Brighton and Sussex University Hospitals NHS Trust

Prevention and Management of Inpatient Falls Policy

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Contents

1. Introduction

1.1 Brighton and Sussex University Hospitals (BSUH) is committed to reducing the rate of avoidable inpatient falls. Whilst we know that it will never be possible to prevent all inpatient falls we know from practical experience that the rate of inpatient falls can be reduced.

2. Purpose

The purpose of this policy is to ensure that consistent standards are adhered to in order to reduce the likelihood of an inpatient falling. This will be achieved by ensuring that:

- All patients have a falls risk assessment completed within 8 hours of admission, then daily, If patient condition changes or after a patient fall.
- Preventative measures and actions are put in place for those patients identified at moderate/ significant risk of falling.
- Appropriate care is given to any patient who has fallen.

3. Definitions

For the purpose of this policy a **fall** is defined as:

"A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force" (Tinetti et al 2003).

An **After Action Review** (AAR) is a structured review or de-brief process for analysing what happened, why it happened, and how it can be done better by the participants and those responsible for the project or event

4. Responsibilities, Accountabilities and Duties

4.1 Registered Nurses

It is the responsibility of the registered nurse to:

- undertake the Trust's falls risk assessment on each patient within 8 hours of admission, then daily, If patient condition changes or after a patient fall. using the Falls Risk Assessment Tool (Appendix 1).
- based on the falls risk assessment score, for patient at risk of falling implement the Falls Action Care Plan (See Appendix 2).
- highlight verbally and document on the handover sheet all patients at risk of falls at each patient handover.
- involve the relatives/carers of the patient where appropriate, in the assessment and implementation of Falls Action Care Plan.
- ensure each patient who is at risk of falling is wearing a green wrist band. (Current evidence is equivocal about the mandatory use of green wristbands as an effective means of falls prevention (NPSA 2007), however as many areas in the Trust have found them useful in identifying patients at risk of falling, wards are to continue using them.)

4.2 Nurse in charge of shift

It is the responsibility of the nurse in charge of the shift:

- to ensure that all staff on the ward – substantive and temporary – are aware of the requirement of when to undertake a falls risk assessment and subsequent expectations set out in the Falls Action Care Plan.

- ensure every new member of bank/agency staff who has not worked a shift in the ward or department for twelve weeks or more complete a Local induction check list (see appendix 3).
- ensure that patients at risk of falling are clearly identified by the ward team and are nursed in a high visibility area.
- ensure that all necessary actions on the Falls Action Care Plan have been implemented for patients at risk of falling
- In the event of a patient falling the registered nurse in charge is responsible for ensuring that appropriate actions are taken (see section 6.8) and that the incident is reported via the Datix system.

4.3 Ward Managers

It is the responsibility of the Ward Manager to:

- be aware of the rate of patient falls for their inpatient area, this information is available from the Safety and Quality Team.
- The Ward Manager should also raise awareness about the number of falls by ensuring that the wards falls counter is kept up to date
- Ensure that information on patient falls is shared with ward staff at appropriate forums.
- Ensure all staff are aware of the Trusts falls policy and their responsibility and accountability for reducing the likelihood of a patient fall and for acting appropriately in the event of a patient falling.
- Ward Managers should assure themselves that their nursing teams are implementing the Falls Care Action Plan.
- Undertake a yearly health and safety inspection of the environment in order to remove or minimise any risks of slips, trips and falls. This should involve the identification and removal of slip and trip hazards (e.g. clutter on the floor) as well as falls hazards (e.g. poorly fitting equipment).
- Ensure all patients at risk of falls are wearing the green wristbands.
- Investigate and undertake a timely After Action Review after every fall (see AAR Questions template in Appendix 4 and use areas to be considered and explored during the AAR), in order to identify any learning or themes from the fall. These should be shared with the ward team.

4.4 Directorate Lead Nurse / Matrons

Directorate Lead Nurse / Matrons need to be aware of the rate of patient falls for the inpatient areas they are responsible for. They also need to be assured that ward staff are taking all appropriate measures to reduce the likelihood of patient falls.

- The Matrons need to ensure that local learning is being shared between ward teams and escalated through the Divisional Clinical Governance Meeting

- Matrons to be trained in immobilisation & to know where nearest immobilisation equipment is stored

4.5 Osteoporosis & Falls Prevention Action Group

To provide integration for sharing lessons between primary the secondary care on Falls Prevention and Osteoporosis

4.6 Directorate Safety and Quality Committee

The Divisional Clinical Governance Meeting will be responsible for reviewing the falls rate in their division each month.

4.7 Safety and Quality Team

Monitor rate of inpatient falls weekly and provide information for the Divisional Clinical Governance Meeting

5. Policy

5.1 Falls management requires an approach that increases patient safety in hospital by identifying patients at risk and implementing interventions that reduce patient falls, including consideration and assessment of environmental risk factors. The first step in reducing the likelihood of a patient falling is to undertake a falls risk assessment using the chart in Appendix 1.

Management of patients at risk of falls should be tailored to individual risk factors. Guidance on what actions to take following a falls risk assessment are detailed in the Falls Action Care Plan (Appendix 2)

It is essential to identify patients considered at risk or increased risk of falling whilst in hospital as part of the admission procedure.
It is, however, recognised that patient safety should be balanced with the promotion of patient recovery and independence, with the aim of discharging patients home safely.

5.2 Patients known to be at increased risk of falls in hospital

- Patient over the age of 65
- Research suggest that in hospital male patients are more at risk from falls than female patients
- History of falls in the community particularly within the last 12 months
- Current hospital admission being fall related.
- Transient risk i.e. surgery, acute onset of confusion ,sepsis, epidurals etc
- Mobility and balance impairment
- Patient in need of frequent toileting especially at night
- Incontinence
- Patient agitated or confused
- Dementia
- Sensory deficits e.g. vision, hearing, sensation
- Neurological changes i.e. stroke, diabetes peripheral vascular disease, seizures
- Medication known to affect balance/cognition or poly-pharmacy
- Postural Hypertension
- History of alcohol misuse

5.3 Medications that increase risk of falls:

Older patients are more sensitive to the effects of medication and evidence suggests that there is a significantly increased risk of falling in those patients that receive Poly-pharmacy (4 medications or more) and in particularly medications from the following groups:

- Antipsychotic
- Antidepressants

- Night sedation
- Opioids/Analgesics
- Cardiac Drugs
- Diuretics
- Laxatives

As recommended by (Royal College of Physicians/2012) all patients should have their drug burden reviewed (see appendix 6). Patients, who have fallen should have their medications reviewed by the pharmacist/Medical team and, if appropriate, altered or reduced (in light of their risk of future falls).

