Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy

V5

February 2019
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1. Introduction

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

1.2 The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore falling has an impact on quality of life, health and healthcare costs (CG161).

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

1.4 This policy identifies how the Royal Cornwall Hospital Trust is committed to reducing the incidence of falls for patients in line with NICE (National Institute for Health and Care Excellence) guidance (June 2013 and January 2014).

1.5 The following group of inpatients is considered at risk of falling in hospital:

- All patients aged 65 years or older.
- Patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

1.6 The policy includes targeted falls prevention strategies. The assessment tools within this policy are evidence-based and designed to assess patients at risk from a fall, support the reduction of risk of falling within the hospital environment and act as a marker for individual patients with regard to preventable causes.

1.7 This version supersedes any previous versions of this document.

2. Purpose of this Policy

2.1 The purpose of this policy is to:

- Ensure that effective processes are in place for assessing patients, and therefore recognising those at risk of falls.
- Incorporate falls risk assessment tools and pathways into the processes
underpinning the admission or pre-assessment of patients entering the care of RCHT.

- Implement effective, timely, multi-factorial intervention which reduces the number of patient falls and subsequent injury to those who have fallen.
- Ensure a safe environment using effective assessment and intervention.
- Ensure effective assessment, management and rehabilitation for those who have fallen or those who are at risk of falling.
- Establish a multi-disciplinary approach to falls prevention and management.
- Support patients to remain independent, empowered and safe.
- Support person centred planning.

2.2 The Trust is subject to a number of legal, statutory and good practice guidance requirements. In order to meet these requirements and to be able to demonstrate sound management within the constraints of the existing legislation, it is necessary to have clear operational policies and procedures.

2.2.1 Principal Legislation and Guidance applicable to this policy are:-

- The Management of Health and Safety at Work Regulations, 1999, in line with the Health and Safety at Work Act 1974, and the Workplace (Health, Safety and Welfare) Regulations 1992 Regulation 12(2)(a) include duties for people in control of workplaces to assess risks (including slips, trips and falls). They require that appropriate arrangements be implemented for effective planning, organisation, control, monitoring and review of any measures to safeguard health and safety identified by risk assessment.

- ‘Standard 6’ of The National Service Framework for Older People, 2001, looks at strategies for falls reductions for older people. The aim of this standard is to reduce the number of falls that result in serious injury and to ensure effective treatment and rehabilitation for those who have fallen. Many of these principles apply across age groups.


- Falling standards, broken promises: Report of the national audit of falls and bone health in older people (2010) identifies a number of key recommendations to improve the identification and management of people at risk of falls.
3. **Scope**

This policy applies to all staff, regardless of grade and profession, and includes bank, locum and agency. This policy concentrates on falls management in a hospital setting. The policy provides all health care practitioners with a clear framework for safe and effective practice relating to preventing and managing the risks of patient falls and sets out the standards and competencies expected when performing this role.

4. **Definitions / Glossary**

**Slip:** To slide accidentally causing the person to lose their balance. This is either corrected or causes the person to fall.

**Trip:** To stumble accidentally, often over an obstacle causing the person to lose their balance. This is either corrected or causes the person to fall.

**Fall:** An event which results in a person coming to rest inadvertently on the ground or floor or other lower level. WHO Jan 2018

**Controlled descent:** Event in which a staff member, to prevent a fall, eases the patient to the floor by lowering them.

**Bedrail:** rails attached to the sides of adult beds within the hospital setting. Bedrails may also be referred to as side rails or bed side rail

**Fall from height:** Any surface above floor level must be considered as a ‘height’. Examples would include: fall out of bed/trolley, climbing out of a window or falling over a barrier

**Datix:** Trust's incident reporting system

**RIDDOR:** Reporting of Injuries, Diseases, Dangerous Occurrences Regulations 1995 requires certain types of incidents to be reported to the Health and Safety Executive. This includes accidents which result in a person not at work (e.g. a patient, visitor) suffering an injury and being taken to a hospital, or if the accident happens at a hospital, suffering a major injury which would otherwise have required hospital treatment that is caused by work activity or failure of equipment. This does not include incidents caused by the clinical condition which were being managed appropriately as part of a risk assessment or care plan.

**NHS Safety Thermometer:** A quality assurance tool which is completed on a
monthly basis by inpatient wards providing a snapshot of any incidents resulting in harm to patients.

**MDT**: Multi-disciplinary team

**Post fall Huddle**: Rapid post fall evaluation by MDT

**Care Rounding**: Regular checks carried out with individual patients at set intervals, addressing patients’ pain, positioning and toileting needs; assessing and attending to the patient’s comfort; and checking the environment for any risks to the patient’s safety.

**Level 3 Enhanced Care**: Supervision provided to patients who have been assessed as being at imminent risk of harm. These patient should be in line of sight and accessible at all times.

**Co-horting Level 3**: Grouping of Level 3 patients in one bay. The observer must have access to call for immediate help (call bell, beds near nurses’ station). The patients must never be left unobserved, if the observer has to assist one level 3 patient, they must call for help from another member of staff to temporary take over the observation of the other patients in the cohort.

**Level 4 Enhanced Care**: Highest level of observation due to an imminent and significant risk of harm to themselves or others. Observation provided within arm’s length.

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5. **Ownership and Responsibilities**

5.1 The Chief Executive has overall responsibility for the strategic direction and operational management, including ensuring that Trust policies comply with all legal, statutory and good practice guidance requirements

5.2 The Trust Board has responsibility for setting the strategic context in which this policy will be implemented.

5.3 The Governance Committee has responsibility for monitoring the assurance framework for this policy and assuring Trust Board on compliance with the implementation of this policy.

