undisplaced, and therefore produce no shortening or external rotation of the limb. Hip movements, although painful, may be possible and the patient may even be able to walk.

In the event of a suspected fracture the patient **MUST NOT BE MOVED.**

POST FALL PATHWAY (to be used in conjunction with flowchart)

Immediate response

- **D**anger
- **R**esponse
- **A**irway
- **B**reathing
- **C**hest Compression(if needed)

Check for injuries

- If no apparent injury, and appropriate and safe assist patient to bed / chair via appropriate means (see Manual Handling Policy) If the patient can get off the floor independently, then allow them to.
- If there are contraindications to moving the patient a doctor/ambulance must be requested to attend to the patient immediately to assess prior to moving
- If head trauma and / or fracture is apparent or suspected – assess/ EWS/ Alert, Voice, Pain, Unconscious (AVPU) .Contact medic for advice/ transfer to hospital/ 999 or local pathway number. For DCIS if no medic available then arrange urgent transfer to A&E.
- Signs of head trauma: conduct neurological observations EWS/AVPU see Head Injury Guidance
- Suspected lower limb fracture – call for ambulance, make patient comfortable on floor. **Do not move patien**t
- Suspected upper limb fracture – immobilise limb, return patient to bed / chair, contact medic and request urgent assessment /transfer to A&E 999 or local pathway number . For DCIS if no medic available then arrange urgent transfer to A&E.
- Check signs of other injuries e.g. bruising, laceration, swelling, abrasion, and record. Contact medic if cause for concern or arrange transfer to A&E if no

medic available 999 or local pathway number

Baseline Observations

- Check and record any symptoms of nausea, confusion, drowsiness, delirium, agitation

- Perform appropriate measurements e.g. pulse, blood pressure, temperature, oxygen saturation and respirations as per EWS Guidance

Make safe any environmental hazards

- Remove or minimise environmental hazard(s) if any contributed to the fall

- If the hazard can't be removed directly ensure necessary warning is implemented that no other person will be at risk

Monitor the patient

- Observe the patient according to EWS/Head Injury Guidance

- Some injuries may not be apparent at the time of the fall – ensure patient is checked regularly following the event for signs of injury such as pain, discomfort, decreased mobility and the appearance of bruising and swelling or for any other changes in presentation.(also see Head injury guidance)

Incident form

- Complete the incident form according to trust policy

Inform relevant contacts

- Inform the patient's relatives, and inform and involve them in any actions planned to reduce the risk of further falls

Review

- Review risk assessment and care plan

- MDT review including medication

Falls Flowchart

PATIENT FALLS
Note type of fall, witnessed or un witnessed

assesses patient following action checklist. .

- **D**anger
- **R**esponse
- **A**irway
- **B**reathing
- **C**ompressions (if needed)

Slight/Minor

- No apparent injury
- No apparent head injury EWS 0
- No complaints of pain/discomfort (verbal/nonverbal)
- Mobility unaffected able to move limbs on command or spontaneously
- No signs of bruising/ wounds
- No signs of limb deformity/ shortening rotation
- No changes in patient presentation e.g agitation

- Assist patient to a comfortable place (using hoist/handling aid as required)if no contraindications
- Contact medic for advice/assessment DCIS – if no medic available refer to GP or falls clinic
- Observe for 24 hours
- Document in notes
- Inform clinical team at earliest opportunity
- Review falls risk assessment and care plan
- Inform relatives and document discussion
- Request medical assessment to determine cause of fall
- MDT review including medication
- Refer to Physiotherapy / OT as indicated

Any change in condition causing concern –call medic or 999/ambulance service

Moderate/Injury

- **Some bruising**
- **Slight skin wounds**
- **Begins to complain of/observed pain or discomfort**
- **Changes in mobility/ability**
- **No apparent head injury EWS 0/ or some change in observation(see EWS guidance)**
- **No signs of limb deformity/ shortening/ rotation**
- **Consider mechanism of injury (e.g fall from height)**
- **Significant fall where trauma suspected (e.g onto hip, head injury))**
- **Evidence of deteriorating condition (see EWS guidance)**
- **High index of clinical suspicion of ill health**
- **Any other suspicion of injury**
- **Based on clinical assessment/judgment**

- **<u>Do NOT initially move patient</u>**
- **(if medical assessment is for transfer to hospital do not move patient)**
- **Carry out physical assessment including obs**
- **Contact medic for initial advice and for assessment**
- **(DCIS to inform GP, if no medic available arrange ambulance if needed)**
- **If no identified injury following medical assessment observe /monitor for 24 hours (see Head Injury guidance)**
- **Document in notes**
- **Review falls risk assessment and care plan**
- **Inform relatives as soon as possible and document discussion**
- **Inform clinical team at earliest opportunity**
- **MDT review including medication**
- **Refer to Physiotherapy / OT as indicated**
- **Arrange transfer to hospital for treatment of skin wound if**

Major/Injury

- **Loss of consciousness**
- **Reduced consciousness**
- **Changes in EWS/AVPU**
- **Head injury (as indicated by head injury guidance)**
- **Airway/breathing problems**
- **Haemorrhage**
- **Chest pain**
- **Limb deformity**
- **Bruising /swelling**
- **Unable to move limbs, joints on command**
- **Pain (verbal/nonverbal)**
- **Unable to mobilize**
- **Unable to stand**
- **Dizziness**
- **Vomiting**
- **Any fall from height above 2 metres**
- **Changes in presentation**
- **Any other concern**

<u>DO NOT MOVE PATIENT</u>

For suspected head injury (see EWS/ Head Injury Guidance)

For suspected spinal or hip fracture Contact medic request urgent assessment/ contact ambulance (based on clinical decision)

999 or local pathway number

Transfer

- Transfer to hospital for possible head injury/ suspected hip fracture will be implemented through **999 or Local inter facility transfer pathway number**
- Patient must be left on the floor and made comfortable, patient **must only be moved if there is a significant risk to the patient to remain in that location**.
- On arrival ambulance staff will administer analgesia and will transport the patient to hospital
- Ward staff to provide information for transfer

Medical Assessment

- Despite the difficulty in taking a reliable history in some patients, an attempt should always be made to find the cause of the fall. Hypotension is often an aetiological factor, exacerbated by medication such as diuretics, beta-blockers and sedatives. The Parkinsonian patient is at particular risk due to postural instability and orthostatic hypotension. The diabetic patient is also prone to falls due to poor vision, peripheral and autonomic neuropathy and hypoglycaemia.
- Hip fracture may be the first presentation of Pagetic or Metastatic bone disease – when fracture may follow minimal trauma, with the fall resulting from the fracture rather than the other way round. Cancers that commonly metastasise to bone are those arising in bronchus, breast, kidney, and prostate.
- Following a fall the medic on duty/ on call will be contacted for advice/assessment as indicated
- On some in patient units there will not always be a doctor on site especially out of hours. However some patients will need urgent medical examination and arrangements must be made as per guidance. For patients with no obvious need to be urgently examined, examination needs to take place within a reasonable timescale. Medical examination is important not only to detect injury but because falls are often a ‘red flag’ for changes in the patient’s underlying medical condition. If the patient has been immobilised as a precautionary measure, access to investigation and treatment must be speedy to avoid the risk of prolonged immobilisation and associated complications.

Medical Assessment must include:

Subjective Assessment

- History of patient including whether they have a diagnosis/high risk of osteoporosis
- Mechanism of injury
- Whether the patient is on coagulation therapy
- Is the patient an IDDM
- Any changes in EWS/patient observations as reported by nursing staff
- Predisposing factors – sudden collapse/dizziness/chest pain

- Complaints of pain especially in groin or proximal femur (in patients with cognitive impairment assessment should be made through the use of a rating scale such as the Abbey if the patient is unable to report pain)
- Any changes in the patient's presentation e.g. increased agitation

Objective Assessment

- Suspicion of other injuries- dislocation, fractured pubic rami
- Examination CVS, RS, Abdomen and Neurology
- Examine the position of the leg and foot for signs of shortening or rotation of limb
- Inability to move affected limb
- Inability to weight bear (will not exclude a #)
- Unable to walk / Changes in gait pattern
- Inspect the skin over the greater trochanter for any bruising
- Gently palpate to identify area of bony tenderness
- Check if patient has sensation to the sole of the foot and palpate pedal pulse
- Advise nursing staff on monitor BP, pulse and respirations for signs of hypovalaemia
- Request nursing staff record core temperature

Impacted undisplaced fractures may present diagnostic difficulty and there may be no shortening or rotation. Consideration must be given to all above.

Patients in whom a hip fracture is strongly suspected but the initial radiograph is normal should undergo further imaging (MRI, CT or bone isotope scan).

Head Injuries
Observation after Head Injury

Any injury to the face or head could constitute a head injury

After any head injury there is a risk of deterioration, and this often is hidden until the effects are serious. It is prudent to observe the injured person for subtle signs of a deteriorating head injury so that action can be taken in a timely fashion. These special observations are known as Neurological Observations, or Neuro obs.

These Neurological observations are to be carried out, after a head injury, at the following intervals AT LEAST;

- half-hourly for 2 hours
- then 1-hourly for 4 hours
- then 2-hourly thereafter until EWS and neuro obs as baseline. If EWS and Neuro obs normal at the initial reading, neuro obs must continue for at least 6 hours.

In addition to any neuro obs, it is important, particularly in our patient group, that after a head injury, any change from the person's normal presentation must be considered a result from the head trauma and action taken appropriately.

Important Points to Consider

Especially in those who do not allow a full examination or completion of the full set of neuro obs, a part set is to be completed. In particular;

Respiratory Rate

The brain controls the breathing, therefore any problems with the brain can affect respirations, (raised intracranial pressure will lower the respiratory rate and alter the respiratory pattern) particularly in the absence of any other observations, the rate, depth and pattern of the breathing should be recorded after head injury, this must be described in the nursing notes.

AVPU

In some patient groups the Glasgow Coma Score is often difficult to obtain. AVPU is a good indicator of a change in a person Central Nervous System (CNS) function level.

A – Alert
V – Responds only to voice

P – Responds only to pain

U – Unconscious

To assess response to pain the following 2 procedures must only be used; suborbital pressure, rub finger along bony rim above eye, or, Trapezium squeeze, use the thumb and 2 fingers to squeeze the muscle.

Changes to Normal Presentation

Any changes after a head injury must be considered to be as a result of the injury until ruled out by a medic. E.g. A person who was not using sentences or appropriate words starts talking normally; a person who gives no eye contact starts to stare, changes to normal muscle tone/normal movement ability, e.g. becomes floppy etc.

WHEN TO CALL AN AMBULANCE AFTER A HEAD INJURY

- Unconsciousness or lack of full consciousness (for example, problems keeping eyes open).
- Problems understanding, speaking, reading, or writing (since the injury).
- Loss of feeling in part of the body (since the injury).
- Problems balancing or walking (since the injury).
- General weakness (since the injury).
- Any changes in eyesight.
- Any clear fluid running from ears or nose.
- A black eye with no obvious damage around the eye.
- Bleeding from one or both ears.
- New deafness in one or both ears.
- Bruising behind one or both ears.

- Any evidence of scalp or skull damage, especially when the skull has been penetrated.

- A forceful blow to the head at speed (for example, a pedestrian hit by a car, a car or bicycle crash, a diving accident, a fall of 1 metre or more, or a fall down more than five stairs).
- A convulsion or fit since the injury.

WHEN TO CALL A DR AFTER HEAD INJURY

- Any previous loss of consciousness (‘knocked out’) as a result of the injury, from which the injured person has now recovered.

- Amnesia for events before or after the injury (‘problems with memory) change from normal presentation.
- Persistent headache since the injury.
- Any vomiting episodes since the injury.
- Any previous cranial neurosurgical interventions (‘brain surgery’).
- History of bleeding or clotting disorder.
- Current anticoagulant therapy such as warfarin or heparin.
- Current drug or alcohol intoxication.
- Age 65 years or older.
- Suspicion of non-accidental injury.
- Irritability or altered behaviour (‘easily distracted’, ‘not themselves’, ‘no concentration’, ‘no interest in things around them’) Change from normal presentation.

Taken from NICE guidance CG56 Head Injury

FURTHER OBSERVATIONS TO BE TAKEN WHEN APPROPRIATE AND POSSIBLE

GLASGOW COMA SCALE

Many clinical staff, particularly in Mental Health and Learning Disability Services, do not use the Glasgow Coma Scale (GCS) assessment tool frequently enough to be competent in its use. Also, the GCS can be difficult to calculate in some of our patient groups and can be very subjective particularly when not used on a regular basis. The preferred measure of CNS state is the **AVPU** score as discussed previously. In most cases a person’s consciousness will have deteriorated before observations start to alter, therefore any change in a person’s AVPU score will mean action is required. Within RDASH the GCS score will be calculated by the attending paramedic or Dr unless carried out in area as norm.

In clinical areas where the GCS is used frequently, such as the Neuro Rehabilitation Unit and the staff are competent in its use, then the GCS should use it as part of the post head injury observations

TEMPERATURE

The hypothalamus is the thermo regulator in the brain, any raised inter cranial pressure will affect the ability to regulate the temperature and therefore there may be a fluctuating temperature.

BLOOD PRESSURE

After a head injury the blood pressure may rise in attempt to perfuse the brain, or fall as a result of a slowed pulse rate.

PULSE

After a head injury the pulse may slow as the body attempts to compensate for an increase in intracranial pressure.

PUPIL RESPONSE

A change in the pupil size and reaction can be an indication of raised inter cranial pressure and therefore the compression of the optic nerve after head injury.

NOTES FOR COMPLETING PUPIL CHECKS

Each pupil should be recorded separately.

- Are the pupils of equal size
- Assess the pupils for their size and shape using a measure of 1-9 see the diagram on the observation chart
- Reaction to light – rapid constriction to light is recorded as a positive reaction; no constriction is recorded as a negative reaction. A slow reaction should be recorded as sluggish.
- Move a light from the outer aspect of the eye directly over the pupil, the pupil should constrict quickly and dilate again when the light is moved away. Both eyes should constrict when a light is shone into one eye.
- In a patient with slight swelling an attempt should be made to open the eye if at all possible.
- If a person refuses to open their eyes document refused to open eyes. If this is a change from normal behaviour it should be documented as this is a change to presentation after head injury, but if this is normal behaviour document refusal as normal behaviour.

LIMB MOVEMENT/MOTOR FUNCTION

Again when checking motor function we must be aware of the person's normal function and record if needed.

Check the limbs for;

- Normal Power – the person's norm they will be able to push against or squeeze with no difficulty.
- Mild weakness – a change/ reduction from the norm they will be able to push against but will be over come easily.
- Spastic Flexion – bending or flexing the limb that is not the norm, if this is the person's norm they would score for normal presentation,

- Extension – straightening or extending that is not the norm, if this is the person's norm they would score for normal presentation.
- No Response – again a change from normal presentation.

The response should be checked by giving simple commands, squeeze my hands, lift your legs etc.
If there is no response to commands and this is a change from normal behaviour, painful stimuli should be used to re asses. Suborbital pressure can be used, rub finger along bony rim above eye, or Trapezium squeeze, use the thumb and 2 fingers to squeeze the muscle.

Always record all possible observations after head injury on a Neuro Obs chart, with any additional observations noted clearly within the Nursing Notes.