Particular attention should also be given to:
Anticoagulation therapy as although this treatment does not increase the patients risk of falling the outcome of the fall could be more serious.

5.4 Assessment for falls

Evidence and best practice guidance for reducing the risk of falling advocate's regular review and monitoring and the following approach, (Oliver and Healey 2009):

- Implementation of standard falls prevention strategies for all in-patients.
- Identification of patients at high risk of falls followed by the implementation of an Action Care Plan based upon falls risk.
- A post-falls assessment for all patients who fall on the ward.

Further guidance is detailed below for the above four stages.

5.5 Reducing the likelihood of falls for all inpatients

The essential steps necessary to maintain a safe environment for **ALL** our patients are outlined below:

- Orientate patients to the ward environment. Ensure they are aware of the nearest toilet/washing facility and light switch. Ensure they are orientated to their bed area including locker, bed table, call bell and light switch.
- If there is a clock in the ward/patient's room ensure it is visible, working and correct.
- Ensure that patients have call bells/buzzers within easy reach which work, and that patients can physically use them. Bells and buzzers should be regularly checked by local staff to ensure that they are working.
- De-clutter put away things that aren't needed. Ensure electrical leads and equipment do not cause an obstruction or risk of tripping. Ensure patient's drips, drains, catheter tubing etc. do not cause a risk of tripping.
- Offer patients and their carers verbal and written information on "ways to prevent falls" whilst in hospital and at home.
- Keep floors non-slip and ensure that any spillages are immediately cleaned up and in particular, ensure that the floor is properly dried afterwards.
- Ensure adequate lighting day and night.
- Ensure bed is in its lowest position with brakes on.
- Ensure the bed is at the most appropriate height for the patient to get into and out of bed.
- Ensure chairs are suitable for patient's needs i.e. correct type, height etc.

- Assess toilet facilities are at a reasonable distance from patient and offer frequent assistance with toileting.
- Keep walking aids, drinks, books etc within easy reach.
- If patient normally wears glasses ensure they are worn and are clean.
- If patient normally uses a hearing aid ensure that it is worn and is working.
- Ensure patient footwear is flat and well fitting. Encourage family to bring in appropriate footwear if necessary.
- Ensure patient does not wear clothing that trails on the floor.
- Maintain staffing levels appropriate to levels of dependency.
- Adequate staff should be available for specific manual handling procedures in order to reduce the risk of injury to patients.
- Risk assessments should be completed and identify the numbers of staff involved in moving patients and the type of equipment used (Trust Manual Handling Policy – RM12).
- Equipment (e.g. hoists, slings, wheelchairs, trolleys, beds, commodes) that is used by patients should be suitable for purpose, safe and well maintained in order to minimise risks of patient falls.

5.6 Reducing the likelihood of falls for at moderate / significant risk of falls

The following additional preventative measures must be considered for patients identified:

- Apply green wristband
- Nurse in high visibility bed
- Nursing staff to accompany/be within arm's reach of patient for high risk activities i.e. dressing, toileting etc.
- Implement "Comfort/Toileting rounds" 2 hourly and before meals
- Ensure medication review is undertaken on ward round
- Perform bed rails assessment
- Consider referral to falls clinic
- Refer to physiotherapist for range of movement, strength, balance and/or gait exercises.
- Identify risk of falls on handover sheet; ensure that all staff are aware of risk status.
- Check lying and standing BP for patients over 65 (using manual sphyg) on admission or as soon as patient mobile. Report any postural drop to medical staff.
- Assess the need for increased supervision/observation- consider one to one specialling.
- Consider low level bed.
- Assess for suitability for bed/chair alarms.

5.7 Safe Use of Bedrails

For patients who have been assessed as being at risk of falling from the bed consider their suitability for having bed rails fitted – see Bed Rail Policy.

5.8 High/Low Beds

The use of Enterprise 500 beds should be the bed of choice for those patients that are a significant risk of a fall or have fallen from the bed and are at risk of

further falls. The rationale for this choice is that these beds have the facility to go slightly lower than a normal bed.

5.9 Management after a Patient Falls

If any patient has a fall, the falls flow chart must be followed (see Appendix 7). A falls re-assessment must be carried out after a patient has fallen and the appropriate care followed as in section 6.6.

There are two methods of retrieving a patient from the floor, the Hover Jack and the hoist. It is the nurse's responsibility to assess the patient fully and decide which piece of equipment is most appropriate. Please note any injuries sustained to a patients head, spine or hip the Hover Jack is the preferred method of retrieval. NB. The hoist will take 34 stone – 227kg. The Hover Jack has no weight limit.

The Incident Reporting Policy must be followed when a patient falls. Ensure that the incident is submitted once the patient has been made safe using the on-line Datix Incident Reporting system.

If any patient sustains a serious injury then it may well be that the incident will have to be reported externally as a Serious Incident, for example, a fracture requiring surgery, a potentially life changing injury or death. The Senior Nurse, Clinical Site Manager and Safety and Quality team must be notified immediately. These incidents need to follow the expectations of the Trusts Duty of Candour Policy. (See Appendix 5) for investigation report.

Unless the patient has refused permission, the patient's next of kin must be informed of their relative's fall, regardless of injury.

Any patient who falls must have a set of vital signs recorded as soon as possible, including a Glasgow Coma Score. This must be marked on the observation sheet as 'Post fall' with the date and time of the observation and continued as per the flowchart "Process for Managing a Patient Fall" (Appendix 7).

Following a patient fall the nursing staff are expected to complete the Post Falls Checklist that can be found in the inpatient Safety Risk Assessment and Care Bundle Booklet Page 16 or as outlines in (Appendix 8). In addition, the medical staff are expected to complete the medical Post Fall Proforma (see Appendix 9). An AAR is also required (see Appendix 4)

5.10 Management of major risk factors

Falls management must always be multi professional. Current evidence suggests that no one factor will reduce the risks but a multifaceted approach can have positive results, these include:

- Pharmacist to review medications of a patient who has fallen.
- Causes of delirium are detected and treated.
- Cardiovascular causes of falls are investigated.
- Physiotherapy, exercise and access to appropriate walking aids.
- Treatment of incontinence or urgency of micturition.