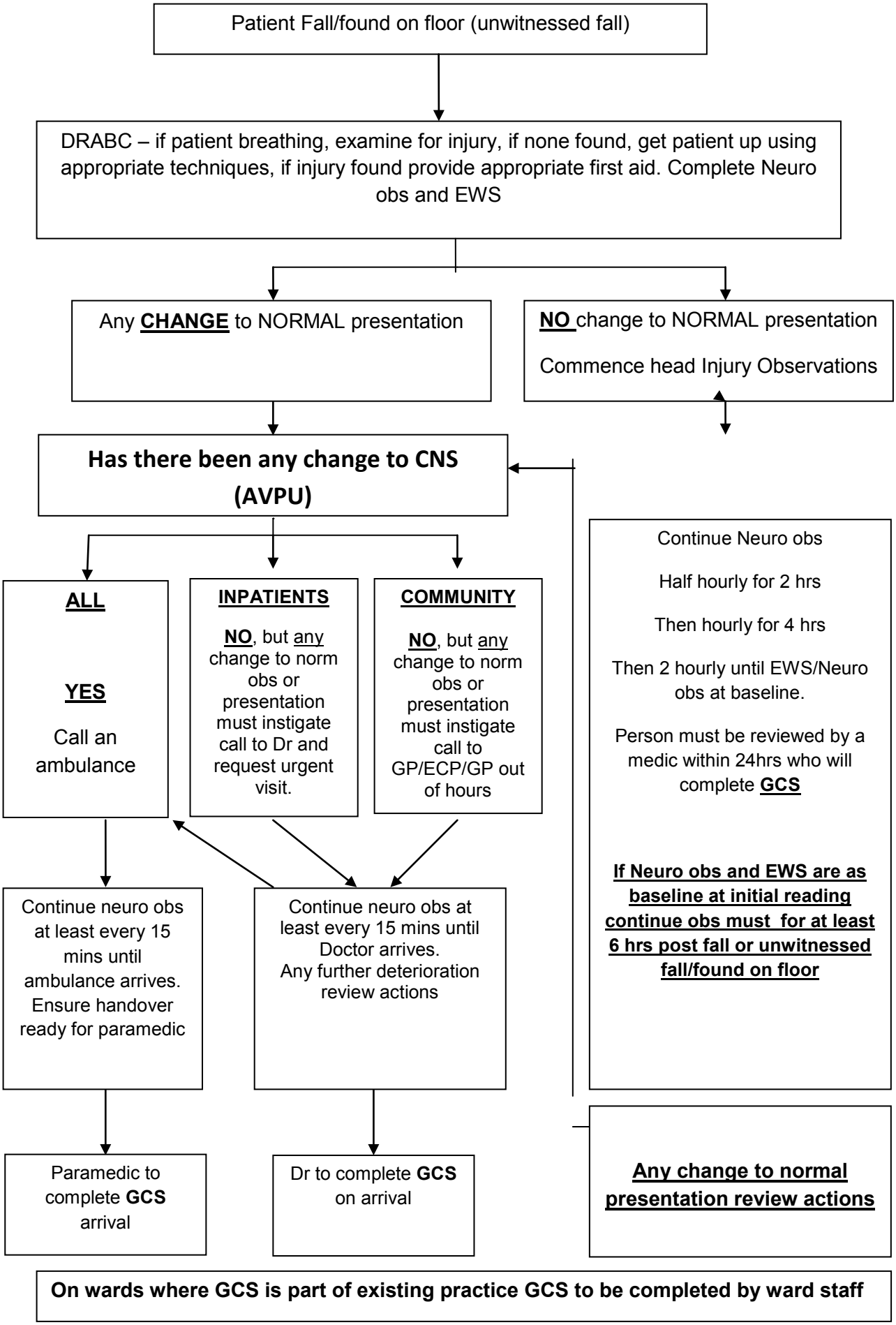
If working in an area where physical observations are not carried out as a matter of course, (community homes etc.), ensure person is closely 'watched' and the advice on when to call an ambulance or Dr is followed. It must be considered good practice to always record, as a minimum, a person's consciousness level and at least, depth and rate of breathing.

Rotherham Doncaster and South Humber NHS Foundation Trust

NAME -				DOB -	WARD -		
Date						Date	
Time			BASELINE			Time	
						40	T
Pupil Scale						39	E
						38.5	M
		260				38	P
		250				37.5	E
SIZE MM		240				37	R
1		230				36.5	A
		220				36	T
2	B	210				35	U
	L	200				34	R
3	O	190				33	E
	O	180					
4	D	170				230	
		160				220	
5		150				210	
	P	140				200	
6	R	130				190	P
	E	120				180	U
7	S	110				170	L
	S	100				160	S
8	U	90				150	E
	R	80				140	
9	E	70				130	
		60				120	
PUPIL RESP		50				110	
		40				100	
						90	
B =						80	
Brisk						70	
		50				60	
S =	R	45				50	
Sluggish	E	40				40	
	S	35				30	
F =	P	30				20	
Fixed	S	25				10	
		20					
C =		15					
Closed by swelling		10					
		5					
CNS AVPU or GCS						CNS	
O2 SATURATION						O2 SATURATION	
O2 DELIVERED						O2 DELIVERED	
PAIN SCORE						PAIN SCORE	
EWS SCORE						EWS SCORE	
PUPILS		R size				R	PUPILS
		R resp				R	
		L size				L	
		L resp				L	
L		normal power					L
I	A	mild weakness				A	I
M	R	severe weakness				R	M
B	M	spastic flexion				M	B
	S	extension				S	
M		no response					M
O		normal power					O
V	L	mild weakness				L	V
E	E	severe weakness				E	E
M	G	spastic flexion				G	M
E	S	extension				S	E
N		no response					N
T		Record right and left separately if there is a difference between the two sides					T

WZT720/DP5704/08.11

Pathway Following Suspected Head Injury



Interventions Post fall if no injury sustained

Post fall monitoring in accordance with policy

- **MDT** review to consider cause of fall and action required
- **Medication** review must be completed.
- Investigate **medical causes** leading to the high risk status, for example cardiovascular factors, other physiological factors. Groundwork for medical interventions are nursing observations including tests of urine, lying and standing blood pressure, and temperature. Consider ECG.
- Falls Risk Assessment and care plan review
- Refer to physiotherapy for assessment/review of the service user's balance and mobility and provide appropriate advice and/or mobility aids, evidence based exercise programmes for fall prevention may be indicated.
- Refer to **occupational therapy** for assessment of the safest ways for individuals to carry out activities of daily living if indicated
- Communicate the advice from physiotherapy and occupational therapy to all staff, and ensure **mobility aids** remain within reach.
- Assess the service user's **continence.** Are there remedial causes of incontinence or urgency, such as dehydration, urinary tract infections or constipation? Would he/she benefit from a tailored routine of offers to assist to the toilet? needs medical review or continence assessment/referral.
- Undertake an **osteoporotic risk factors review** and if necessary treat /request GP intervention (as per NICE osteoporosis guidance, 2008)
- High risk of falling needs to be considered as part of the **discharge planning** and aftercare, therefore those involved in this planning need to be aware. Consider need for follow up/referral to specialist services.
- **Consider use of bed rails using identified tool ,** review is a complex issue especially in mental health units
- Although many of the service users who fall may be too confused to access help before mobilising, any service user who is able to safely use a call bell/staff alert system should have it within sight and within reach

Manual Handling

If a hoist and a fabric sling are used for a patient with a fractured hip this method could displace the fracture causing internal bleeding and severe pain and make surgical intervention more complex.

Manual handling the falling and fallen person

The causes of falls are multi factorial and diverse and include both intrinsic and extrinsic factors

Aim

To minimise assisted manual handling and manual lifting as far as is reasonably practicable, so as to eliminate as far as is reasonably practicable the risk of injury to staff and patients.

Managing the falls by looking at risk factors as covered other places in this policy.

The Patient Moving and Handling assessment form is used which includes the Functional Independence Measure. (FIM).

Independent /Able Bodied

Level 7 Complete independence: Performs independently and safely.

Level 6 Modified independence: Requires an assistive device, or there is consideration for time / safety.

Dependent

Level 5: Supervision or set-up: Requires only cueing or coaxing but no physical contact - or help just with set-up.

Level 4: Minimal assistance: Requires incidental help but performs 75% or more of the task themselves.

Level 3: Requires moderate assistance: but still performs more than half the task themselves (50-74%).

Complete Dependence

Level 2: Maximal assistance: provides less than half of the effort to complete the task (25-49%).

Level 1: Requires total assistance - contributes less than 25% of the effort. Or does not perform the activity at all

Assisting people following a fall

When a person has fallen the handler should always check the following:

- **D**anger, **R**esponse, **A**irway, **B**reathing, **C**ompressions(if needed)
- Check for injuries, bruising, possible fractures, pain and behaviour, if handlers are not competent in checking for fractures and injuries, they should always ask for medical assistance.
- If there was any obvious reason for the fall.
- If there is any doubt, the person should be left safe on the floor and handlers should request medical assistance
- The environment for obstacles and space.
- The number of handlers required for the task.
- If the handler has been trained to undertake the task
- In a confined area such as a toilet, it can be difficult getting the hoist in place. Most toilets for able-bodied patients are very limited in space. If this is the case, transfer sheets should be inserted under the patient and the patient should be slid out of the toilet.
- If a patient has fallen between a bed and a chair / bedside locker, wherever possible, these items should be moved away to allow access.
- At all times, the safety of the patient and staff members should not be compromised.

Techniques

1 Instructing a person to get up from the floor, using minimal supervision (backward chaining) Patient FIM score 7, 6, 5.
2 Rolling a person on the floor to position handling equipment
3 Management of a person who has fallen in a confined space.
4 Use of the inflatable cushion (ELK) without back rest to assist a person **up** from the floor
5 Hoisting from the floor

1 Instructing a person to get up from the floor, using minimal supervision (backward chaining) Patient FIM score 7, 6, 5.

Person ability criteria

- Person being verbally instructed should have the physical ability to be able to roll onto their side and be able to kneel.

- The person should be compliant and be able to follow instructions.
- The task is scored FIM 7,6,5

Description

- Position a chair at the head end of the fallen person.
- Verbally support the person to bend their knees up and to bring one arm across their chest
- Ask the person to roll onto their side into side lying
- Once on the side, ask the person to bring their arm over their body until the hand is flat on the floor.
- Support the person to push up on their hand and at the same time push up on their forearm that is resting on the floor until they are half sitting
- Support the person until they end up on all fours until they are facing the chair
- Ask the person to position lower arms into the chair and ask them to lean onto the seat of the chair
- Ask the person to raise the stronger leg and place the foot flat onto the floor.
- The handler inserts another chair under the raised buttock of the person
- The person sits back onto the second chair.

Perceived exertion of the handler

- There would be little exertion for the handler

Comfort for the person

- People with knee and hip problems may find the task difficult and uncomfortable
- A manual handling risk assessment needs to be completed that is specific to the person and the handlers.

Skill level of the handler

- The handler needs to instruct the person confidently.

Dangers

- If assessed inappropriately, the person may lose their balance.

2 Rolling a person on the floor to position handling equipment FIM 1 and 2

Personal ability criteria

- The person may be able to assist with the transfer, e.g. assist with turning.
- The person may be able to assist with transfer and require full assistance from the handlers.

Description

- Ask or assist the person to position the furthest arm across the chest.
- At the same time ask or assist the person to bend one or both knees, ensuring that feet are flat on the floor.
- Bring the nearest arm away from the body and leave flat on the floor, to prevent the person rolling onto their arm or hand.
- Ask the person to turn their head and face the direction of the turn.
- One handler kneels down on both knees and starts off with their heels off the buttocks, high kneeling.
- At the same time the handler holds the person's hip and shoulder
- The handler brings the hips and shoulders over as they sit back onto their heels, low kneeling.
- Once the equipment, i.e. sling has been fitted, roll the person onto their back and repeat on the other side.

Perceived exertion for the handler

- The handler should be fit and able to work in low-level and high-level kneeling

Comfort for the person

- The person will require a pillow or cushion to protect their head.
- If the person has fallen on a hard surface, they will find the transfer uncomfortable.

- A manual handling risk assessment should already be completed that takes into account the patient and the handlers.

Skill level of handlers

- The handlers should be physically fit and be able to work in high and low kneeling positions.

- Some handlers with a high body mass index may not be able to reach the person's hip and shoulder and transfer their weight from high kneeling to low kneeling.

Dangers/precautions

- This method of rolling should not be used for people with spinal problems.

- Some people who are confused and / or resist movement will not suit this technique.

3 Management of a person who has fallen in a confined space

Person ability criteria

- The person may be able to assist with transfer.

- The person may not be able to assist with transfer.

- Useful technique where there is sufficient room to roll over and get up onto all fours

Description

- After completing an assessment of the person and the environment, the handler should encourage the person to lie flat.

- The handler takes a transfer sheet and concertinas this up.

- Two handlers are required from now on.

- Kneel down beside the person, one at either side.

- This transfer sheet is inserted under the head end of the person.

- The two handlers each hold onto the bottom corner strap of the transfer sheet

- Pulling all of the time, shimmy this underneath the person down to the ankles and checking when the transfer sheet sticks.

- If the transfer sheet sticks, unstick it
- Keep pulling the transfer sheet by the handles until the transfer sheet is all the way under the person.
- Handlers stand up, have a walk posture and pull the bottom two straps.
- On a given signal, the handlers should transfer their weight to the back leg.
- Instruction is READY- Steady- **PULL** (Pull being the action word)
- This instruction may have to be continued until the person is in a place of safety.
- As in all team handling one handler should be responsible for co-ordinating the move.

Option

- Handling can be in started in high kneeling then into low kneeling
- This is repeated until the transfer sheet is under the person.

Perceived exertion of the handler

- Some people may fall in a confined area, e.g. adjacent to a toilet. This may result in handlers working in compromised postures

Skill level of the handler

- The handlers should be fit to undertake task and be able to work in confined areas.
- The handlers may have to work in high and low level kneeling.
- The handlers should receive instruction on how to undertake task safely.

Dangers/precautions

- Sometimes people fall in a confined space and are unable to get up independently or with verbal prompting.
- People are likely to fall adjacent to a bed, in a small room, or become wedged by a toilet or bath.
- The handlers using the option position may require larger working space because they would be kneeling either side of the person during the positioning of the transfer sheets.

4 Use of the inflatable cushion (ELK) without back rest to assist a person up from the floor

Person ability criteria

- This technique is useful when a person is unable to roll onto their knees for instructing a person to get up from the floor, using minimal supervision (backward chaining)

- The person should be compliant and be able to assist with the transfer, e.g. by shuffling onto cushion, rolling onto cushion or bridging

- The cushion (ELK) .is used in RDASH and requires good trunk control.

Description

- The handlers should undertake a risk assessment of the person and the environment

- Ask if the person is unable to assist, one handler should roll the person onto their side while the second handler rolls the pipe free side of the cushion and positions it under the person's bottom.

- Repeat on other side and ensure the pipes are not entrapped under the person.

- Ask the person if they are able to sit themselves up.

- Alternatively, both handlers should assist the person from supine to sitting.

- Handlers should kneel on either side of the person and use a cross over technique to sit an individual upright.

- On a given command the handlers should transfer their weight from high kneeling into low kneeling until the person is in a sitting position.

- One handler should support the sitting person by low kneeling behind the person and placing their hands onto the person's shoulders

- The second handler should secure the pipes, according to manufacturer's instructions to the battery pack.

- If required place a chair either side of the cushion for the person to hold onto.

- Inflate the cushion until the person is in a position to stand or transfer safely.

Perceived exertion for the handler

- The handler should be of good fitness and be able to kneel in high and low kneeling positions.

Comfort for the person

- During the transfer, the person's head should be protected with either a pillow or cushion.

- During the cushion inflation, the person should be supported with h1 or 2 handlers to ensure the person does not fall off the cushion

Dangers/precautions

- If the handlers find the level of assistance physically overloading they should stop the task immediately and decide if transfer with a hoist is more appropriate.

- Some people may find the inflation of the cushion makes them feel uneasy.

5 Hoisting from the floor

Providing there is no injury

If a fallen person is not able to get up independently or with the aid of the inflatable cushion, it may be necessary to use a hoist to lift from the floor.

Ref Back Care (2011) *The Guide to handling people* 6th edition.

Inter Facility Transfer – Transfer of the patient post fall

The inter facility transfer protocol was developed having identified a need for prioritisation of IFT requests based on clinical need. A national model was signed off by the Directors of Clinical care of the national Ambulance Services in November 2010. The IFT model was then extended to Acute Trust Hospitals that do not provide acute services and mental health trusts with inpatient facilities.

Clinical responsibility remains with the healthcare facility requesting the transfer and priority determined by clinical assessment and need. Nursing staff to ensure key information of patient need is provided to inform decision making/priority which should include vulnerability of patient and any identified risks.

Prepare the patient for transfer.

Priority 1

Examples include:

- Neurosurgery (e.g. extradural, subarachnoid haemorrhage) /head injury
- Vascular surgery (e.g. leaking aortic aneurysm)
- Primary or Rescue coronary angioplasty (PCI)
- Paediatric sepsis or emergency not involving dedicated retrieval teams
- Major trauma treatment or management (e.g. transfer to Major Trauma Centre)
- Stroke transfer for thrombolysis
- Obstetric emergencies requiring immediate operative intervention (e.g. foetal distress)
- IABP transfers

Priority 2

Examples include:

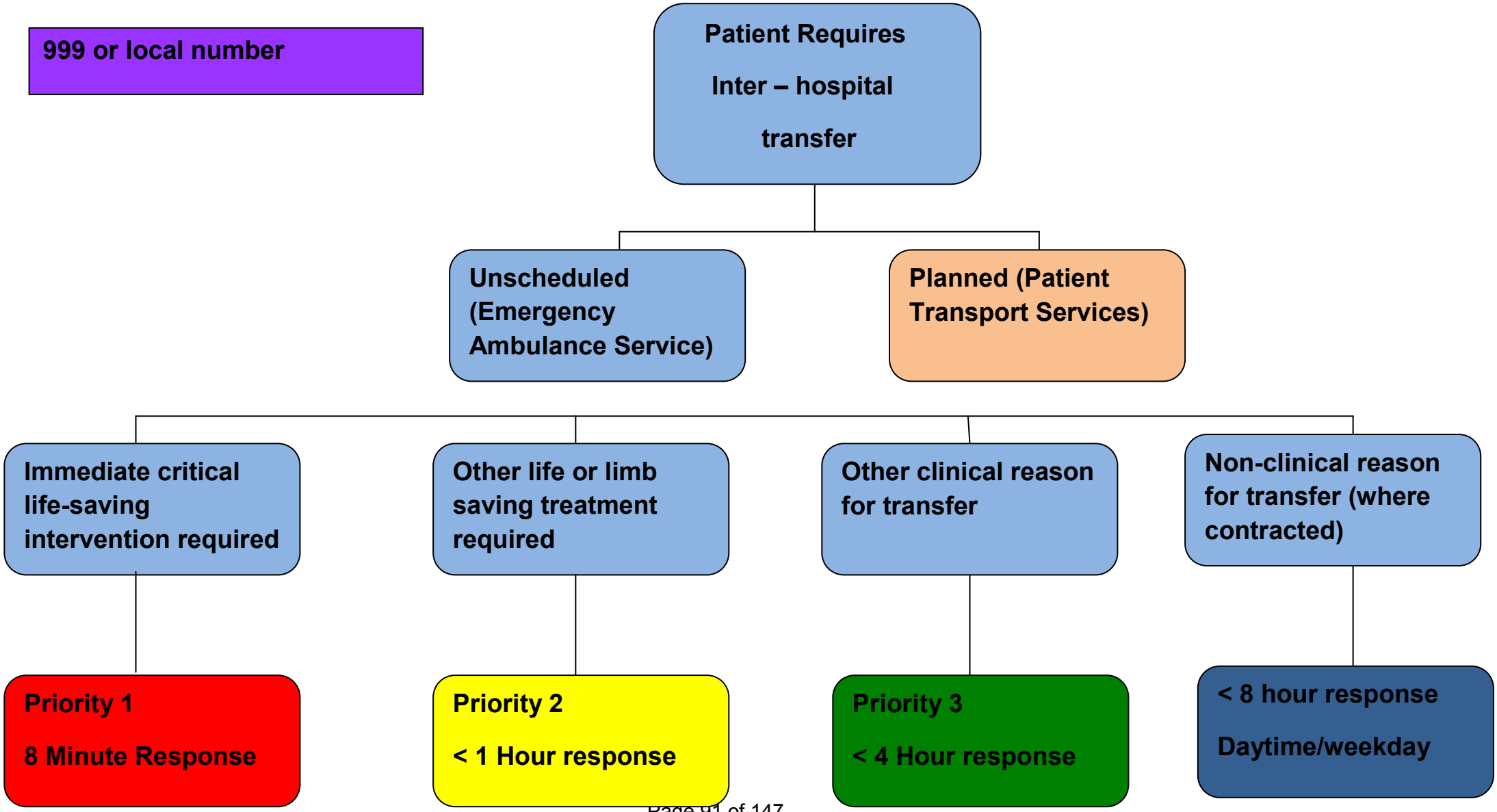
- Sudden loss of vision
- Immediately limb-threatening injury, inc. open fractures (for orthoplastics)
- New onset ischaemic limb (NB: may be appropriate for Priority 1 if immediate intervention planned)
- Cauda equina syndrome, spinal cord compression
- ENT emergency
- Transfer between CCU or ITU Admission to CCU or ITU (patient may not be ventilated)
- Obstetric complications not requiring immediate surgical intervention (e.g. failure to progress)
- Patient with monitors, infusions and/or sedation which cannot be disconnected for the journey
- Acutely sick patient in a non A&E hospital (e.g. community hospitals, Minor Injury Units, mental health hospitals, private hospitals (admission to NHS hospital))
- Child requiring >5 l/min oxygen
- Emergency renal dialysis, i.e. not a routine dialysis session
- Testicular torsion
- Mental Health patients under MHA
- Burns patients (for admission)
- Non-ST elevation MI or Acute Coronary
- Syndrome for admission to CCU

Priority 3

Examples include:

- Patient requiring intervention or investigation not available at current location (e.g. MRI scan, interventional radiological procedure)
- Transfer to specialist unit (e.g. inpatient haematological unit)
- Stroke patients for admission to Stroke Unit (not suitable for thrombolysis)
- Mental Health Patients (voluntary admission) where other form of transport not suitable
- Burns (not admission)
- Plastics
- Urology

Transfer to Hospital from Mental Health and Community Hospital



APPENDIX 11

Medication which may increase the risk of falls

Note this is not an exhaustive list and any further advice and updates should be sought from pharmacists and medical colleagues

CLASS/ TYPE	EXAMPLES	POSSIBLE SIDE EFFECTS	SUGGESTED ACTIONS
Antidepressants	TriCyclic Antidepressants (TCA) e.g.Amitriptylline, Dosulepin (Dothiepin), Imipramine, Lofepramine. SSRIs e.g. Citalopram, Fluoxetine. Others Trazodone, Mirtazepine, Venlafaxine.	Drowsiness, blurred vision, dizziness, postural hypotension, constipation, retention of urine.	Review appropriateness with prescriber/ GP. Stop if not required, may need to withdraw slowly. Consider changing a Tricyclic (TCA) to a Serotonin Specific Reuptake Inhibitor (SSRI) Consider specialist referral if further advice needed
Antipsychotic	Chlorpromazine, Haloperidol, Lithium, Promazine, Trifluoperazine, Quetiapine, Olanzapine, Risperidone.	Postural hypotension, confusion, drowsiness. Parkinsonian symptoms	Review appropriateness and check if prescribed in line with relevant protocols. In long term use do not stop without specialist opinion. Avoid in management of delirium, consider specialist referral if further advice needed.
Antiemetics	Prochlorperazine, Cyclizine, Metoclopramide	Postural hypotension, Confusion, drowsiness. Parkinsonian symptoms	Review appropriateness and indication for use with prescriber/ GP (often given for “dizziness”) Domperidone may be a suitable alternative.
Sedatives and Hypnotics	Temazepam, Diazepam, Lorazepam, Nitrazepam, Zopiclone, Chlordiazepoxide, Chloral Betaine, Clomethiazole	Drowsiness which can last into the next day, light-headedness, confusion, loss of memory	Review appropriateness and indication for use with prescriber/ GP. Stop if possible. Long term use will need slow withdrawal No new initiation on transfer of care – seek specialist advice if required.
Medication for Parkinson’s Disease	Cobeneldopa, Cocareldopa, Rotigotine, Ropinirole, Pramipexole, Amantadine, Entacapone, Selegiline, Rivastigmine.	Sudden daytime sleepiness, dizziness, insomnia, confusion. Low blood pressure, blurred vision.	May not be possible to change. Do not change without specialist opinion. Check for postural hypotension
Medication with Anticholinergic Side-effects	(Benzhexol), Prochlorperazine, Oxybutynin, Tolterodine.	Dizziness, blurred vision,retention of urine,confusion, drowsiness, hallucinations.	Review appropriateness and indication for use with prescriber/ GP. Reduce dose or stop if possible.

Cardiovascular Medication	ACE inhibitors / AngiotensinII antagonists: Ramipril, Lisinopril, Captopril, Irbesartan, Candesartan. Vasodilators: Hydralazine Diuretics: Bendroflumethiazide, Bumetanide, Indapamide, Furosemide, Amiloride, Spironolactone, Metolazone. Betablockers: Atenolol, Bisoprolol, Carvedilol, Propranolol, Sotalol. Alphablockers: Doxazosin, Alfuzosin, Terazosin, (Tamsulosin).	Low blood pressure, postural hypotension, dizziness, tiredness, sleepiness, confusion	Check lying and standing BP. Review appropriateness and indication for use with prescriber/ GP (note alphablockers are also used for benign prostatic hyperplasia). Review dose. May not be possible to stop. Consider alternative to alphablocker.
Analgesics	Opioids: Codeine, Tramadol, Nefopam, Dihydrocodeine, Buprenorphine, Alfentanyl Opiates: Morphine, Oxycodone.	Drowsiness, confusion, hallucinations, postural hypotension.	Review dose. • Use analgesic pain ladder to avoid excess use. • In older people start low and go slow
Anticonvulsants	Carbamazepine*, Sodium Valproate*, Gabapentin, Lamotrigine, Clonazepam, Phenytoin*, Phenobarbitone*, Primidone*.	Drowsiness, dizziness, blurred vision.	Consider indication (some are also used for pain control or mood stabilisation). • May need specialist review in problem cases. • *Consider Vitamin D supplements for at risk patients on long-term treatment with these drugs.

Guidelines for Good Prescribing in Older Patients

- Carry out a regular medication review and discuss and agree all changes with the patient/carer. Make sure changes are highlighted in information to GP at Transfer of Care.
- Stop any current drugs that are not indicated. Check with GP for long term treatments e.g. antidepressants
- Prescribe new drugs that have a clear indication. Make sure changes (including the indication) are highlighted in information to GP at Transfer of Care.
- If possible, avoid drugs that have known deleterious effects in older people, such as benzodiazepines, and recommend dosage reduction when appropriate.
- Use the recommended dosages for older patients
- Use simple drug regimens and appropriate administration systems
- Consider using once daily or once weekly formulations and using fixed dose combinations when possible
- Consider non pharmacological treatments if appropriate
- Limit the number of people prescribing for each patient if possible
- Where possible, avoid treating adverse drug reactions with further drugs

APPENDIX 12

In Patient Services: Walking Aid & Gait Training

Walking Aid Training Introduction

Rationale

The Royal College of Physicians (RCP)National Falls and Bone Health Audit 2010 required organisations to ensure that walking aids are available within in patient areas 24 hours a day, 7 days a week.

Training programme has been developed and will be delivered by the Physiotherapists.

The training will provide education and guidance to enable staff to issue a walking stick or frame temporarily until a fuller Physiotherapy Assessment can be completed.

Staff who issue walking aids independently must be supported by their manager and have attended the required training.

Staff competence in the issue of walking aids will be assessed and monitored by the Physiotherapist

Training

The purpose of the walking aid training is to enable multidisciplinary staff, to assess for, supply, and ensure the safe use of walking aids in circumstances when a physiotherapist is not available.

The walking aids that are covered in this training booklet are:

- Wheeled walking frame (Standard, Ultra narrow)
- Static walking frame
- Walking stick (Metal adjustable)

Examples where these walking aids might be indicated are with a client who:

- has arrived from home without their current walking aid
- has balance problems (unsteady on their feet)
- rely on furniture to support them whilst mobilising
- can not mobilise without assistance of staff
- has decreased confidence in their ability to mobilise
- fear of falling
- has a history of falls

A client may have one or more of these problems resulting in a decreased level of mobility:

- During recovery from: Orthopaedic or other surgery e.g. hip replacement

- Fractures
- Neurological disorders e.g. Stroke, Multiple Sclerosis, Parkinson's Disease
- Arthritic conditions with pain and/or deformity
- Muscle weakness
- Palliative care/long term conditions clients e.g. shortness of breath from COPD
- Fatigue

It is advised that at the earliest opportunity the Physiotherapist should be informed of the equipment issued so that they can make a more in depth assessment of the situation and identify the patient's mobility needs.

This training is not a substitute for an in-depth physiotherapy assessment. Its purpose is to enable any member of the team to feel confident that they can solve an immediate situation by making the patient safe using the walking aids described, when a physiotherapist is not available.

Some considerations:

- Does the patient actually need a walking aid?
- Has the patient given consent to the equipment after having the reason for its use discussed with them?
- Does the patient have capacity to understand the risks of not using a walking aid, if one is needed?
- Do they have the cognitive ability to use a walking aid safely and follow instructions?
- Will they still require continual supervision with their mobility & the walking aid?
- Is the patient likely to use the walking aid inappropriately?
- Is the environment suitable for the walking aid chosen?
- Have all other contributing factors to falls been considered/ modified?
- Is the surface the client is sitting on conducive to standing up. E.g. is the chair too low, does it not have arms?

Safety Guidelines for Provision of Equipment

All relevant policies and procedures regarding: infection control, moving and handling, falls etc can be found on the trust intranet site.

Safety Checklist

- Select the most appropriate equipment for the situation.
- If in doubt about safety, do not leave the equipment with the patient.
- The patient should only use the walking aid that they have been assessed to use.
- Ensure provision of a walking aid is clearly documented in client's notes.
- The ward physiotherapist should be informed of any walking aid provision at the earliest opportunity.

- Faulty walking aids should be brought to the attention of a Physiotherapist and not used.
- Any return walking aids should be returned to the ward physiotherapist if the patient is an in patient or to REWS if they are in the community.
- Ensure all walking aids are cleaned with hard surface wipes prior to being issued and upon return.
- Ensure all walking aids are clearly labelled with the patient's name.

Walking aid specific safety advice is covered in more detail later in this booklet.

Safety Rules and Risk Assessment When Assisting Clients to Walk

When assisting a client to walk the assessor should assess the individual's current physical and mental condition, plus their surroundings and intended route.

The following factors should be considered:

- Is it the first time/day that the client has walked?
- Is the client tired?
- How good is the client's sense of balance?
- Is the client anxious or lacking confidence?

Preparation:

- Check the client is alert and orientated e.g. if they have just woken up
- Does the client's footwear fit correctly and offer enough support?
- Does the client need to wear their glasses and are they clean?
- Does the client wear hearing aids and are these switched on?
- Is the route that you wish to walk with the client clear and safe i.e. no obstacles or wet floors?
- Is clothing well fitting and unlikely to interfere with their mobility? (ie trousers dropping down while the client is walking)
- Watch how the client prepares to walk. Is he/she able to position himself/herself independently in the chair ready to stand?