5.11 Major Risk Factors

A comprehensive list of potential risk factors are listed in the Falls Risk Assessment document (Appendix 1)

5.12 How the organisation raises awareness about preventing and reducing the number of slips/trips and falls involving patients.

The following are the methods used to raise awareness of falls management

- Falls counters on each ward area- focusing on the number of days since the last fall as well as the record maximum number of dates achieved without a fall.
- After Action Reviews on all falls (using form on Appendix 4)
- Serious incident report feedback to individual clinical teams and wider through divisions.
- Falls are reported on the Directorate Safety and Quality report.
- Falls rates are sent to ward managers and matrons monthly.
- A daily update on the number of falls in the previous 24 hours is sent to all ward managers.
- Falls form one of the scenarios on the new "Alert" course.

6. Training Implications

All substantive and temporary staff are familiarised at local induction with the policy "Prevention and Management of inpatient Falls" in particular with the expectations relating to falls prevention and management. Staff are made aware of the flowchart "Process of managing a Patient fall" and top tips for falls management, and a signature is required to ensure that these issues have been addressed on the induction checklist.

A fall scenario features on the current ACUTE Course and an E-Learning module on preventing falls in hospital is available. It has been developed primarily for registered nurses working in acute or community hospitals, but any staff member with an interest in falls prevention is welcome and encouraged to use it. It can be accessed via the following link www.esrsupport.co.uk/nlms. Please contact Learning and Development for a user name and password.

7. Monitoring Arrangements

Measurable Policy Objective	Monitoring / Audit Method	Frequency	Responsibility for performing monitoring	Where is monitoring reported which groups / committees will be responsible for progressing and reviewing action plans
The requirement to undertake appropriate risk assessments for management of slips, trips and falls involving patients	Completion of the inpatient falls risk assessment documentation is one of the indices in the nursing metrics	Monthly case note review	Divisional Heads of Nursing	Concerns monitored through Nurse and Midwifery Board. Compliance monitored at appropriate Divisional Clinical Governance Meeting by exception the patient safety Group
Process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients	Monthly Patient Safety Dashboard for Directorate Quality and Safety Meetings	Monthly dashboard report	Patient Safety Team	Divisional Clinical Governance Meeting Concerns about performance will be escalated through the appropriate Divisional Clinical Governance Meeting and by exception the Patient safety Group

8. Due Regard Assessment Screening

This policy has been subject to a Due Regard Assessment Screening and it is not foreseen that it will disadvantage any group. Please refer to Appendix 10.

9. Links to other Trust Policies

Policy and Procedures for the Internal and External Reporting of Incidents and Managing Serious Incidents

10. Associated documentation and References

See Appendix 1, 2, 3 and 5

NICE (2013) Falls: assessment and prevention of falls in older people, Issued: June 2013, NICE clinical guideline 161

Tinetti ME. Preventing falls in elderly persons. (2003) N Eng J Med. Jan 2; 348:42-49

Head Injury (updated) NiCE guideline publication expected

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

Implementing fallsafe care bundles to reduce inpatient falls (Royal College of Physicians 2012)

Appendix 1: Falls Daily Risk Assessment Chart

Calculate the risk score for each section. Then add the scores to find the risk factor & follow action plan.

Date														
D (day) or N (night)														
Age / Sex														
0 – Under 65 years **1** – 65 years or over **1** – Female, **2** – Male														
Falls history														
0 – No history of falls prior to hospital admission **1** – Current/PMH of falls community/hospital or fear of falling **2** – History and recent increasing frequency **3** – Admission related to fall														
Mobility														
0 - Independently mobile **1** – Unsteady, needs assistance but knows to call for help **2** – Bed / Chair bound hoist transfer **3** – Unsteady needs assistance **but may not remember** to ask for assistance/postural gait instability and or balance problems. **4** – Requires constant observation/specialing														
Comprehension														
0 – Alert and able to call for help **1** – Reduced awareness but responds appropriately **2** – Agitated / can't call for help / learning difficulties **3** – Disorientated / overestimates or forgets limitations														
Sensory impairment														
1 – Visual impairment: e.g. cataracts, untreated glaucoma, glasses **1** – Decreased hearing/wears hearing aid as well **2** – Both														
Medication														
0 – No meds **1** – 3 or less prescribed meds **2** – 4 or more meds, + **1** for each of the following: *Cardiac*☐ *Night sedation* ☐ *Antipsychotics* ☐ *Opiate* ☐ *Diuretic* ☐ *Anti-anxiety* ☐ *Laxative* ☐														
Sleep pattern														
0 – Sleeps well, **1** – Broken sleep, **2** – reversed day/night pattern **3** – Minimal/no sleep/exhausted														
Neurological / Cognitive impairment														
1 – Diabetes / Peripheral Vascular Disease **3** – Parkinson's Disease **3** – Dementia e.g. Alzheimer's / Delirium **4** – Stroke / TIA's / Seizure / Acquired brain/head injury/ syncope syndrome														
Toileting / Continence														
0 – Continent **1** – Catheter and/or ostomy **3** – Incontinent & dependent / needs assistance **4** – Incontinent & independent														
Other risk factors														
3 – Known alcohol misuse, **3** – Is on anti-coagulant therapy **3** – Postural hypertension / surgery / sepsis / epidural														
Score														
Initials & staff no														

POST FALLS CHECKLIST

	Date/time	Date/time
Check for any injury particularly to the neck & spine. Take necessary first aid measures		
As soon as it is safe, return the patient to bed (use lifting aids as indicated eg (Hover jack or hoist)		
Follow flow chart for 'managing a patient fall'		
Inform medical staff for SBAR visit & ensure medical post fall proforma completed		
Unless otherwise requested inform family / carers (day or night)		
Reassess falls risk and consider bed position on ward		
Complete Datix report. Matron should review if graded as moderate severity or above		
AAR review to be held by (state band 6 name) & attach to Datix		
What action taken post fall eg Special, move to visible area		
Time and date the patient's family/carers informed		
Time and date a Datix report completed		
Initial & staff no		

APPENDIX 2: FALLS ACTION DAILY CARE PLAN

RISK SCORE ↓	**INTERVENTIONS** Date														
	D (day) or N (night)														
	Discuss falls history (including fear of falling) and normal activities of daily living with patient & carers. Complete "reach out to me" if appropriate.														
	Provide written and verbal information on falls prevention														
Score of 0 – 10 **Undertake all of the actions** → **Plus the actions below depending on score**	Check lying and standing BP for pts over 65 (using manual sphyg) on admission or as soon as patient mobile. Report any postural drop to medical staff.														
	Ensure call bell within reach, is working and patient can use it (consider other ways of communication if required)														
	Ensure footwear is non-slip, low heeled and well fitting. Check feet, refer any problems to Podiatry – 01273 242184														
	Ensure correct use of hearing aids /ensure spectacles are within reach and clean														
	Urinalysis to be taken on admission. Respond to requests for toilet facilities (no more than 5 minutes - consider communication needs)														
	Ensure commode facing bed														
	Assess for urinary continence (P22 Risk Assessment). Implement continence care plan.														
	Assess gait balance and mobility / ensure walking aids are appropriate and within reach at all times														
	De-clutter bed space														
	Ensure personal belongings are within reach														
Score of 11 – 20 **MODERATE RISK** ↑ **Undertake all of the above actions AND those to the right** →	Apply green wristband														
	Nurse in high visibility bed														
	Nursing staff to accompany/be within arms reach of patient for high risk activities e.g. dressing, toileting														
	Assess frequency of 'comfort / toileting' rounds. Implement toileting chart														
	Request medication review on ward round														
	Perform bed rails assessment														
	Consider referral to falls clinic														
	Refer to physiotherapist for range of movement, strength, balance and / or gait exercises														
	Identify risk of falls on handover sheet, ensure that all staff are aware of risk status														
Score of 21 – 30 **SIGNIFICANT RISK**	Assess the need for increased supervision / observation – consider one to one pathway														
	Consider one to one pathway on infonet														
	Consider low level bed														
	Assess for suitability for bed / chair alarms														
	Initials & staff no														

Date	**Document reason for variance here**	Sign & staff no

Appendix 3

Local Induction check list

Brighton and Sussex University Hospitals NHS Trust

This proforma must be completed at the beginning of the shift for every new member of bank / agency staff who has not worked a shift in your ward or department for twelve weeks or more.

Please keep this document in the ward/department Bank & Agency file

Bank Staff	RGN		HCA	
Agency ……..	RGN/RMN		HCA	

Introduction to key staff on duty - Values and Behaviours	**Y**	**N**
• Staff Rest / Locker Room		
• Break entitlement/toilets.		
• Completion of Time Sheets.		
• Dress Code Uniform Policy		
• Sickness & Absence Reporting		
Environment - Layout of ward / department	**Y**	**N**
• Location of Fire Exits & Assembly Point		
• Emergency number for Fire, Cardiac Arrest, MET call • Security		
• Security Procedure & Alert Number		
• Location of Crash Trolley and Defibrillator		
• Piped Oxygen and Suction Equipment		
• Emergency Call Bell System for Wards and Patients		
Observations	**Y**	**N**
• NEWS scoring and escalation policy • SBAR		

Patient Safety	**Y**	**N**
• **Falls awareness** – beds, arms reach approach, and falls safe behaviours		
• Post falls flowchart observations/ Neuro		
• Pressure Damage Prevention		
• Datix – how to report an incident		
• Safe and secure handling of medicines		
• Pts own drug policy		
Infection Control	**Y**	**N**
• Use of Macerator and Vernacare Disposables		
Nursing Documentation	**Y**	**N**
• Confidentiality & Data Protection Policy Awareness		
• Identify confidential waste for handover sheets at end of shift.		
• Location of Nursing Documentation		
• Expectations relating to updating nursing documentation		

Bank / Agency Staff Name ……....	Signature……	Date: ……

Appendix 4

Falls After Action Review (AAR) Proforma
(File in medical notes on completion)

Brighton and Sussex University Hospitals NHS Trust

Patient Name:	**Hospital No:**
Location of fall e.g. Bay/side-room number or toilet	**Staff involved:**
Date/Time of fall:	**Nurse leading AAR:**

Question	Points to Consider	Notes
What was happening on the ward	Describe ward events leading up to fall, note acuity/dependency	
What were the nurse to patient ratios and skill mix?	Comment on use of Bank and Agency usage. Was induction checklist completed?	
Was the fall witnessed/un-witnessed? Describe where and what the nursing team were doing at the time?		
Is the Datix description of the fall accurate i.e. What was the patient doing when they fell?	Ask the patient/nurse	
Describe any injury sustained?	Include all harm from moderate to low severity	
Did we expect the patient to fall? E.g. Has the patient fallen before in/out of hospital? What was their falls Risk Score? If yes, please elaborate.	Patients who have fallen have a 50% chance for subsequent falls so previous falls are main indicator for future falls in the older person (Oliver 2007).	
How many days had the patient been on the ward before they fell?	Have they recently been transferred from another ward area?	
Was the patient medically ready for discharge?	What were they waiting for?	
Is the falls risk assessment up to date/ Is it accurate?	1st objective of falls assessment is to understand the events/factors leading to fall. Ask friends relatives and carers to substantiate pt's history.	

Have all actions in the falls action plan been completed?	If not are variances documented?	
Was the post falls checklist completed?	Please note if the N.O.K was informed promptly?	
Was the medical falls proforma completed?	Has the patient been reviewed by a doctor post fall?	
Were post fall observations undertaken?	Check as per flow chart for managing a patient fall	
Has the medication chart been reviewed?	Comment on polypharmacy sedation etc.	
Was the patient nursed in a high visibility area on the ward?	If not, describe rationale and what other measures have been put into place	
If bed related fall was a low level/Enterprise 500 bed in use?	Do staff know how to override Enterprise 500?	
What was footwear/condition of feet? Check patients own slippers, grips on slipper socks- replace PRN/ encourage own footwear	Poor footwear, bunions, ulceration, toe abnormalities or malformed nails an alter gait and balance and affect the patients performance during ADL's	
Has patient's condition changed recently i.e. Diarrhoea sepsis etc?	Greater risk of dehydration which exacerbates postural hypotension & can lead to confusion.	
Is the fall related to toileting? Note time the patient was last toileted. Has a toileting chart been considered/implemented?	Think about Continence issues, UTI, retention of urine, diarrhoea	
Is it common practice to turn the commode to the bedside?	Look at practice –Are all 4 brakes on commode?	
Describe any continence issues, was a continence assessment completed Was a ward urinalysis completed?		
If patient fell whilst toileting was the patient escorted to and from the toilet? Do staff use an arm's reach approach?		