Physical Assessment Prior to Issue of Walking Aids

Physical Assessment Checklist in Sitting

Assess:	Why?	Assessed? Yes/No
Head Eyesight Hearing Cognition	To assess if the client has sufficient sensory and cognitive input to follow commands and safely mobilise.	
Arms Grip Strength at hands Can client raise arms upwards in to flexion?	To assess if the client has enough strength to hold/move a walking aid.	
Trunk Can client sit forward in their chair – so their back is unsupported? Can client transfer their weight from right to left in the chair?	This assesses their sitting balance and gets them in the right position for testing the leg strength and ability to stand up	
Legs Can client move their ankles up and down, achieving a 90 degree bend at the ankle? Can the client straighten their knee and hold a straight leg raise independently? Can they march on the spot in sitting, raising their knees?	To assess if the client has enough range of movement/ muscle length in lower limbs to be able to stand upright. To assess if the client has enough muscle strength to achieve and maintain an upright standing position and a further assessment of sitting balance.	

Once you have established that the client is physically able to stand, demonstrate the use of the selected walking aid to the client.

STANDING UP

Ask the client to move forwards to the edge of their chair. To get their feet in a good position, e.g. feet hip width apart, knees bent to 90 degrees. Prompt the client to put their hands on the chair arms, lean forwards (bend in the middle) and to push up on the arms of the chair they are sitting on, keep the forward momentum and stand up.

NB: some clients may benefit from rocking backwards and forwards a few times to gain momentum and counting to ready themselves, e.g. ‘on 3 we will stand up, 1, 2, 3, stand up’

The stand can be facilitated by the assessor standing close and using their arm to support around the back of the client. THE ASSESSOR SHOULD NEVER LIFT THE CLIENT UNDER THEIR ARMS OR PULL THE CLIENT OUT OF THE CHAIR BY THEIR HANDS. (See moving and handling policy and further training).

Once the client is stood the assessor should remain close, with a good base of support and keep their arm around the back of the client and offer their other hand for further support, until the clients standing balance has been achieved. When in standing you will be able to assess the client’s ability to weight bear, you can also assess whether the client’s posture, dizziness, pain or confidence are going to limit their ability to safely mobilise. From here you can move onto measuring the height of the walking aid required (see below) and try a step forward, if the client is confident you can then move onto a short walk.

SITTING DOWN

To return the client into a sitting position, mobilise to the designated chair, prompt the client to back up against the chair slowly, until they can feel the back of the chair against their legs. Once this has been achieved prompt the client to reach back with one hand for the arm of the chair, and once gained, reach back with their other hand. Now the client can be prompted to bend in the middle and to use their arms on the chair to sit down.

NB: Do not let the client sit down while holding on to a walking frame as this will become unstable, always make sure both hands are on the chair or surface they are moving to.

If the client is mobilising with walking sticks, again the client needs to be able to reach back with both hands to the chair, the sticks can be propped against the chair (see training demonstration).

Walking Aid Specific Advice and Fittings

WALKING FRAMES

Fitting Instructions

- Stand the person up with as straight a posture as they can maintain with their arms by their side, looking straight ahead.
- Place the frame in front of the client, close to their body.
- The handles of the frame should be in line with the client’s wrist crease.
- Adjust the height of the frame by the pins on the legs of the frame. Note: Turn the frame upside down, place foot on the frame to stabilise it and then adjust the legs.

- Width selection: depends on natural width of client's stance, size of patient and width of doorways.
- The client should always be instructed in the use of a walking frame, because poor technique, such as placing only 2 feet of the frame on the floor, turning too fast or putting their feet too close to the front rail, may lead to instability and falls.

Weight limit

Wheeled Narrow Frame: 160kg (25.2 st)

Static Frame: 158.7kg (25 st)

General Advice

- Wheeled frames may be useful for people who find it difficult to lift a static frame and require the client to expend less energy.
- Wheeled frames allow a more normal gait pattern to be achieved, as compared with a static frame, as the client does not have to stop walking to lift the frame upwards when walking straight. Note: The frame must always be lifted to turn round.
- When the client has been issued with a frame you may want to encourage them to use the larger bathrooms as there is more room to manoeuvre.

Precautions

- Frames must be lifted over door thresholds to ensure the frame clears the threshold safely and the rear ferrules do not get caught, putting the client off balance.
- If unequal weight is applied to one side of the walker it may track to the left or right.

METAL (ALUMINIUM) WALKING STICKS

Fitting Instructions

- Stand the person up with as straight a posture as they can maintain with their arms by their side, looking straight ahead.
- Place the stick by the side of the client, close to their body.
- The handle of the stick should be in line with the client's wrist crease.
- Adjust the height by the pins on the stick.

Weight limit

125kg (19.5 st)

General Advice

- The walking stick should be used in the opposite hand when one leg is affected. This increases the client's stability and reduces load on the affected limb.
- Using a walking stick requires good strength in the forearm and upper arm and good grip.
- The stick must be placed slightly out to the side when walking to prevent the client tripping over the stick.
- Heel height of shoes worn should be taken into consideration when measuring the height of the stick.

Precautions

- Using a stick at the incorrect height may predispose to falls.
- A metal walking stick has the same function as a wooden walking stick and does not provide more stability than a wooden one.
- If the client has their own wooden walking stick that is in a poor state of repair e.g. it bends under pressure, large wood knots, no ferrule etc then the client should be discouraged from using this and it should be replaced with a metal stick.

Walking Aid M.O.T.

Whenever you see a client that already has a walking aid or they tell you they use a walking aid, as a matter of good practice, you should give the walking aid a quick M.O.T.

- Ask the client how long they have had the walking aid?
- Ask if it is their own walking aid? (It may be borrowed from a friend/ neighbour/ relative)
- Ask the client if they have had any problems with the walking aid recently?
- Ask the client if you can have a quick look at it (you must get their consent before doing anything with the walking aid)

And check……..

- Ferrules - are they worn through/smooth; do they need to be replaced?

- Adjustment pins – check both sides of the pins are out and not stuck in the holes of the legs (of the frame)/stick; check the metal is not worn around the holes causing the legs to rattle. If the pins are not supporting the legs, a replacement frame must be given.
- Metal work – check the metal of the frame/stick is not bent or buckled. If so, you must order a replacement frame.
- Height of the walking aid – if you think the walking aid is at the incorrect height for the client, ask if it was set at that height by their physiotherapist (it may be at a specified height for a reason). If it is a borrowed frame/stick, adjust the height appropriately, if you feel competent to do so

Patient name……. DOB:……..

Temporary walking Aid: checklist

Has the member of staff issuing the walking aid, attended walking aid training & deemed competent to issue a walking aid?

YES □ NO □

Has consent been gained from the patient for assessment?

YES □ NO □

Has the walking aid been safety checked and deemed safe to use and cleaned prior to being given to the patient?

YES □ NO □

Has the walking aid been labelled with the patient's name?

YES □ NO □

Does the patient require supervision by staff when mobilising with this walking aid?

YES □ NO □

Has a message been left for the ward physiotherapist, informing them of a walking aid being issued?

YES □ NO □

Has it been documented in the patient's notes that a walking aid has been issued?

YES □ NO □

Signed/print…… Date issued……..

Walking aid Competencies for: ……

The member of staff named above has attended the walking aid training session on:……

Following the training they were then observed in the following areas:

- **Assessing suitability of a walking aid.**
- **Checking the environment is safe.**
- **Safety of the patient.**
- **Assessing the patient prior to issuing a walking aid.**
- **Safety checking the walking aid.**
- **Measuring for a walking aid.**
- **Giving instruction/carrying out sit-stand-sit.**
- **Mobilising a patient with a walking aid.**

The above member of staff was deemed competent in the above areas and is now able to issue walking aids, when a physiotherapist is not available.

The above member of staff should:

- **Never issue a walking aid unless they feel confident / competent in doing so.**
- **Never issue a walking aid that is not deemed safe.**
- **Always inform the ward physiotherapist at the earliest availability.**
- **Keep up to date with regular training in walking aid provision.**

Signed……..

Date……...

APPENDIX 13

Falls Prevention and Footwear

Information for Ward Staff: the importance of healthy feet and safe footwear

Our feet are vital in enabling us to mobilise safely and confidently so they need to be looked after and maintained well. Footwear also makes a big difference to mobility, safety and confidence and a person is much more likely to trip or fall if they are not wearing suitable footwear or if they wear footwear incorrectly. It is therefore very important that patients wear appropriate footwear to prevent slips, trips and falls and also to prevent injuries to their feet.

What is appropriate footwear?

There is no definitive research on the safest type of footwear and different patients will have different footwear needs and preferences. Appropriate footwear can be described as a well fitting shoe/ slipper with a low heel, firm supportive sole, deep toe and a secure fastening i.e. laces or Velcro (so the width is adjustable). There should be plenty of room for toes (half inch gap between the end of the shoe and the toes), most of all they should be comfortable for the patient.

Some footwear is clearly unsafe or less safe in a ward environment, including:

- Anti-embolism stockings / Bandages or dressings only
- Backless shoes or slippers except for very confidently mobile patients
- Shoes or slippers that are visibly too big; Shoes or slippers that are visibly too small
- Foam disposable slippers except for very confidently mobile patients
- Shoes or slippers worn with squashed backs
- Lace up shoes without laces, or with trailing laces
- High heeled shoes except for very confidently mobile patients.

Checking the feet

On removing the shoes the patient's feet should be checked for any red marks, pressure areas or blisters, any leakage of fluid, also check for overgrown nails, corns and other foot conditions. If any of these are present, consider if the shoes are the correct size, and consider referral to a podiatrist for further assessment and treatment. Bare feet or socks should always be avoided. If the patient has difficulty getting their shoes on, try a shoe horn.

When should slipper socks be used?

- When a patient has been admitted with no adequate footwear.

- When the patient's current footwear is ill fitting and unsafe and poses more of a risk to them than wearing slipper socks.
- When the patient continually removes their shoes/slippers and mostly mobilises in bare feet.

The decision to use slipper socks is as a **temporary measure** or **last resort only**. It should be discussed with the MDT and regarded as a **short term option** until proper fitting footwear is available. Staff must ensure relatives (or patient's representatives) are given the support and information to enable them to supply safe footwear as soon as possible.

What about patient choice?

Hospital patients, with mobility problems and long term conditions, are at an increased risk of falls. Patients with confusion, dementia, depression, cardiovascular problems, respiratory problems, neurological problems, visual impairments, musculoskeletal conditions or any combination of these also are at increased risk. Patients taking medication which affects the central nervous system are also in a high falls risk group. So whilst staff must of course allow for patient choice with relation to footwear, they also have duty to inform patients and their relatives about the risk of falls and ways the risk can be managed or reduced – including the choice and safety of footwear. If patients do not have the mental capacity to understand the risks and issues, then staff have a duty to make decisions in their best interests.

For specific guidance about footwear needs of individual patients, ward staff are advised to discuss further with Physiotherapy / Occupational Therapy /Podiatry or Chiropody colleagues.

For more information see:

Help the Aged/ Age UK: *Fitter Feet, Caring for your Feet* leaflet.

Society of Chiropodists and Podiatrists – http://www.feetforlife.org/

Reference: *How to Guide for 'Reducing Harm from Falls'* – DH document 2009*, see* http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/FALLSHow-to%20Guide%20v4.pdf

To find out more about patient safety in general visit www.patientsafetyfirst.nhs.uk

APPENDIX 14

LEARNING DISABILITIES COMMUNITY HOMES SERVICES

SLIPS, TRIPS AND FALLS POLICY

Learning Disabilities: Community Procedures

The Learning Disabilities Community Homes Service recognises its responsibility to ensure that all reasonable precautions are taken to minimise the risks of slips, trips and falls for staff, service users, visitors and contractors.

The service is compliant with the **Care Standards Act 2000,** which requires the registered manager of a home to have effective arrangements in place to protect service users and staff from health and safety hazards in the home and/work environment and/or domiciliary care services. A Learning Disabilities Community Homes Falls Risk Control Policy is in place (Appendix 7).

A briefing paper, Research Briefing 1/01 "Preventing falls in care homes" produced by the Social Care Institute for Excellence (SCIE) recommends that care homes should have falls prevention strategies in place. The Community Homes Service comply with this by the following means:

- A Learning Disabilities Community Falls Risk Assessment (Appendix 8) is carried out for community living service users with limited mobility, or with conditions such as osteoporosis or with conditions affecting their balance.
- Service users who are assessed as being at high risk of falling are referred for specialist/ further assessment.
- Reviews of falls incidents are carried out to identify and plan for risk factors and underlying medical conditions.
- Systems are in place to monitor and learn from falls occurring within the homes. e.g. review of incidents by care team/ MDT; review of incidents by service managers; reporting systems for health and safety concerns; multi-agency care standards monitoring

Policy Statement

The Community Homes Service recognise slips, trips and falls to refer to any accidental slip, trip or fall which may have the potential for injury or harm to a member of staff, to a service user or to visitors and contractors. We understand that such falls represent one of the most common causes of workplace injury in the UK. We also understand that such accidents may be especially dangerous for elderly or frail service users who may suffer serious injury as a result of a fall. The Community

Homes Service recognises its responsibility to ensure that all reasonable precautions are taken to minimise the risks of slips, trips and falls for staff, service users, visitors and contractors. The service fully complies with the **Care Standards Act 2000**, which relates to the degree to which the registered manager of a home ensures that service users and staff are protected from health and safety hazards in the home and/work environment and/or domiciliary care services.

Risk Control Policy

It is the Community Homes policy that we will reduce and control risks of slips, trips and falls by: -

- Ensuring that all health and safety risk assessments include an assessment of the risk of slips, trips and falls for all service users and especially for service users who are elderly and/or have impaired vision or mobility
- Putting in place policies and procedures for reducing the risk of slips, trips and falls in the home environments
- Ensuring that all service users are assessed on admission for any history of falls and those with a history of falls have a risk assessment conducted and the results added to the Service Users Plan
- Regularly scrutinising accident reports to identify if slip, trip and fall hazards are being effectively controlled
- Ensuring that all care and support staff are trained in the recognition and reporting of potential slip, trip and fall hazards.
- To reduce the risk of slip hazards: Non-slip floor surfaces will be used wherever possible, especially in higher risk areas such as kitchens, toilets, sluices and bathrooms
- Access to areas where floors are wet after cleaning or where spillages have occurred will be restricted to authorised staff only by use of appropriate warning or barriers to prevent access
- Safe systems will be in place for cleaning up spillages, including water left on the floor after baths, quickly and efficiently
- The use of loose rugs and mats will be avoided in areas where service users have a risk of falling
- Procedures will be in place for ensuring that the clothing and footwear of staff are of a satisfactory standard and service users will be advised accordingly
- Procedures will be in place for de-icing external footpaths
- Good quality doormats will be used around entrances and exits to the outside with doorways protected from the weather and the ingress of rain.

To reduce the risk of trip hazards:

- Activities involving electrical equipment will be planned to minimise trailing wires, i.e. staff should always use the nearest socket available
- An adequate number of fixed electrical sockets will be provided in areas where electrical equipment is situated
- The use of trailing socket extension leads should be discouraged

- Regular checks will be carried out to ensure that worn or frayed carpets, and raised carpet edges, are identified and repaired or replaced
- Good housekeeping procedures will be implemented to prevent items and objects being left on the floor, especially in busy communal areas
- Dependent or frail service users will be supervised as appropriate, e.g. to ensure shoe laces are securely tied and that slip-on shoes are not loose fitting and likely to fall off Edges or variations in floor height, such as step and stair edges, will be clearly marked wherever possible.