Check/walk the environment where they fell *Hazards or obstacles, lighting, uneven flooring footwear inappropriate furniture height.*		
Was the call bell within reach? Could the patient use the call bell?		
Has patient falls alarm been considered?		
Is patient over 65 years - has a lying and standing BP been taken manually since admission? (Was patient lying down, then standing and repeated after patient walking around.	Orthostatic hypotension defined as drop of at least 20mm Hg Systolic or 10mm Hg diastolic BP on moving from supine to upright position.	

Action Points to be considered to minimise repeat fall

- Are you moving the patient to a more observable bay?
- How frequently will observations be done?
- How do you plan to inform colleagues and share the learning i.e. is the fall verbally discussed at bedside handover documented on handover sheet/discussed at "SAFETY" briefing?
- Have you updated Handover?
- Does the patient need 1:1 specialing? If yes , commence 1:1 Care Pathway
- Were expectations and responsibilities clear for the special/NIC?

Actions Taken (please document what changes in practice have been made following AAR)

Appendix 5: Post Fall Investigation Template

Post Fall Investigation		
Patient Name: **Age:**	**Date of Fall:** **Time:**	**Ward:** **Speciality**:
Aims & Objectives	1. To establish the facts of what happened, when, where, how and why 2. To establish whether failings occurred in care or treatment 3. To look for improvements rather than to apportion blame 4. To establish how recurrence may be reduced or eliminated 5. To formulate recommendations and an action plan as required 6. To provide a report as a record of the investigation process and findings 7. To provide a means of sharing learning from the incident Individual errors noted are not necessarily intended to imply negligence. Rather, the open reflection on such errors, and analysis of any system failures, is intended to contribute towards a culture of continuous improvement.	
Who commissioned the report	This internal investigation was instigated by the Safety and Quality Team in accordance with the Trust policy on Investigation of Incidents, Complaints and Claims using Root Cause Analysis.	
Names of individual members of staff who contributed to this investigation		

Events leading up to fall	
Date of admission / Reason for Hospital Admission / Past Medical History / Hospital Timeline / Working Diagnosis	
Was the **admission related to falls?**	.
What was happening on the ward leading up to the fall e.g. **what was the acuity/ dependency on the ward.**	.
Had the patient recently been **transferred to the ward**	
Description of the fall - What *was the patient doing when they fell?*	
About the Fall	**Findings**
Did the patient suffer "**Harm**"?	

Was the **fall witnessed/un-witnessed**?	
Where were the nursing staff at the time of the fall and what were they doing?	
What was the patient's **falls risk assessment score**?	
Was the **falls risk assessment score** accurate?	
Was the **falls risk assessment** been completed daily, if condition changes or after a fall?	
Were all expected actions in the **falls action care plan completed**?	
Did the patient have a history of **dementia /cognitive impairment or delirium**?	
Was the **patient assessed for capacity**?	
What was the **patient's normal mobility**?	
Was a **manual handling** assessment performed?	
Was the patient **assessed by a Physiotherapist/ Occupational Therapist**?	
Was the patient using a **walking aid**, did the patient have access to this aid?	
Did the patient have identified **hearing problems**?	
Did the patient wear a **hearing aid**?	
Were they wearing a **hearing aid at the time of the fall**?	
Did the patient have identified **sight problems**?	
Did the patient wear **glasses**	
Were they **wearing glasses** at the time of the fall?	
Did the patient have a **lying and standing BP** taken manually before they fell? If yes what were the findings / actions taken?	

Was there was a drop in either **systolic / diastolic blood pressure** was this acted upon and documented?	
Was the patient **Medically Ready for Discharge** (MRFD)?	
If the patient was **MRFD** how long had they been and what were they waiting for?	
Environmental Factors	**Findings**
Was the patient nursed in a **high visibility area** on the ward?	
Was the **bed at its lowest height**?	
Was the **call bell within reach**?	
Could the patient physically use it?	
Were there any **additional communication requirements** i.e.BSL/lip-speaking/ interpreter required	.
Was the **patient assessed for bedrails**?	
Did the patient have capacity to agree to using bedrails**?**	
Was a **"one to one Special being used"**	
Was the **one to one pathway** in use / Reach out to me document	
Was the **"Butterfly" scheme** considered?	
Did the patient had an **AMT performed**? What was the score and date performed?	
List the last four **NEWS scores** prior to the fall	
Was a patient **falls alarm** considered? If not why not?	

Toileting	
If the patient was on the **commode**, how was the commode positioned in relation to the bed?	
Was a **urinalysis** been taken on admission?	
Was a **Continence assessment** /and or a toileting chart been commenced?	
When was the patients **bowels** last opened?	
Did the **patient's condition improve/ deteriorate prior to the fall** e.g. increased mobility, risk taking, diarrhoea sepsis, delirium, sleep disturbances etc.? If yes, was the falls risk reviewed in view of this?	
What **footwear** was being used /condition of feet? If using hospital slipper socks was the size correct, what condition are the grips on slippers - do they need re-placing	
Ward / Staffing	**Findings**
Ward falls rate (per 1,000 bed stay days) in the last 12 months? Is the ward above or below the Trust's falls rate	
What is the normal **Nurse to patient Ratio** for the ward on each shift?	
What was the **Nurse to Patient Ratio** on the day of the fall (shift by shift)	
Were there **bank and agency staff** working on the ward at the time of the fall?	
Were the **bank and agency staff aware of expectations** in relation to falls management?	

Were the **substantive members of the ward** team familiar with the expectations re falls management	
Post falls management	
How was the **patient moved** from the floor?	
Was the **post falls checklist** in the Safety Booklet been completed?	
Were **N.O.K contacted** in a timely manner?	
Was the **Post Medical falls proforma** used for a medical review post fall?	
Was the **medication chart reviewed** with particular focus on polypharmacy, anticoagulants and night sedation post admission?	
Were **post fall observations** undertaken as per "Managing a patient post fall flow chart"?	
Learning	
Did we do everything we could to prevent this fall?	
How has the **learning** been shared with the team?	
Involvement and support of patient and relatives. **How has the learning been shared with the family**?	
Root cause	
Lessons Learned: 1.	
Investigation/AAR report written by: **Date of After Action Review (AAR)/investigation commenced:**	

Action Plan

Issue	Action	Lead	Review Date	Evidence of Implementation

Appendix 6

Medicines and Falls in Hospital

All patients should have their drug burden reviewed with respect to its propensity to cause falls. The history should establish the reason the drug was given, when it started, whether it is effective and what its side effects have been.
An attempt should be made to reduce the number and dosage of medications and ensure they are appropriate, and not causing undue side effects.