To reduce the risk of fall hazards:

- Secure and obvious hand rails will be fitted where appropriate for all steps and stairs – on both sides if necessary for stability
- Step and stair edges will be clearly marked
- A planned preventive maintenance programme will be in place, linked to regular risk assessment inspections, to ensure that all floor and other entry and exit routes have flat, even surfaces (see appendix A)
- Protruding or obstructing items of furniture or equipment, especially at low level, will be removed
- Lighting should be adequate to enable people to see obstructions and potentially slippery or uneven areas, etc so that staff can work safely and service users can move about safely
- Lights will be replace, repaired and cleaned whenever light levels become too low and new lights should be installed wherever poor lighting levels are identified as a hazard.

Cleaning

Due to their high risk, cleaning activities in each home environment will be given special attention in relation to slips on wet, polished or soapy surfaces. Staff will be trained in the correct use of any safety and cleaning equipment provided and cleaning methods and equipment must be suitable for the type of surface being treated. Staff should take care not to create additional slip or trip hazards while cleaning or supporting service users to clean and to always use appropriate warning signs whenever floors are wet.

Maintenance

In each home environment all necessary maintenance or repair work should be reported as quickly as possible and attention paid to slip and trip hazards while work is actually being carried out either by estates department or by contractors. While waiting for repairs signs should be displayed to clearly mark areas that might present a hazard.

Falls Prevention

The Community Homes Services is committed to an active approach of falls prevention. In this context additional control measures will be considered when performing a slips, trips and fall risk assessment for high-risk service users such as those with limited mobility, with conditions such as osteoporosis or with conditions affecting their balance (see appendix 9)

To help reduce the risk of falls amongst such higher risk residents and tenants we will put in place the following measures:

- The provision of regular falls prevention advice from care professionals
- Systems for summoning help
- Beds and chairs appropriate to individual needs and in good repair
- Physiotherapist and occupational therapist support where required to implement treatment and prevention strategies
- Appropriate levels of supervision
- The provision of an adequate, nutritious diet.

Falls prevention advice for this service can be obtained from the Clinical Lead Physiotherapist.

Staff, service users and carers will be made aware of drug side effects related to falls as the service understands that some medications can disturb balance and mobility.

Incident Reporting

Regular scrutiny of accident reports will be conducted to identify if slip, trip and fall hazards are being effectively controlled, i.e. if reported incidents are reducing in number. Annual audits of the management of slips, trips and falls within the service should also highlight strengths and weakness and clarify areas where improvements may be necessary.

Training

In the Community Homes Service all staff will be trained in prevention and in the recognition and reporting of potential slip, trip and fall hazards.

All slip, trip and fall training should include:

- Staff responsibilities and limitations, for health and safety as defined in the Trusts health and safety policy
- Vulnerable clients and familiarity with their disabilities and conditions
- Service users who require supervision for certain activities
- The risks and control measures associated with slips, trips and falls, both to themselves, the service users and any other visitors
- The procedures for cleaning up spillages, including any controls required by the **Control of Substances Hazardous to Health Regulations 2002** (COSHH) where the substances are defined as being hazardous
- The need to maintain high levels of housekeeping and tidiness in all areas at all times.
- During induction all staff should be encouraged to immediately report any slip, trip or fall hazards.

LEARNING DISABILITIES COMMUNITY RISK ASSESSMENT - FALLS

NAME:.....

DATE OF BIRTH: .....

HOME: .....

DATE OF ASSESSMENT: .....

DEFINITION:

a. A fall is a sudden unexplained change in position in which the individual comes to rest unintentionally on the floor;

b. An individual relates falling;

c. An individual found lying on the floor and unable to account for the situation may also be considered to have fell, though other medical reasons may exist and should be considered.

Score the shaded area.

Sex	**Yes**	**No**	
Female			**2**
Male			**1**
Age			
over 81 years of age			**3**
between 71 and 80			**2**
between 60 and 70			**1**
Under 60			**0**
Gait			
Poor transfer ability			**5**
Is hesitant when walking			**3**
Gait Unsteady			**10**
Mobility			
Has restricted mobility			**3**
Uses aid			**2**
Is bed bound			**1**
Has full mobility but is unsafe			**10**
Has balance difficulties			**10**
Medication			
Is on medication with relevant side effects, i.e. dizziness, confusion, sedation etc			**3**
Undergoing medication change regime			**3**

Sensory Defects			
Is partially sighted or blind			**10**
Is hard of hearing or deaf			**1**
Visual perception problems affecting safe mobility such as difficulty with patterned carpets etc.			**3**
Environment	**Yes**	**No**	
Has history of falls on stairs			**10**
Can safely ascend any stairs unattended			**2***
Can safely descend any stairs unattended			**2***
Can safely ascend familiar stairs			**3***
Can safely descend familiar stairs			**3***
Can safely use escalators unaided			**2***
Can safely use escalators with assistance			**2***
Can negotiate steps/pavements/uneven/unstable ground unaided			**3***
Can negotiate step/pavements/uneven/unstable ground with assistance			**3***
Can use aid safely and independently			**2***
Can use aid safely with assistance			**2***
Reaches for support inappropriately when walking			**3**
Medical history			
Poor nutrition/anaemia			**3**
Continence, i.e. urgency or other affecting safe mobility			**3**
Inner ear or cerebella disease/vertigo			**3**
Decreased sensation in lower extremities			**3**
Foot Problems			**3**
Postural Hypo tension			**3**
Motor deficits (decrease in mass, strength, co-ordination and loss of balance)			**3**
Arthritis			**2**
Osteoporosis			**2**
Parkinson's			**2**
TIA			**2**
Acute heart condition and/or arrhythmia's			**1**
Epilepsy			**1**
History of CVA			**1**
Falls History			
History of falling indoors			**2**
History of falling outside			**2**
Vulnerable to being pushed over by others			**8**
Mental Condition			
Has faulty judgement regarding personal mobility limitations			**5**
Confused			**2**
Highly anxious			**1**

Fear of falling (normal day to day activities)			**1**
Impulsive regarding mobility			**5**
Mobility Aids			
May become unco-operative whilst using a mobility aid			**10***
Uses walking aid but is unsteady			**5***
History of tipping chair over			**3***
History of falling out of chair			**3***
Will release the brakes of the chair			**3***
Would unfasten lap belt/harness			**3***
Will refuse to wear lap belt/harness			**3***
Will attempt to get out of the chair			**3***
TOTALS			

*** MAY SCORE N/A ON THOSE WITH AN ASTERISK IF THEY DO NOT APPLY**

RISK SCORING AND ACTION

Low Risk: 0 to 24 Medium Risk : 25 to 49 High Risk : 50 plus

DATE _____

SIGNATURE: _____

DESIGNATION: _____

REVIEW DATE: _____

Low Risk

All staff to be made aware of potential risk and to be aware of any mobility difficulties arising and any aids or measures that are necessary to ensure safety, e.g. well fitting shoes, appropriate chair, etc. This will be documented in pages 1-24 of the profile.

Medium Risk

As low risk but in addition there should be consultation with the relevant MDT professionals clear guidelines to follow to ensure supervision or assistance is provided at specific times when risk of falls is higher.

High Risk

A care plan is devised with MDT input to ensure all staff are aware and provide the appropriate assistance and supervision at all required times. All areas attended must also have a copy of the care plan. The individuals mobility may need to be restricted if the risk level is very high. This should be decided by a multi-disciplinary team and reviewed accordingly.

NB: If consideration is being given to the development of greater independence in this area then the risk management process should be applied.

Action agreed and further information can be located as follows:

1. _____ Located in _____
2. _____ Located in _____
3. _____ Located in _____
4. _____ Located in _____

APPENDIX 15

DONCASTER COMMUNITY INTEGRATED SERVICES PROCEDURES

1. INTRODUCTION

This appendix contains information specifically for Doncaster Community Integrated Services. It should be used in conjunction with the main policy and associated appendices.

DCIS provides a wide range of community services, residential and non residential, working with multiple partners. It is the responsibility of staff to ensure that individuals who have fallen or are at risk of falling are assessed, treated and referred to the appropriate services in a timely manner.

2. RISK ASSESSMENT

The following information is relevant to community services, residential services and non residential services.

Falls risk case identification/ screening (as per NICE CG21) should form part of the role for **all** health professionals working with older and vulnerable people.

Where a SOP (Standard Operating Protocol) exists then that should be adhered to. See DCIS Appendix 2 for SOP's.

IN PATIENT SERVICES

The in patient falls risk assessment should be completed within 12 hours of admission to an in patient service.

Clinical staff undertaking the falls risk assessment must take into consideration the clinical information about the falls risk presented by service user and review the risk assessment as follows:

- Any RED flag rating indicates that further falls assessment is required. This must include MDT actions, falls prevention plans records of any MDT discussions. It is essential that. the patient's falls risks and actions are discussed with the MDT as soon as is appropriate and documented accordingly. Service users should be re assessed weekly until the red flag issues have been resolved. Service users and their risk assessments should be reviewed after any changes such as a fall or in medication which may alter their falls risk.
- For AMBER patients, decide, on an individualised basis, if a specific falls care plan is required and use clinical judgment/ reasoning to make this decision. The care plan should be completed if any risk issues are identified and should show how you intend to manage these risks. If the course of action is unclear discussion must be made with senior colleagues and other members of the

MDT and documented. Service users should be re assessed monthly or as the condition alters.

- For those service users assessed as being at risk of falling or for service users having had recurrent falls *'individualised multi factorial interventions'* should be considered as stated in NICE clinical Guideline 21. These should be instigated and delivered by professionals that are competent to do so and consideration should be given to onward referral to Day Hospital if there is not adequate time available on an inpatient area to fully implement all of the multi factorial interventions.

- Rationale for any actions that have not been taken will be recorded and made explicitly clear. Once the issues have been addressed a review of the risk assessment will be undertaken.

Where risks have been identified relevant actions will be taken and recorded to minimise the risks. If falls have been identified as a risk, a falls risk assessment must be used to identify more specific information about the risks posed by the service user. This risk assessment can be found in Appendix 2.

These actions will be clearly documented in the service users care record.
This may be on TPP (electronic record system for DCIS) or paper based dependent on the local record keeping guidance and process.

COMMUNITY SERVICES

All patients in high risk groups will have a falls risk assessment completed as part of the single assessment process. This will be recorded on System One.

High risk patients include older people, people with a learning disability, people with long term conditions

All other patients will have a risk assessment completed if falls risk is identified as part of their core assessment/ they have an underlying condition/recent intervention which may place them at risk of falls

Falls risk assessments should be completed as soon as possible once a service user has been identified as a falls risk and an action plan completed. All practitioners are expected to complete their relevant sections and must be completed prior to a referral to the falls service

Falls risk assessment should be completed by the lead clinician/professional unless otherwise indicated or agreed within an MDT

Falls risk assessments must be completed prior to any referral to the falls service and an interim care plan written.

Patient consent to share records should be obtained (if the patient has capacity) so that other teams within DCIS can access the record to prevent duplication

The falls risk assessment within community services should be completed upon referral using the Falls Risk Assessment Tool (FRAT).

Clinical staff undertaking the FRAT must take into consideration the clinical information about the falls risk presented by service user in the following areas:

- History of falls
- Four or more medications prescribed
- Diagnosis of stroke or Parkinson's Disease
- Patient reported problems with balance
- Ability to rise from a chair of knee height.

Following this risk assessment, if there are positive answers to 3 or more of the questions, the clinician is responsible to arrange onward referral or further assessment, as competence allows.

For further explicit guidance on completion of the FRAT refer to the tool in Appendix 2

Specialist falls management services e.g. Community Intermediate Care Team (CICT) and Day Hospital will use the falls **template.** This comprises of three sections which relate to nursing, physiotherapy, occupational therapy. A fully completed falls template would require assessment by all three specialties. Once started it can be completed by other services. All services which use System One have access to the falls template.

PROCEDURE FOR THE MANAGEMENT OF PEOPLE WHO HAVE FALLEN

POST FALL PROTOCOL FOR DCIS INPATIENT SERVICES

The procedure for people who fall whilst on an in patient areas is described in Appendix 10.

COMMUNITY AND NON RESIDENTIAL AREAS

In all community areas (including Day Services) the following community protocol and pathway, must be used in circumstances where staff discover a person who has fallen.

Follow Standard Operating Procedure (SOP)

If transfer to hospital is required dial 999.

If in a day setting hospital (e.g Day Hospital use local inter facility transfer pathway number). Day Hospital - Refer to Appendix 10, Post Fall Protocol, Transfer to Hospital from Mental Health and Community Hospital, for flowchart on inter hospital transfer.

Head Injuries

If no doctor is available then community staff to ring 999 and transfer to A & E for assessment and observations. If community staff have skills, training and competency they should start neurological observations immediately and provide any information for ambulance personnel.

Interventions Post fall if no injury sustained

In addition consider referral onwards to locally provided falls assessment and intervention services. These services will provide multi factorial assessment and interventions and include:

- CICT – (refer via Single Point of Contact 01302 796413) for fallers within the previous 1-2 weeks.

- Falls Clinic at Day Hospital – (01302 796456) for fallers over 2 weeks or with requirements for medical review. Paper referral - see later section for details.

- Hawthorn ward – (refer via Single Point of Contact 01302 796413) for individuals who require intensive rehabilitation for no more than 7 days.

Some service users may already be involved with falls services and further communication should be made with these services to update the care plan accordingly.

CARE HOMES

It is the responsibility of Care Homes to have a Moving and Handling Policy, which includes guidance on the management of the fallen resident. Mechanical aids should be available and staff trained in their use. If a resident falls frequently then consideration should be given for a referral to the relevant service for further assessment.

If a resident falls frequently then consideration should be given:

- GP assessment to rule out any medical cause
- Medication review by GP
- Environmental assessment to rule out falls due to environment e.g poor lighting, rugs,
- Check whether resident has suitable footwear
- Eyesight and hearing check
- Ensure adequate nutrition and hydration
- Review re pain
- Monitor for any trends/themes/patterns to falls

In the absence of above consider referral to specialist services

FALLS CLINIC

The Falls clinic is based at Day Hospital at Tickhill Road Hospital, Balby, Doncaster. The aim of the service is to investigate cause(s) of the fall and treat the cause(s) of the fall so future falls are prevented or minimised. This will involve medical examination and depending on outcome of medical assessment may involve medical investigation, further nursing assessment, physiotherapy, occupational therapy, speech and language therapy and/or dietetic assessment.

Referral

Referrals to Day Hospital are made on the paper referral form (attached). The reason for referral, falls history, symptoms, possible services required, e.g. medical review, further nursing assessment, physiotherapy, OT should be indicated on the referral form.

Inclusion Criteria

Clinicians should refer if their service user meets any of the following criteria:

Any unexplained falls with the following symptoms (only needs to be one fall)

- dizziness
- light headedness
- postural hypotension (deficit of 20mm/Hg is significant)
- patient reports their “legs give way”
- muscle weakness

N.B. Simple mechanical falls do not need to be referred.

Multiple falls.

Multiple near misses.

Any fall due to or involving blackout/loss of consciousness.

Unexplained falls and patient has multiple risk factors, such as:

- 4+ medications, especially medication which can contribute to falls (mainly cardiac, antihypertensive, sedating antidepressants, anti psychotics, sedatives, Parkinson’s disease medication)
- See NICE CG21 for more information.

Doncaster Community Integrated Services

Standard Operating Procedure for management of patients who fall in their own home

Aim:

This SOP provides guidance for community staff for a patient has fallen in their own home.

Procedure:

If the patient is still on the floor:

- Check the environment is safe for self, patient and others and take appropriate steps to make safe if possible. If it is not safe to approach the person (e.g electricity), provide reassurance if the patient is conscious and call the appropriate emergency services for assistance.

- If the environment is safe scan the patient for injuries, check for pain, bleeding, swelling, lacerations, abnormalities or deformities.

- Take the appropriate first aid action if required in line with role and competence. If there are concerns that the patient may be seriously injured (for example shortening or rotation of a limb) do not move the person and call an ambulance. If an ambulance is requested make the patient as comfortable as possible and give reassurance.