Falls can be caused by almost any drug that acts on the brain or on the circulation. Usually the mechanism leading to a fall is one or more of:

- **sedation**, with slowing of reaction times and impaired balance,
- **hypotension,** including the 3 syndromes of paroxysmal hypotension – OH, VVS and VD-CSH
- **bradycardia, tachycardia or periods of asystole**

Falls may be the consequence of recent medication changes, but are usually caused by medicines that have been given for some time.

Red: High risk: can commonly cause falls alone or in combination
Amber: Moderate risk: can cause falls, especially in combination
Yellow: Possibly causes falls, particularly in combination

Drugs acting on the brain (aka psychotropic drugs)
There is good evidence that stopping these drugs can reduce falls (1).

Taking such a medicine roughly doubles the risk of falling. There is no data on the effect of taking two or more such tablets at the same time. (2)

Sedatives, antipsychotics, sedating antidepressants cause drowsiness and slow reaction times. Some antidepressants and antipsychotics also cause orthostatic hypotension.

Sedatives: Benzodiazepines	Temazepam, Nitrazepam Diazepam, Lortemazepam Chlordiazepoxide, Flurazepam, Lorazepam, Oxazepam, Clonazepam	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term
Sedatives: "Zs"	Zopiclone, Zolpidem	Drowsiness, slow reactions, impaired balance.
Sedating antidepressants (tricyclics and related drugs)	Amitriptyline, Dosulepin Imipramine, Doxepin Clomipramine, Lofepramine, Nortriptyline, Trimipramine Mirtazapine, Mianserin Trazodone	All have some alpha blocking activity and can cause orthostatic hypotension. All are antihistamines and cause drowsiness, impaired balance and slow reaction times. Double the rate of falling
Monoamine Oxidase Inhibitors	Phenelzine, Isocarboxazid, Tranylcypromine	MAOIs are little now used; all (except moclobemide) cause severe OH
Drugs for psychosis and	Chlorpromazine, Haloperidol,	All have some alpha receptor

Agitation	Fluphenazine, Risperidone Quetiapine, Olanzapine	blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
SSRI antidepressants	Sertraline, Citalopram, Paroxetine, Fluoxetine	Cause falls as much as other antidepressants in population studies.
Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause OH and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.		
SNRI antidepressants A combination of an SSRI and a noradrenaline re-uptake inhibitor	Venlafaxine, Duloxetine	As for SSRIs but also commonly cause orthostatic hypotension (through noradrenaline re-uptake blockade)
Opiate analgesics	All opiate and related analgesics – Codeine, Morphine, Tramadol	Sedate, slow reactions, impair balance, cause delirium,
Anti-epileptics	Phenytoin	Phenytoin may cause permanent cerebellar damage and unsteadiness in long term use at therapeutic dose. Excess blood levels cause unsteadiness and ataxia.
	Carbamazepine Phenobarbitone,	Sedation, slow reactions. Excess blood levels cause unsteadiness and ataxia.
	Sodium valproate, Gabapentin	Some data on falls association.
	Lamotrigine, Pregabalin Levatiracetam, Topiramate,	Insufficient data to know if these newer agents cause falls
Parkinson's disease: Dopamine agonists	Ropinirole, Pramipexole	May cause delirium and OH
MAOI-B inhibitors	Selegiline	Causes OH
The subject of drugs and falls in PD is difficult, as falls are so common, and OH is part of the disease. In general only definite drug related OH would lead to a change in medication		
Muscle relaxants	Baclofen, Dantrolene	Sedative. Reduced muscle tone.
No falls data on these drugs. Tend to be used in conditions associated with falls.		
Vestibular sedatives Phenothiazines	Prochlorperazine	Dopamine antagonist – may cause movement disorder in long term use. Alpha receptor blocker and antihistamine.
Vestibular sedatives Antihistamines	Cinnarazine, Betahistine	Sedating. No evidence of benefit in long term use.
Sedating Antihistamines for allergy	Chlorphenamine, Hydroxizine, Promethazine, Trimeprazine	No data, but sedation likely to contribute to falls. Long half lives.
Anticholinergics acting on the bladder	Oxybutinin, Tolterodine, Solifenacin	No data, but have a known CNS effects

Drugs acting on the heart and circulation

Maintaining consciousness and an upright posture requires adequate blood flow to the brain. This requires an adequate pulse and blood pressure. In older people a systolic BP of 110mmHg or below is associated with an increased risk of falls.

Any drug that reduces the blood pressure or slows the heart can cause falls (or feeling faint or loss of consciousness or "legs giving way") (3). In some patients the cause is clear – they may be hypotensive, or have a systolic drop on standing. Others may have a normal blood pressure lying and standing, but have syncope or pre-syncope from carotid sinus hypersensitivity or vasovagal syndrome. Stopping cardiovascular medication reduces syncope and falls by 50%, and reduces the prevalence of these 4 syndromes (4, 5).

Alpha receptor blockers	Doxazosin, Indoramin, Prazosin, Tamsulosin, Terazocin, Alfluzosin	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
	Sedating antidepressants	See above. Orthostatic hypotension.
	Drugs for psychosis and agitation	
Centrally acting alpha 2 receptor agonists	Clonidine, Moxonidine	May cause severe orthostatic hypotension. Sedating
Thiazide diuretics	Bendroflumethiazide, Chlorthalidone, Metolazone	Cause OH, weakness due to low potassium. Hyponatraemia
Loop diuretics	Furosemide, Bumetanide	Dehydration causes hypotension. Low potassium and sodium
Angiotensin converting enzyme inhibitors (ACEIs)	Lisinopril, Ramipril, Enalapril, Captopril, Perindopril	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.
	Fosinopril, Trandolapril, Quinapril	Excreted by liver and kidney
Symptomatic hypotension in systolic cardiac failure • ACEIs and beta blocker have a survival benefit in systolic cardiac failure and should be maintained whenever possible. • NICE recommends: stop nitrates, calcium channel blockers and other vasodilators. If no evidence of congestion, reduce diuretics. If problem persists, seek specialist advice. • The mortality risk from a fall at age 85 is about 1% per fall. The frequency of falls determines the balance between risk and benefit. • Most cardiac failure in older people is diastolic (preserved left ventricular function). ACEIs and beta blockers have little survival benefit in diastolic failure.		

Angiotensin receptor blockers (ARBs)	Losartan, Candesartan, Valsartan, Irbesartan, Olmesartan, Telmesartan, Eprosartan	May cause less OH then ACEIs. Excreted by liver and kidney.
Beta blockers	Atenolol, Sotalol - Renally excreted. May accumulate	Can cause bradycardia, hypotension, CSH, OH and VVS
	Bisoprolol, Metoprolol, Propranolol, Carvedilol, Timolol eye drops	
Antianginals	GTN	A common cause of syncope due to sudden BP drop
	Isosorbide mononitrate, Nicorandil	Cause hypotension and paroxysmal hypotension
Calcium channel blockers that only reduce blood pressure	Amlodipine, Felodipine, Nifedipine, Lercanidipine	
Calcium channel blockers which slow the pulse and reduce BP	Diltiazem, Verapamil	May cause hypotension or bradycardia
Other antidysrhythmics	Digoxin, Amiodarone, Flecainide	May cause bradycardia and other arrhythmias. Data on digoxin and falls probably spurious due to confounding by indication
Acetylcholinesterase inhibitors (for dementia)	Donepezil, Rivastigmine, Galantamine	Cause symptomatic bradycardia and syncope

1) Campbell AJ, Robertson MC, Gardner MM, Norton RN, Buchner DM. Psychotropic medication withdrawal and a home-based exercise program to prevent falls: a randomized, controlled trial. J Am Geriatr Soc 1999; 47: 850–3.
2) Darowski A, Chambers SCF and Chambers DJ. Antidepressants and falls. Drugs and Aging 2009 26 (5) 381-394
3) Darowski A and Whiting R. Cardiovascular drugs and falls. Reviews in Clinical Gerontology 2011, 21 (2), 170-179
4) Van der Velde N, van den Meiracker AH, Pols HA, Stricker BH, van der Cammen TJ. Withdrawal of fall-risk-increasing drugs in older persons: effect on tilt-table test outcomes. J Am Geriatr Soc 2007;55:734–739.
5) Alsop K, MacMahon M. Withdrawing cardiovascular medications at a syncope clinic. Postgrad MJ 2001; 77:403-5.

Dr Adam Darowski, Consultant Physician, Clinical Lead, The FallSafe Project
Dr Jeremy Dwight, Consultant Cardiologist
Dr John Reynolds, Consultant in Clinical Pharmacology
John Radcliffe Hospital, Oxford.

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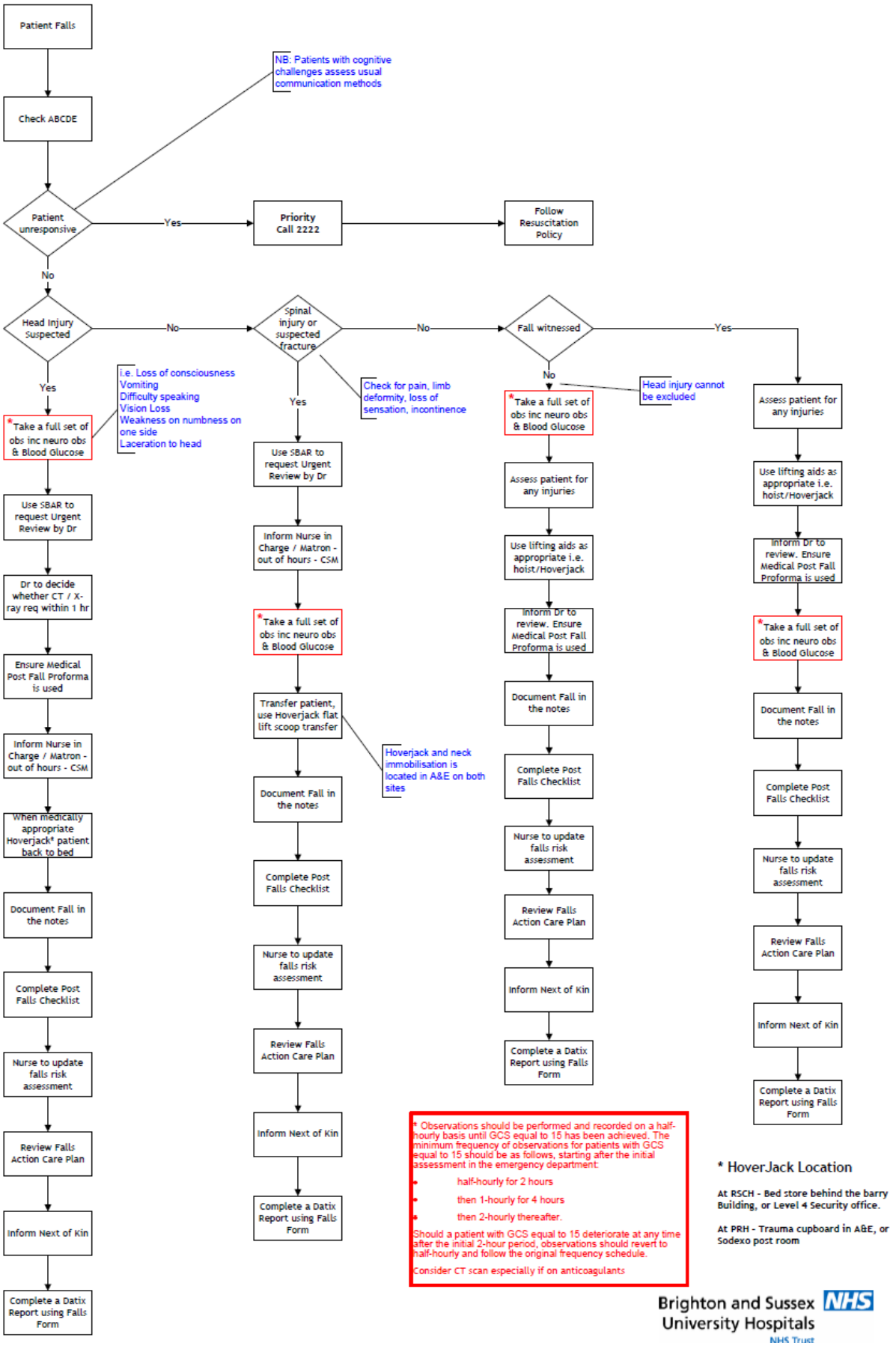
Appendix 7: Process for Managing a Patient Fall



Appendix 8: Checklist to be completed after a patient Falls

Name of Patient
NHS Number
Ward
Date of fall
Time of fall

This is to be completed whenever a patient falls and the nurse completing this must sign each section as to whether or not actions have been undertaken.