- If the person is able, encourage them to turn on to their hands and knees and place a chair or other sturdy object close to them so that he/she can lever him/herself up. If the patient reports pain at any time **stop** and reassess the need for emergency services assistance.

If the person is unable to get him/herself up with minimal assistance do not attempt to lift them.

- Stay with the patient and provide reassurance.

- Call emergency services if indicated

- If the person has a communication system linked to Doncaster Metropolitan Borough Council's central control service (pendant alarm or pull cord system). Activate the communication channel and request assistance from the mobile warden service explaining that an ELK cushion will be required to assist the person from the floor.

NB: This service is dependent upon availability of the wardens and response time to attend may be up to an hour. Consider risks to elderly person of laying on floor for extended period i.e. pain, tissue viability, hypothermia

- Make the person as comfortable as possible using pillows, cushions, blankets or other supportive objects and provide reassurance.
- Contact as many colleagues as may be necessary to attend and assist.
- Agree on the actions to be taken.
- One staff member to take the lead.
- Using recognised moving and handling techniques move the patient in small stages allowing time between each movement to reassess the patient's condition and plan the next movement until they are in a position to be transferred to a chair or bed.
- If lifting equipment e.g. Elk is used in the service follow local procedures

If the patient reports pain at any time **stop** and reassess the need for emergency services assistance or contact the patients GP or Out of Hours GP service for instruction regarding administration of pain relieving medication.

THEN:

- Reassess the patient and take appropriate first aid actions if necessary.
- Record BP lying/sitting/standing if possible.
- Contact the patients GP or out of hours service to establish if U&Es and FBC blood tests are required and the time frame for the blood to be taken.
- Arrange for a urinalysis to be undertaken at the earliest convenience.
- With the patients consent contact their family or carers to inform them of the event.
- Document the outcome of the incident but DO NOT COMPLETE THE TPP FALLS ASSESSMENT TEMPLATE.
- Refer to Community Intervention C Team on 01302 796413 for a falls assessment who will then complete the TPP Falls Assessment Template.

If a patient reports that they have fallen in the past seven days:

- Treat any evident injury as appropriate and continue any previously planned care. DO NOT COMPLETE THE TPP FALLS ASSESSMENT TEMPLATE.

- Record the patients basic observations including:
    - Lying/Sitting/Standing blood pressure
    - Urinalysis
    - Contact the patients GP or out of hours service to establish if U&Es and FBC blood tests are required and the time frame for the blood to be taken (liaise with Community Intervention Care Team if this is non urgent).

- Refer to Community Intervention and Care Team on 01302 796413 for a falls assessment who will then complete the TPP Falls Assessment Template

If the patient reports that they have fallen over seven days ago:

- Assess and treat as appropriate any injury or medication issues.

- Continued any planned care as normal.
- Record the patients basic observations
    - Lying/Sitting/Standing blood pressure
    - Urinalysis
    - Contact the patients GP or out of hours service to establish if U&Es and FBC blood tests have been taken and if the results are recent enough to inform a multi-factoral assessment, otherwise obtain a blood sample
- Refer to consultant lead falls clinic at Day Hospital for multi-factoral assessment by completing the Day Services referral form and faxing to 01302 796112 or telephone 01302 796459 to make a verbal referral.

Document the outcome of the incident in all cases and inform the patients GP of the event.

Complete an incident report.

DAY SERVICES REFERRAL FORM

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

DAY SERVICES REFERRAL FORM
TICKHILL ROAD HOSPITAL, WESTON ROAD, DONCASTER DN4 8QL
TELEPHONE 01302 796456 / FAX 01302 796112

Please complete this form fully and accurately to prevent delay

PATIENT DETAILS	**GP DETAILS**
NHS No ……..... District No …….. Surname ……. Forename(s) ……... Date of Birth ……... Address…… …… ……..... Telephone No ……......	GP ……. Surgery …….. Telephone No …… NEXT OF KIN Name ……. Telephone No …… Relationship ……
REASON FOR REFERRAL (please be specific) IS PATIENT AWARE OF REFERRAL YES / NO	**INVESTIGATIONS, RESULTS AND TREATMENT TO DATE** (please attach any relevant documentation)
PAST MEDICAL HISTORY	**CURRENT MEDICATION**

OTHER AGENCIES INVOLVED / REFERRED TO	ADDITIONAL INFORMATION

HOME SITUATION

House ☐ Flat ☐ Bungalow ☐ Residential / Nursing Home ☐

Lives Alone ☐ With Relative / Carer ☐ Warden ☐ Carers (inc number of calls) ☐

MOBILITY

No Aid ☐ Sticks ☐ Crutches ☐ Frame ☐ Wheelchair ☐

TRANSFERS

Independent ☐ Assistance of 1 ☐ Assistance of 2 ☐ Hoisted ☐

FALLS HISTORY

Recent falls? YES ☐ NO ☐
Any Near Misses? YES ☐ NO ☐
Fear of Falling? YES ☐ NO ☐
Any Injuries? YES ☐ NO ☐ - please specify
Osteoporosis Risk? YES ☐ NO ☐ DON'T KNOW ☐

REFERRER DETAILS

Referred by …… Occupation ……
Place of work / Tel No ……
Date and Time Referred ……

OFFICE USE ONLY

Referral taken by …… Date & Time ……..

APPOINTMENT DETAILS

First Appt Date ……/……/…… Time ……
Register to …….. To be seen by ……

Doncaster Community Healthcare: Profiling Beds

Standard Operating Procedure for the prescription of profiling beds from Doncaster ICES

Aim

This Standard Operating Procedure (SOP) represents the current recommended good practice for the assessment and provision of a profiling bed.

This detail contained within this SOP applies to Occupational Therapists and Community Nurses working in Doncaster Community Healthcare.

This SOP is to be used in conjunction with the following documents:

- ICES Practice guidance for the prescription of community equipment;
- Bed rails/ Bed Bumpers Protocol

Assessment of need

- The user requiring a profiling bed must have had a SAP assessment to identify their needs
- The user must have a nursing/medical need or a need to prevent injury to carers to be prescribed a profiling bed. If they do not have a nursing/medical need other intervention may be appropriate. Refer to the flowchart (appendix 1).
- The user must live in their own home or a residential home. Profiling beds **must not** be provided into nursing homes.
- A risk assessment should be carried out and documented taking into account the information on the checklist
- Plans should be put in place to minimise each risk identified and documented.
- An assessment should be made to ascertain if the user requires any additional equipment for the bed e.g. cot sides.
- If additional equipment is required risk assessments should be completed following appropriate policy e.g. safety side policy.

Ordering the profiling bed

- A stock requisition form will be fully completed by the prescriber and faxed to the British Red Cross at Marshgate (or equivalent equipment provider)

Indication of hazards to the delivery drivers should be identified on the requisition.

- British Red Cross staff .(or equivalent equipment provider) will inform the service user of a delivery date

Review

- When the equipment has been installed a member of staff, preferably the prescriber, should visit the property to ensure that it has been installed as directed and the user and carer can operate it competently.

Appendix 16

Mental Health Services

Mental Health Community Services: General Procedures

- Rdash community mental health services are provided in a range of geographical locations working in partnership with different primary care service providers. These providers all have community based falls prevention services and these differ based on the locality.

- Supporting Rdash service users/ patients to maintain active and healthy lifestyles is an important component of maintaining good mental health and wellbeing and all mental health community staff have some role in health promotion (for some patients i.e those with mobility problems, physical health problems increasing falls risk, medication use which increases falls risk or who have a history of falls, this health promotion work will include falls risk awareness and falls prevention activities). Mental health community staff should therefore follow the falls assessment and prevention procedures in their locality, and work collaboratively with the providers of these services as is required. Rdash Physiotherapy, Occupational Therapy or health education staff are best placed to further advise on this if necessary.

Community Mental Health Services for Older People: Procedures

Service users/ patients in ***high falls risk*** groups (including - older people with mental health problems) should receive falls screening and/ or further assessment of individual multi-factorial falls risks as part of the patient pathway. Note: NICE CG21 2004 recommends that **all** health professionals working with older people should contribute to basic falls risk screening for **all** patients.

- Falls risk screening procedures vary across localities: In some Rdash community mental health services for older people localities, falls screening is incorporated into the overall care planning assessment process/ patient pathway, in other localities a standard falls risk assessment screening tool is used in line with the *primary care* locality falls screening procedures. For example in Rotherham, a Falls Risk Assessment/ Screening Tool (FRAT) is used by all health care staff working with older people irrespective of the work setting or specialism – and so this is also routinely used by Rdash staff working in community mental health services for older people.

- **Staff working in Community Mental Heath Services for Older People have a responsibility to familiarise themselves with the falls risk screening/ assessment procedures in their locality and carry these out in accordance with their role and duties –as advised by their line manager**

- Prescribing and management of medication should take into account falls risk effects/ side effects. Medical management and medication review with relation to falls risks, especially of psychotropic medication, should also occur as part of routine care planning and review by medical staff and other MDT members

- Certain staff working in community mental health services for older people (e.g. Physiotherapy, Occupational Therapy, Health Education staff) may have an identified role in leading on falls prevention and the delivery of associated interventions. Interventions delivered in these services (in line with recommendations of NICE CG21 2004) may include: falls education and information giving, strength and balance training, exercise and activity programmes, rehabilitative programmes, and home hazard assessment and intervention. In some localities these interventions are delivered in collaboration with or solely by specialist falls services**. Each locality should have referral systems and procedures in place to ensure patients have access to the range of services available.**

.

- For patients with dementia, there is evidence that **identification at an early stage of the dementia** of falls risks, falls risk management and participation in activities and programmes aimed at maintaining bone health, strength and balance, mobility and physical wellbeing reduces the risk of falls and fractures longer term. The health benefits therefore of a proactive approach to falls prevention, include increased independence and a better quality of life for people with dementia and their carers. It is also now accepted that physical exercise and activity and good nutrition and hydration may improve cognitive function as well as reduce falls risks. **Clinical staff working in Rdash memory clinics / services (and similar settings)**, in addition to routine falls risk screening (and onward referral as necessary etc), should also make available falls prevention and health education information (including information about healthy lifestyles and the importance of exercise and activity) to patients and carers. Any patient or carers education groups being run in these services, or similar settings (e.g. day services) should also include falls prevention and related health and wellbeing information/ components.
- Older people **with a diagnosis of depression** are also at increased risk of falls and suffer more serious consequences when they fall i.e, they have increased morbidity following a fall, are slower to recover from a fall, and are more likely to lose independence and have long term disability if they are injured in a fall.
- Fear of falling and the psychological effects following a fall are known to be contributory factors in some cases of depression and anxiety.
- RDaSH staff working in community mental health services for older people therefore have a key role and influence in falls risk identification and falls prevention work. **Service Managers and Clinical Leads must ensure care and patient pathways include appropriate falls risk assessment, management and intervention procedures in line with patient needs and in line with advice from the Trust Falls Prevention Leads/ Trust wide Falls Prevention Steering group.**

Adult Community Mental Health Services
(including Psychological Therapies, Substance Misuse) Procedures
Pathways for specialist falls service dependent on locality services. All community staff to refer to Physiotherapy services or liaise with GP.

CAMHS – Staff working in CAMHS will follow locality primary care guidance in relation to falls for children and young people/Liaise with GP.

APPENDIX 17

Documentation Guide

Document	Guidance
Falls Prevention & Bone Health Policy for Managing the Risks Associated with Slips Trips and Falls (including falls from a height) involving service users, staff and others	Trust Intranet under Clinical Policies Include in local Induction Use in staff supervision and training – updates staff as per PDR or in line with mandatory training requirements for role and setting
Appendix 1 Multi-factorial Inpatient Falls Risk Assessment and Guidance (Mental Health Services for Older People/ Learning Disability Inpatients)	Complete as part of admission procedure in MHSOP and LD inpatients. Copy to community professionals in preparation for discharge/ transfer. Laminate flow chart and place on wall/ notice board
Appendix 2 Multifactorial Inpatient Falls Risk Assessment (DCIS); Community Falls Risk Assessment Tool 'FRAT' and Guidance (DCIS)	Complete as part of admission procedure in DCIS. Copy to community professionals in preparation for discharge. Community Falls Risk Assessment Tool 'FRAT' to be completed by community staff; use guidance notes to support decision making. Refer on to falls clinic/ day hospital or other services as per policy
Appendix 3 Protocol for the use of Bed Rails (including examples of risk assessment tools)	Complete as part of in patient assessment and place within patients nursing/ MDT notes.
Appendix 4 Bedrails: Patient Information Leaflet	Provides information to patients and carers if bed rails issued or if questioned with regards to decision not to use bed rails
Appendix 5 Protocol for the use of Hip Protectors	Complete as part of patient assessment and place within patients nursing/ MDT notes
Appendix 6 Protocol for the use of Bed Alarms	Complete as part of patient assessment and place within patients nursing/ MDT notes
Appendix 7 Protocol for the Use of Ultra Low Beds	Consult as necessary Useful in training and staff supervision
Appendix 8 Advice About Potential Restraint- inc wheelchair lap belts, bean bags, protective headgear, nursing on the floor (including checklist for use if these being considered)	Useful to use in training and staff supervision re: ethical dilemmas related to risk, rights and responsibilities Complete and file in patients nursing notes
Appendix 9 Osteoporosis	Information for clinicians
Appendix 10 Interventions after a patient has fallen in hospital including management of suspected head injury and possible hip fracture.	Laminate flow chart and place on wall/ notice board Consult as necessary Useful in training and staff supervision

Appendix11 Medication Which May Increase the Risk of Falls	Print and laminate. Take into ward round/ clinical meetings. Consult as necessary
Appendix 12 Walking aid and gait training information	Consult as necessary Useful in training and staff supervision Physiotherapists/ ward managers to share with staff; use to accompany training sessions
Appendix 13 Falls Prevention and Footwear	Consult as necessary, can be give to patients or carers
Appendix 14 Learning Disabilities Community Homes Slips, Trips and Falls Policy	Use in staff supervision and training for updates; contains LD community falls risk assessment tool Complete as part of service user assessment and place within records.
Appendix 15 DCIS	For Information and use by DCIS staff; contains guidance about all DCIS inpatient and community procedures; contains various tools and SOPs (inc those for fallen patient, referral to day hospital, referral for profiling bed in community, info on falls clinic e.t.c) Use in staff supervision and training for updates
Appendix 16 Mental Health Community Services	For Information and use by Community Mental Health Staff Use in staff supervision and training for updates
Appendix 17 Documentation / Pathway Guide	Laminate and display/ keep to hand
Appendix 18 In patient Documentation guide	Laminate and display
Appendix 19 Patient Information	Copy and provide for patients and carers as required
Appendix 20 Terms of Reference Strategic Falls Prevention Group	The purpose of the Strategic Falls Prevention Group is to establish and monitor a strategic approach and action plans for falls prevention relating to service users, staff and others, based on the national guidance provided by NICE, NPSA, NHSLA, HSE etc, and to provide assurance to the Clinical Governance Group.
Appendix 21 Get a Grip – stop slips & trips in Healthcare	Provides a range of useful information on safeguards that serves to protect patients, staff and others in the workplace. It uses the acronym SHOES in order to aid recall the following key areas for slips, trips and falls: • **S**pills • **H**igh risk areas • **O**ver used signs • **E**nvironmental cleanliness • **S**hoes
Appendix 22 Staff Falls Information Leaflet	Provides Level 1 Basic Awareness for all Staff

APPENDIX 18

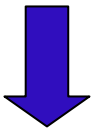
FLOW CHART FOR COMPETION OF INPATIENT DOCUMENTAT ION

PT ADMITTED

Complete documentation

- Falls Risk assessment including action taking
- Bed Rails risk balance tool and assessment
- Consider hip protectors/bed alarms
- Complete a falls care plan if indicated
- Carry out repeat assessments as required

PT FALLS



- Take immediate actions to deal with situation
- Document event in patient's notes (entering IR1 number after this has been completed)
- Review Falls Risk assessment and identify actions required to minimise risk of further falls
- Medication review: this should be given prompt attention, with any changes needed to be made immediately
- Review care plan
- Inform NOK and document in notes (unless the service user specifically objects)
- Discuss and review in MDT meeting and record any actions/recommendations.
- Refer to Physiotherapist/ others as indicated

When completing IR1, record:

- Time and place of incident
- Circumstances surrounding the fall e.g. how patient fell, any pertinent staffing or other factors
- Actions taken at time e.g. Medical review/ Dr consulted, observations done,
- Strategies in place prior to fall e.g. patient had bed alarm
- Actions taken/ strategies to be put in place following the fall- e.g. falls risk assessment reviewed; referred to physio; medical review

APPENDIX 19

Inpatient Patient Information Sheet

What can you do to reduce your risk of falling?

- Use the call bell to get help if you need to move.
- Sit upright for a few moments at the edge of your bed to get your balance
- Before standing up, make sure you have your walking aid close at hand – ask a member of staff if you need help.
- Make sure that you feel safe and balanced before you start to stand or walk
- Be careful and aware of equipment that may be in your way.
- Switch on lights if you need to, to help you find your way.
- Do some simple leg exercises before getting up from your bed or chair.

LEG EXERCISES

POINT YOUR TOES AND RELEASE – DO THIS A FEW TIMES

TIGHTEN THE MUSCLES IN YOUR CALVES AND

- If you wear spectacles or a hearing aid, make sure they are working, clean and worn as prescribed.
- Please wear your shoes or slippers when walking but make sure that they fit properly. Do not wear slippers with heels.
- Make sure that you cannot trip over your nightdress or pyjamas.
- DO NOT USE non-fixed hospital furniture as a walking aid – most are on wheels and may move unexpectedly.
- If your bed or chair is too high or too low for you to use safely, please ask for assistance.
- Please report any wet floors to a member of staff as soon as possible.
- Avoid using or spilling talcum powder, it can make surfaces slippery

- The ward staff may recommend the use of bedrails on your bed if they feel it is appropriate for you, this will be discussed with you and an information leaflet is available.

If you or your relative/ carer would like further advice about falls prevention or specific help please speak to the ward manager, or ask to see one of the physiotherapists.

APPENDIX 20

ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. **NAME OF COMMITTEE/SUB-GROUP:** Strategic Falls Prevention Group

2. **PURPOSE:** To establish and monitor a strategic approach and action plans for falls prevention relating to service users, staff and others, based on the national guidance provided by NICE, NPSA, NHSLA, HSE etc, and to provide assurance to the Clinical Governance Group.
Falls prevention is multifactorial and complex and requires that there be a robust organisational infrastructure, with executive leadership and mechanisms for involvement and input from senior clinicians, senior operational managers and also senior leaders with responsibility for governance, training & development and facilities.

   The appointment of an Executive Lead ensures that a reduction in harm from falls is an integral part of the trust's improvement agenda. They can provide a voice for falls prevention work and projects at the Board, have the leverage to remove barriers to progress and ensure that falls is included in core work streams related to patient and staff safety and physical health and well-being (NPSA (2009) the 'How To' Guide to Reducing Harm from Falls.

3. **MEMBERSHIP**

   - Deputy Chief Executive/Director Nursing & Partnerships
   - Deputy Director Clinical Governance/Allied Health Professions (AHP) Lead
   - Patient Safety Lead
   - Consultant Occupational Therapist, Older People Business Division
   - Trust Physiotherapy Professional Lead
   - Clinical Lead Physiotherapy, Learning Disabilities Business Division
   - Head Occupational Therapist, Doncaster Community Integrated Services Business Division (DCIS)
   - Falls Coordinator, DCIS
   - Health Promotion Lead, Older People Business Division
   - Mandatory Training Lead
   - Deputy Director of Nursing

   <u>The above will function as the core group and relevant others will be co-opted as appropriate and may include:</u>
   - Other Business Division representatives
   - Pharmacy
   - Medical
   - Estates and Facilities
   - Health and Safety Lead
   - Physical Health and Well-Being Practice Development Lead
   - Back Care Advisor
   - Modern Matron Practice Development

   (NB this is not an exhaustive list)

4. **QUORUM** The group will be considered quorate with any 4 members in attendance.

5. **MEETING ARRANGEMENTS (FREQUENCY, CHAIR, VENUE, ADMINISTRATIVE SUPPORT ARRANGEMENTS):** Meetings will be chaired by the Deputy Director of Clinical Governance AHP Lead and will be held quarterly. Meetings will normally take place at St. Catherines, Doncaster and administrative support will be provided by the Nursing and Partnerships Directorate.

6. **KEY RESPONSIBILITIES/OBJECTIVES/DUTIES/ POWERS**
   1. To provide a forum for monitoring and review of falls incidents and trends
   2. To provide a forum for discussion and exception reporting to improve reporting, analysis and learning from falls incidents

3. Oversee the implementation of the Trust *Falls Prevention & Bone Health Policy For Managing The Risks Associated With Slips, Trips And Falls (Including Falls From A Height) Involving Service Users, Staff And Others,* and support, direct and oversee the work of related task group(s)
4. To look at strategic falls prevention issues which go beyond individual wards or departments
5. To oversee partnership and joint working projects i.e. to link RDaSH Falls prevention work and activities with falls prevention work and projects of local partners - recognising the widespread benefits of this in reduced morbidity and mortality (BGS 2006). In particular to focus on key areas of vulnerability and risk, including:
    - Nutrition groups - any interventions to improve service users' strength or balance will rely on them being as well nourished as possible.
    - Physical health - mental health and learning disability units need to link their falls prevention group to any local projects seeking to improve the general health of service users and the diagnosis and treatment of any physical illnesses, as this in turn is likely to reduce the risk of falling from medical causes.
    - Parkinson's disease - initiatives to ensure service users get their medication on time.
    - Osteoporosis/bone health
    - Delirium – prevention, early recognition and treatment can bring widespread benefits in reduced morbidity and mortality (British Geriatrics Society 2006) and is also likely to have a positive effect on the risk of falls (Stenvall 2007) and is the subject of NICE (2010) guidance.
    - Local projects to improve the care of patients with dementia (because of its high prevalence in older inpatients, and the high rate of falls in people with dementia); nutrition;
    - Falls also links to the national Dignity agenda, and the Department of Health's guidance on the protection of vulnerable adults and the focus on quality.
      (NB this is not an exclusive list)
6. To monitor and evaluate front line falls prevention actions required from frontline staff working on clinical wards and departments including ward and departmental managers, doctors, nurses, physiotherapists, pharmacists, occupational therapists, porters, cleaners and all other team members.
7. Governance/ Risk/Quality and Standards: to ensure compliance/ assurance to national standards and guidelines; including:
    - *NPSA* How to guides and *Slips*, *trips and falls in hospital*
    - CQC Essential Standards of Quality and Safety
    - NICE Guidance
    - Essence of Care
    - High Impact Actions
    - NHS Litigation Authority Risk Management Standards
    - Royal College of Physicians (RCP) (who lead on the National Audit of Falls and Bone Health)
    - Falls are a proposed key outcome measure in *Transparency in Outcomes – a framework for the NHS* (Department of Health 2010) and a nurse sensitive metric in the Indicators for Quality Improvement (details at http://www.ic.nhs.uk/services/measuring-for-quality-improvement).
    - Health and Safety Executive (HSE) guidance http://www.hse.gov/healthservices/
8. Oversee the development, planning and effectiveness of falls prevention training
9. Oversee environmental risks and facilities matters related to Falls

Disseminate themes and trends from incidents, including discussion at the Organisational Learning Forum in order that appropriate improvement actions are taken.

7. RECEIPT OF MINUTES AND REPORTS FROM:

The Falls Prevention Group will receive:

- Relevant clinical audit results
- External /internal reports, including from multiagency groups

8. REPORTING ARRANGEMENTS:

The Falls Prevention Group will report to the Clinical Governance Group via the Deputy Director of Clinical Governance and Allied Health Professions Lead (or nominated deputy), which reports to the Board of Directors.

9. DATE APPROVED BY CLINICAL GOVERNANCE GROUP: 19 March 2012

10. REVIEW DATE: March 2013

11. DOCUMENT OWNER/RESPONSIBILITY FOR REVIEW (LEAD DIRECTOR):

Deputy Chief Executive/Director of Nursing and Partnerships

Get a Grip

Stop slips & trips in Healthcare

HEALTH AND SAFETY AUTHORITY

www.hsa.ie

This document deals with slips, trips and falls (on the level) for workers in the healthcare sector, the safeguards in this document will also serve to protect patients, residents, visitors and others at the workplace.

Don't underestimate the importance of preventing slips, trips and falls.

- Slips, trips and falls account for about one fifth of all reported accidents in Healthcare
- In 2009 slips trips and falls was the second highest reported accident trigger in the Healthcare sector (manual handling was the highest)
- 44% of Injuries Board employer liability awards in 2008 were for slips, trips and falls
- 30% of reported slips, trips and falls in Healthcare in 2009 resulted in an absence of over a month

Employers, managers and employees all have responsibilities to control risks from slips, trips and falls.

Employers/Managers must

✓ Manage health and safety in the workplace

✓ Commit to and provide the resources to control the risks from slips, trips and falls

✓ Include slips, trips and falls in the safety statement

✓ Conduct workplace specific slips, trips and falls hazard identification and risk assessment(s). (An analysis of workplace incidents will inform this process)

✓ Take specific precautions based on risk assessment if employees are:

- working in overcrowded conditions
- undertaking manual handling tasks that limit ability to detect slip, trip or fall hazards
- under time pressures
- physically disabled

✓ Ensure appropriate information, training, instructions and demonstrations as required (posters and visual aids can be a useful reminder of safe work practices and help raise awareness)

✓ Provide personal protective equipment (e.g. slip-resistant footwear) if required

✓ Have a system in place for reporting and investigating work related accidents and near misses

✓ Consult with employees on safety, health and welfare matters and seek employee involvement

✓ Conduct audits to ensure controls are effective and responsibilities are met

Employees have an important role in preventing slips, trips and falls.

Employees must

✓ Take reasonable care to protect themselves and others

✓ Co-operate with their employer with regard to health and safety at work

✓ Report anything potentially dangerous at work of which they are aware

✓ Use and take proper care of any personal protective equipment (e.g. slip-resistant footwear)

Manufactures and Suppliers must

✓ Ensure their products are safe and comply with relevant standards

✓ Provide adequate information about the appropriate and safe use of articles for use at work (this includes manufacturers and suppliers of floor treatment substances, slip resistant footwear, workplace equipment etc)

Remember paperwork alone will not prevent injuries. It is important to take action once a hazard has been identified. You can use the safeguards in this document as a guide. When identifying controls priority must be given to avoiding risk and where this is not possible to combating risk at source in keeping with the General Principles of Prevention in Schedule 3 of the Safety Health and Welfare at Work Act, 2005.

Key areas for slips, trips and falls include:

- **S**pills
- **H**igh-risk areas
- **O**ver-used signs
- **E**nvironmental cleanliness and
- **S**hoes

You can recall these with the acronym SHOES

Spills

✓ Deal with spills straight away (where a delay is unavoidable try to ensure that others are aware of the spill and make the area safe as soon as possible)

✓ Use absorbent material to soak up the spill

✓ Where particular procedures are specified for cleaning and disinfecting areas following a spill of hazardous liquid/material e.g. spills of blood, body fluids, hazardous chemicals, ensure staff are aware of correct procedures and that the floor is dry when the procedure is complete

✓ Identify areas at high spill risk and locate absorbent materials near likely spills

✓ Avoid where possible using a wet cleaning approach that may just spread the potential danger area

✓ Consider nominating one person each shift to be responsible for spills. (This will only work if that person is advised of any spills and is available to deal with spills immediately)

✓ Consider using spill kits

✓ Ensure spills cleaning equipment is readily available for use

✓ Ensure slip resistant footwear is provided and worn as needed

High-risk areas

Identify and deal with high-risk areas for slips, trips & falls.

✓ Mapping may be helpful to highlight 'hotspots' in an area, this can be done by:

- drawing a rough map of an area
- marking all slips and trips in a period
- asking workers about near misses and causes of slips and trips and adding them to the map

'Hotspots' will quickly show up, once the problems and causes are identified, controls can be agreed on and implemented. Monitor to ensure controls are working and communicate improvements. For further information on mapping see the Slips Trips and Falls topic at **www.hsa.ie.**

Some examples of potential high risk areas and associated controls are given below.

a. External areas

External areas such as the grounds of a premises, car park etc can present a risk for slips, trips and falls.

✓ Keep external traffic routes free from holes or obstructions

✓ Keep outside pathways free of algae, leaves etc. Consider a regular inspection and cleaning programme where this is a recognised problem

✓ Cut back/control plants and trees that overhang paths and create a hazard

✓ Ensure the lighting is adequate, both inside and outside buildings

- Provide hand rails to steep slopes on outside paths

Monitor weather conditions and put a snow and ice procedure in place, this may include.

- Gritting and salting of pedestrian routes, e.g. the route from the car park to the main entrance
- Locating grit/salt bins near where grit/salt is likely to be needed and keeping them properly stocked
- Clear allocation of responsibility for dealing with snow/ ice on walkway

✓ Highlight any changes in level on paths that are not easy to see, e.g. small steps. Improve lighting, apply contrasting eye-catching colour(s) to steps (e.g. non-slip paint)

✓ Barrier off holes, potholes or uneven paving on footpaths and highlight the hazard as a temporary measure. Ensure barriers cannot be easily moved. Fill in holes, re-lay paving, repair/replace damaged paving stones as soon as possible

✓ Improve the grip on fire escapes if slippery when wet. Consider applying slip-resistant coating/strips or bolt-on slip-resistant material (caution – do not create a trip hazard)

b. Sources of liquid

As well as leading to a moist/wet floor, liquid could damage a floor over time.

Identify sources of liquid. e.g. equipment using water/ liquid, wash-up, showers, cleaning store, toilets, deep fat fryers. Consider areas where liquid products are stored.

✓ Ensure that work equipment is properly maintained

✓ Repair leaks from equipment

✓ Prevent liquid spreading – drip trays beneath plants/ machines/water coolers

✓ Insulate overhead pipework if condensation is forming on it and dripping onto the floor

✓ In toilets, bath and shower rooms check shower curtains/screens to ensure they work to maximum effect in keeping the surrounding area as dry as possible, position sufficient hand dryers close to sinks, ensure floor drainage is adequate and the floor has adequate slip resistance.

✓ Ensure adequate local drainage

✓ Use suitable mats to reduce the risk

c. Damaged flooring

Ensure that floors have no dangerous bumps, holes or slopes. Identify poorly maintained, damaged floors.

✓ Repair or replace damaged floors and take steps to prevent further damage

✓ Fix down loose tiles and curling carpet edges, replace if necessary.

d. Level changes

Identify areas where levels change, e.g. slopes, ramps, steps/ stairs, unexpected holes, bumps, drainage channels.

✓ Provide slip resistant surfaces to eliminate or reduce the risk

✓ Provide proper lighting

✓ Highlight changes in level

✓ Highlight slopes, small steps – improve lighting, use eye-catching colour(s) on slope/step

✓ Keep the stairway free from obstruction

✓ Avoid having to carry items on stairs, e.g. by use of dumb waiters

✓ Ensure stairs are properly maintained, constructed and well lit

✓ On stairs

- Provide easy-to-reach, useable handrails
- Provide steps of equal height and steps of equal depth throughout the flight of stairs
- Provide nosings in good condition, not slippery and easily visible
- Check lighting is sufficient to see step edges clearly

e. Slippery surfaces

Try to get flooring right from the start and choose floors that have adequate slip resistance and are suitable for the work environment and work activities.