Follow the post falls flow chart for managing a patient fall	Achieved	Variance
Check for any injury particularly to the neck and spine. Take necessary first aid measures.		
As soon as it is safe, return the patient to bed (using lifting aids as indicated eg. Hover jack)		
Follow flow chart for 'managing a patient fall'		
Inform medical staff for SBAR visit & ensure medical post fall proforma completed		
Unless otherwise requested inform family / carers and document time (day or night)		
Reassess falls risk and consider bed position on ward.		
Complete Datix report. Matron should review if graded as moderate severity or above.		
AAR review to be held by (state band 6 name) & attach to Datix		
What action taken post fall eg. Special, move to visible area		
Time and date a Datix report completed		
Time and date the patient's family/carers informed		
Initial and staff number		

Appendix 9

Brighton and Sussex University Hospitals NHS Trust

Hospital No:
Forename:
Surname:
DOB:

Insert patient sticker here

BSUH Falls Proforma

Time of Fall	Name of Doctor	
Date of Assessment	Signature	
Time of Assessment	Bleep	Grade

History

Witnessed?
Head Injury?
Any of Sepsis/Delirium/Dementia?

Red Flags	Present?
LOC	
Amnesia	
Vomiting >1	
Seizure	
Visual Sx	

Clinical Examination

C-Spine Clear?
PEARL?

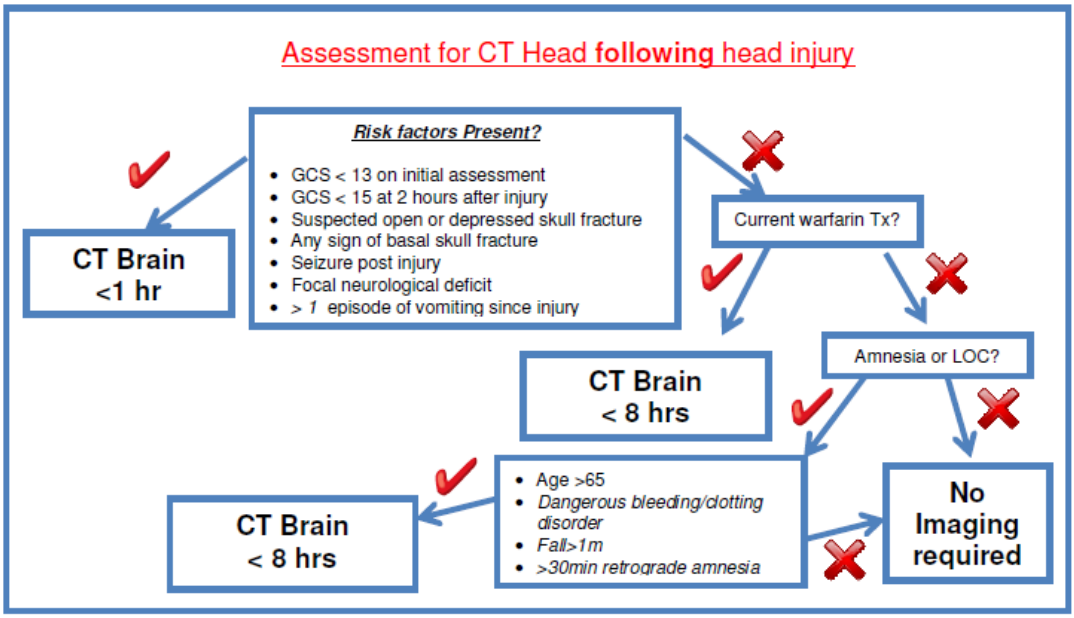
GCS

E	Not opening eyes	1	M	No movement	1
	Painful stimuli	2		Extension	2
	Voice	3		Abnormal flexion	3
	Spontaneously	4		Withdraws to pain	4
V	No sounds	1		Localises	5
	Incomprehensible	2		Obeys commands	6
	Inappropriate words	3	TOTAL		/15
	Confused	4			
	Oriented	5			

Fractures? **Yes** to any including previous→ **Hip XR**

Tenderness in groin or knee?	
Unable to straight leg raise?	
Limited hip movement?	
Leg shortened or rotated?	

Signs of boggy swelling/skull fracture?



Initial Management Plan

Cause of Fall/Impression?	

Imaging:

Suggested Neurological Observations:
- GCS <15 → every 30 min until 15
- If GCS 15 Then
  → every 30 min for 2 hrs
  →1 hourly for 4 hrs
  → 2 hourly thereafter

Hold/Cross off Sedative Medication:

Other Proposed Management:

Consider in Management Plan:
- Medication Review
  red flags:
  → sedation
  → anticoagulants/antiplatelets
  → cardiac/BP
  → Osteoarthritis
  → frailty
- Lying & Standing BP
  →Drop of 20 Sys/10 Dias
- BM
- Urinalysis
- ECG

Consider senior help if:
- Significant head injury/LOC
- New/worsening medical problems

Ensure handed over to nursing staff

Help Prevent Future Falls!
Do they need:
- *A special?*
- *Bed rails?*
- *Curtains pulled back?*
- *To be closer to nursing station?*
- *Their table closer?*
- *Better lighting?*
- *Walking aids readily available?*
- *Appropriate foot wear ie cositoes?*

Further information:

FallSafe guidance from RCP:
http://www.rcplondon.ac.uk/resources/falls-prevention-resources
Medications to be aware of with falls:
http://www.rcplondon.ac.uk/sites/default/files/documents/medicines-and-falls2.pdf
NICE guidance Falls
http://publications.nice.org.uk/falls-assessment-and-prevention-of-falls-in-older-people-cg161/key-priorities-for-implementation#preventing-falls-in-older-people-during-a-hospital-stay
NICE guidance Head injury:
http://pathways.nice.org.uk/pathways/head-injury/head-injury-overview

Appendix 10: Due Regard Assessment Screening

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	Yes	
	• Gender Identity	No	
	• Marriage and Civil Partnership Status	No	
	• Pregnancy and Maternity status	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	Yes	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	Yes	See Page 5 (section 5.2)
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	N/A	By undertaking the process highlighted throughout the policy, we are limiting any discriminatory outcomes for those groups highlighted above.
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**		
6.	**What alternative is there to achieving the document/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form ?**	N/A	

If you have identified a potential discriminatory impact of this policy, please refer it to Head of Nursing Safety and Quality, together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact Paula Tucker on ext 64581