Identify slippery surfaces

Tests can scientifically assess the slipperiness of floors

✓ Consider changing or treating floor surfaces if the surface is not suitable for purpose – this might include addition of slip resistant materials

✓ Pay particular attention to areas that may become slippery during severe weather (see External areas above)

✓ Ensure slip resistant footwear is provided and worn as needed

f. Transition areas

"One of the most dangerous situations is a rapid change in the friction coefficient. In one study, 64% of 108 slip, trip and fall accidents that occurred in one hospital took place at a transitional area: dry to wet, or one type of floor to another." *(Reference 1)*

Transition areas are areas with a sudden change in the level of grip.

Identify areas where pedestrians move between surfaces with very different levels of grip, e.g. from wet surface to a dry surface or vice versa.

- ✓ Stop water entering buildings. Consider providing canopies over entrances, improve external drainage, keep doors closed when you can. Providing umbrella holders at entrances may help prevent rain water getting onto the floor
- ✓ Take precautions to remove excess moisture from footwear e.g. fit large and absorbent entrance mats to dry shoes
- ✓ Mats must be properly designed, installed and maintained
- ✓ Mats must be placed where people actually walk
- ✓ Changes from one type of flooring material to another should be clearly visible

g. Cables and hoses

Identify trailing cables and hoses and poorly sited electrical outlets.

- ✓ Site electrical outlets to avoid trailing cables
- ✓ Use retractable reels
- ✓ Position equipment to avoid cables crossing walkways and circulation areas
- ✓ Ensure staff are aware of the importance of avoiding trailing cables

h. Mats

Identify areas where mats are used.

- ✓ Ensure mats are properly designed/ fitted and maintained and appropriately placed and do not present an additional hazard
- ✓ Consider – recessing mats into flooring; using weighted edges, fixing edges in place
- ✓ Where mats deal with a floor that is regularly wet additional controls may be required such as local floor drainage in the area

Over-used warning signs

Warning signs do not physically keep people away from wet floors.

- ✓ Warning signs do not substitute for necessary protective measures. For programmed/ routine floor cleaning, use a system that keeps pedestrians away from wet/moist floors, e.g. physical barriers
- ✓ Warning signs alone may not be adequate for many circumstances
- ✓ Warning signs must be removed when they no longer apply

Environmental cleanliness

- ✓ Where possible stop contamination from getting onto the floor – change the system of work, improve the work area layout, provide bins and lids on containers, reduce the quantity of product in containers, fix leaking machinery
- ✓ Housekeeping is vital – especially when busy
- ✓ Encourage a 'see it, sort it' mentality among staff
- ✓ Don't leave tidy up until the end of shift
- ✓ Provide and maintain adequate storage space and avoid clutter
- ✓ Keep floors & access routes clear
- ✓ Keep particularly messy operations away from pedestrian routes
- ✓ Consider using dry cleaning instead of wet cleaning
- ✓ Clean floors at quiet times when there will be no traffic or minimum traffic

- ✓ Wherever possible cordon off the floor area being cleaned using a barrier
- ✓ Organise cleaning to provide dry paths through/around areas being cleaned
- ✓ Where wet cleaning, use water at the right temperature and detergent in line with manufacturer's instructions
- ✓ Remove excess liquid to assist the floor drying process. As far as possible, clean the floor until dry
- ✓ If necessary use cleaning schedules to plan cleaning and cleaning checklists to check results
- ✓ Ensure cleaning staff have received proper training, instruction and demonstrations and slip resistant footwear where required

Shoes

Employees should wear suitable footwear for the work environment and work activities. A sensible footwear policy can inform staff of the type of footwear that is most appropriate. Wearing shoes which stay on the feet, with low or flat heels and avoiding smooth soles may help to prevent slips and trips. Where personal protective equipment (PPE) such as slip resistant footwear is required this must be provided by the employer.

Personal Protective Equipment

The provision of PPE should be considered after all other reasonable precautions have been taken to eliminate or control risks. The provision of PPE should be based on a risk assessment. The risk assessment shall take account of the type of risks the employee is exposed to, and the characteristics which PPE must be effective against. Take account of any risks the personal protective equipment may itself create. Risk assessments must be reviewed where circumstances change which could affect the original assessment.

- ✓ The General Application Regulations state an employer shall ensure personal protective equipment (PPE) is provided where risks cannot be avoided or sufficiently limited by other means
- ✓ These regulations require that the employer providing PPE should ensure it's properly maintained and replaced as necessary
- ✓ Section 8(5) of the 2005 Act states that required PPE should be provided free of charge to the employee
- ✓ Consider asking the supplier to provide trial pairs to help you make the right choice. Do not select footwear on the basis of brochure descriptions or laboratory test results alone
- ✓ Consult with staff when choosing safety footwear
- ✓ Undertake a footwear trial before you buy. Footwear marked 'slip resistant' may not perform well in your workplace
- ✓ Footwear trials should involve a representative sample of the workforce (men and women, possibly workers with foot problems) and must last long enough to produce meaningful results
- ✓ For slip resistance, choose a shoe with a well-defined tread pattern, the more edges, the firmer the grip. Good tread pattern and a flexible sole are important. The sole tread pattern and sole compound are both important for slip-resistance
- ✓ Footwear that performs well in wet conditions might not be suitable where there are food spillages. Sole tread needs to be kept clear of waste. If they constantly clog up, the sole design is unsuitable for your workplace
- ✓ With clogs, ensure an ankle strap is in place and used properly
- ✓ Ensure employees have adequate information on PPE and inform employees of the risks they are protected against by wearing PPE provided
- ✓ If safety overshoes are provided, check that they provide adequate slip resistance
- ✓ Put in place routine checks of slip resistant footwear to ensure it is in good condition and continues to be effective
- ✓ Put in place a system to replace slip resistant footwear as required

Use slip resistant footwear that

- ✓ Provides a good grip and good slip resistance
- ✓ Has been selected in consultation with staff
- ✓ Has a good tread pattern and a flexible sole
- ✓ Has been tested in the actual workplace for slip resistance
- ✓ Is comfortable and fits well (People might not wear uncomfortable shoes)
- ✓ Is reasonably easy to clean
- ✓ Will be reasonably easy to maintain
- ✓ Will last a reasonable time

IMPORTANT NOTE:

The text provides typical hazards and control measures that need to be considered when carrying out risk assessments. This document should not be considered exhaustive as no two work-places are identical and other hazards will need to be taken account of.

References

1. Getting to grips with why we slip – New Scientist 29Dec09


Spills
S
High-risk areas
H
Over-used signs
O
Environmental cleanliness
E
Shoes
S

Rotherham Doncaster and South Humber NHS Foundation Trust

Preventing Slips, Trips and Falls (Basic Awareness Level 1)

Staff information leaflet

RDaSH leading the way with care

Corporate Services

Staff Safety in the Workplace: Did you know?

- Slips and trips are the biggest cause of serious injuries to health care workers. Slips and trips can happen anywhere.
- Many result in broken bones or worse.
- Everyone is at risk but you are at greater risk if you are a care assistant, nurse, housekeeper, caretaker, or cleaner.
- Most accidents to patients and visitors are due to slips or trips - 50% of all reported accidents to members of the public, that happen in workplaces, are falls related.
- You have a legal duty to look after yourself and your colleagues at work.

All staff have a responsibility to prevent falls and other accidents

"Slips and trips are often seen as a joke, but they are no laughing matter and occur too frequently."

(Unison Health / Safety Information Sheet 2010)

Falls are the most common cause of injuries at work – causing over a third of all reported major injuries.

Cost to employers - in lost production and other costs estimated to be £512 million per year. Cost to health service – in post falls health care and follow up are high. Incalculable human cost -including anxiety, pain, distress and loss of independence.

(Health and Safety Executive 2011)

Many slips, trips and falls are avoidable, and falls prevention continues to be a top priority throughout the NHS.

This leaflet contains some useful falls prevention information and guidance about the Trust's falls prevention work, policies, health and safety procedures and resources.

Slips, Trips and Falls Involving Staff: What are the risks, what can be done?

Falls: Environmental Risk Factors:

Spillages and wet floors: Slips rarely happen on clean, dry floors.

Ensure any spillages are dealt with **immediately**, close off wet areas until they are dry.

Contamination: Contaminants like water, bodily fluids, cooking oil, talcum powder, dust and disposable gloves can reduce the slip resistance of a floor making a slip accident more likely. Have procedures in place to deal with contaminants quickly, and note that an incomplete cleaning process may leave a floor slippery after cleaning – so be sure to use the correct systems and equipment for floor cleaning / mopping. *If you are unsure about these or require further training please inform your manager.*

Trailing cables and trip hazards: e.g. bags, boxes, deliveries. People trip over unexpected obstacles and items. Place equipment to avoid cables crossing pedestrian routes or thorough fares, use cable guards to cover cables where required. Store items appropriately, be vigilant to anything at lower levels and floor level that may cause an accident and remove it.

Change of surface from wet to dry: e.g. outdoors to indoors.

Warn of risks by using signs, and locate doormats where these changes are likely. **Close off** wet areas until they are dry, seek further advice and report concerns or recurrent problems.

Inadequate or unsuitable lighting: Report any problems immediately, ensure corridors and communal areas are adequately lit. If lighting is operated by timers or occupancy sensors then ensure this is adjusted properly and appropriate to the setting – vulnerable patients and visitors must not be put at risk of being left in the dark or in poorly lit areas inappropriately.

External environments: Be aware of any seasonal problems, such as wet leaves , darkness in the winter, paths in winter with ice and snow especially areas that may not be gritted. Alert colleagues, patients and visitors to any hazardous conditions and report your concerns.

Poorly organised and cluttered working or clinical areas: De-clutter regularly and follow an '**everything in its place**' regime. Move and handle loads correctly – if in doubt seek advice.

Working at a height: Take extra care on steps, stairs and landings. Handrails and banisters should be adequate and secure. Ensure any step ladders or climbing apparatus is fit for purpose, meets with regulations, and is only used as designated (this also applies to contractors - see 'safe working at a height' policy and regulations).

Falls and Human Risk Factors: These can increase the risk of accidents / falls, including:

Communication problems and misunderstandings: Do you always understand and follow safety instructions, signs, labels and directions?

Fatigue: Tiredness can affect the ability to carry out a task. Staff who are tired are more prone to make mistakes, lose concentration, misjudge situations and take unnecessary risks.

Personality, attitude, behaviour: Whilst individuals may have different personal attitudes and approaches to risk and safety, in the workplace it is everyone's responsibility to understand the requirements of their role and obligations that go along with this.

Capability and Capacity: Staff must discuss with their manager any outstanding training needs, capability or capacity issues.

Physical health: Illness, mobility problems, breathing problems, balance problems, visual problems, side effects or effects of medication e.g. dizziness, blood pressure drop, alcohol use. All these and more increase falls risk – discuss any personal concerns about fitness at work with your manager or GP.

What about Footwear?

Footwear plays an important part in preventing slips, especially where floors can't easily be kept dry or clean. Staff working in certain areas (e.g. kitchens, laundry, workshops, clinical areas) or whose duties involve moving and handling, use of equipment, physical tasks or delivery of physical care **must wear suitable footwear** and adhere to any dress and footwear policy in their area.

Footwear - general advice for all staff: Choose shoes that fit well are comfortable, have sensible heels and stay on the feet. Certain footwear, such as open-toed shoes, sandals, flip-flops, high heels and smooth soles can all increase the chance of slips, trips and falls.

Falls / Accident Prevention: Put it On the agenda!

Environmental and human factors are not always controllable, but may be predictable. Evidence shows that staff teams who discuss safety risks and work towards resolving problems together have fewer accidents.

Team meetings and supervision sessions provide good opportunities for managers and staff to discuss issues and ways to reduce falls and other accidents in the workplace.

Preventing Slips Trips and Falls: Patient/ Service User Safety

Falls prevention is a key area with regards patient safety and the quality of care delivered.

(Dept of Health 2011)

In England and Wales approximately:

- 208,000 falls are reported every year in acute hospitals
- Mental Health Trusts reported over 36,000
- Community Hospitals reported 38,000

(NPSA 2011)

Causes of falls are complex, but the outcome can be devastating, resulting in:

- Death, severe or moderate injury
- Up to 90% of older patients with a fractured hip fail to recover their previous level of mobility or independence and mortality rates are high.
- Incalculable human cost -including anxiety, pain, distress, loss of independence, loss of confidence, loss of quality of life
- Healthcare costs – £15 million per annum for acute treatment alone. This is believed to be an underestimation and does not include rehabilitation and social care costs.

(NPSA 2007; 2009)

Falls prevention work within RDaSH

The Falls Prevention and Bone Health Strategic Steering Group:

This group meets quarterly. Its purpose is to implement and monitor a strategic approach and action plans for falls prevention. Its priorities are based on national falls prevention guidance and directives.

The Falls Prevention and Bone Health Policy:

This policy provides 'the ways and the means' for staff to carry out falls prevention work and to maintain safe environments. It covers all areas but focuses more on the needs of those who are higher risk of falls, it covers:

- Prevention, risk assessment and management of slips, trips and falls, involving all staff, patients/ service users, services, and premises. It sets out standards and procedures, and includes useful resources e.g. falls risk screening tools.

- Post fall procedures and management – including emergency procedures and protocols.
- Environmental issues and safety.

The falls Policy can be accessed via the Intranet and the following link: http://www.rdash.nhs.uk/wp-content/

Safe working at height: Extra caution must be taken by staff and service users to prevent falls from height. RDaSH staff and contractors working at height should follow the Trust

"Safe Working at Height Policy ";

This can be accessed via the Intranet and the following link: http://www.rdash.nhs.uk/wp-content/uploads/2009/11/Working-at-heights-policy-PAG-approved-16.09.10.pdf

Falls Prevention and Bone Health Pages on the Intranet: Find out much more about falls prevention work and resources in the Trust on the Falls and Bone Health section of the intranet.

This can be accessed via the Intranet and the following link http://nww.intranet.rdash.nhs.uk/support-services/falls-prevention-and-bone-health/

Falls Prevention and Bone Health Training: All staff need awareness and understanding of falls risk factors and of falls prevention. This leaflet provides this awareness level information, alongside workplace induction.

Most clinical and facilities staff also require further training or information and individual requirements should be discussed with managers. Further details of falls prevention training are available via the RED centre/ via Falls section on Intranet, or contact the falls prevention leads / health and safety leads in your area.

Reporting:

The Trust aims to promote a positive health and safety culture and learning environment in order to continuously improve services, staff are asked to report any hazards, incidents or concerns and to be involved in the review of incidents.

Staff are expected to participate in the identification of environmental and clinical slips, trips and falls hazards.

Report any incidents and/ or concerns, seek advice as required and implement polices and agreed measures to manage risks

The Incident Reporting policy can be accessed via the Intranet and the following link: http://www.rdash.nhs.uk/wp-content/uploads/2009/11/Incident-Reporting-Policy-approved-RMG-21.02.2012-V6.pdf

Falls Prevention/ Health and Safety contact details

Liz Copley
Consultant Occupational Therapist/
Joint Clinical Lead for Falls Prevention
liz.copley@rdash.nhs.uk

Kay O'Neill
Clinical Lead Physiotherapy - Learning Disabilities
kay.o'neill@rdash.nhs.uk

Steven Hague
Community Falls Coordinator (DCIS)
steven.hague@rdash.nhs.uk

Alan Irwin
Health & Safety Lead
alan.irwin@rdash.nhs.uk

Michael Ibemesi
Trust Patient Safety Lead
michael.ibemesi@rdash.nhs.uk

Any training enquiries please contact the RED Centre on 01302 796241.