5.4 Patient Falls Work Programme

Monitoring of the work programme will occur at the RCHT Patient Safety Group who will ultimately provide assurance to the Clinical Cabinet and the Quality Assurance Committee, of effective progress with implementation. The
delivery of the work programme is supported through a network of agreed professionals in the Trust.

5.5 General Manager / Care Group is responsible for ensuring that:

- The policy is implemented and adhered to in their services.
- Training or education needs are identified and met.
- Requirements for implementation of the policy are built into the delivery planning process.
- Staff have received, are aware of and comply with all relevant policies and supporting documents.

5.6 The Head of Nursing / AHP’s is responsible for:

- Monitoring compliance with the policy.
- Utilising data to monitor the effectiveness of fall prevention strategies in areas under their management.
- Ensuring the competencies of staff in their area is maintained.
- Ensuring that RIDDOR action plans are implemented and monitoring their outcomes.
- Ensuring staff are able to attend available education and training opportunities for falls prevention and management.
- Providing support and guidance to enable the Ward Sister to deliver their responsibilities, as listed below.

5.7 The Ward Sister / Deputy Sister is responsible for:

- Undertaking Ward Sister round, checking the assessment, care plans and treatment regime are current, valid and evaluated.
- Taking part in a monthly safety thermometer data collection.
- Ensuring high risk patients are flagged and care is planned and discussed as part of the safety briefings.
- Ensuring that all their staff are trained to care for patients at risk of falls.
- Promote a culture of patient involvement in falls prevention and treatment care planning.
- Ensuring that all falls incident reports are investigated thoroughly and escalating any possible RIDDOR reportable incidents to the Health and Safety team.
- Ensuring appropriate equipment and resources are available to support the management of patients assessed as being at risk of falls including resources being allocated appropriately.
- Encouraging an open and honest culture including, if appropriate, displaying a safety cross with the number of falls reported in the month.
• Ensuring any incidents that occur which are linked with falling and/or falls management are reported and investigated using Datix. This should be supported through the application of the post falls huddle.
• When a patient has a fall that results in moderate harm or above offering a full and a complete apology on behalf of the Trust in accordance with the Duty of Candour.
• Feed outcomes from actions back through relevant governance groups.
• Reporting on Datix falls and near misses

5.8 Consultants and other medical staff are responsible for:

• Identifying the patient’s fall history, including the causes and consequences on admission and arranging appropriate investigations and treatment such as 24 hour tapes, carotid sinus massage and tilt testing.
• Considering underlying medical conditions which may contribute to the patient’s risk of falling.
• Reviewing medication (especially sedatives, anti-psychotics, anti-hypertensives and anti-dysrhythmics). Appendix 2
• Ensuring all relevant information is clearly documented in the medical notes and shared with services in the community, as appropriate.
• Ensuring an In Patient Post Falls Assessment is completed in order to reduce the risk of further falls.
• Considering investigation and treatment for osteoporosis.
• Considering referral to specialist falls services.
• Reporting on Datix falls and near misses.

5.9 The Registered Nurse (RN) is responsible for:

• Providing patients at risk of falling and their carers’ information, orally and in writing about falls assessment and prevention.
• Listening to and acting upon any concerns raised by the patient and/or their carers.
• Ensuring that the patient’s risk of falls has been identified in order to support your clinical judgment of risk within 4 hours of the patient’s admission (to include elective inpatient admissions).
• Completing Holistic Nursing Assessment within 12 hrs of admission.
• Completing individualised Falls Prevention Care Plan for all patients found to be at risk of falls immediately following the assessment.
• Undertaking a bedrail assessment for any patient that has or requires bed rails in situ.
• Evaluating and updating the Prevention of Falls Care Plan if/when the patient’s condition changes and/or following a fall.
• Following each internal move between wards all patients should have their falls risk reassessed.
• Escalating non concordance with prevention/treatment strategies to the ward sister and Medical team responsible for patient care.
• Ensuring all equipment is ordered and appropriate care is organised for the patient on discharge from hospital.
• Ensuring that all falls are reported via Datix.
• Ensuring Falls Care Bundle- Immediately Following a Fall is completed and placed in the notes.
• Ensuring that at risk patients are highlighted during safety brief and MDT meetings
• Reporting on Datix falls and near misses

5.10 The **Physiotherapy Team** is responsible for:

• Providing a general assessment of patients to include footwear, balance, gait, range of movement, strength, functional ability including transfers and the need for and provision of a walking aid. Once the patient has reached their physiotherapist goals, they may be discharged by the physiotherapist, but can be re-referred should the situation change.
• Ensuring that patients that are identified at risk of falling are discussed at the MDT board round and appropriate referrals established.
• Education of patients with regards to falls prevention.
• Provide advice to other members of the MDT on the best methods of patient movement and mobility.
• Reporting on Datix falls and near misses

5.11 The **Occupational Therapy Team** is responsible for:

• Carrying out a capacity assessment where appropriate.
• Ensuring that patients that are identified at risk of falling are discussed at the MDT board round and appropriate referrals established.
• Where appropriate, assessment of home environment, identifying the daily activities which place the patient at risk of falls.
• Reporting on Datix falls and near misses

5.12 The **Pharmacist** is responsible for:

• Providing an advice to the multidisciplinary team and assisting with medication review for patients at risk of falls following a request from multifactorial risk assessor.

5.13 Unregistered clinical staff are responsible for:
• Implementing the Falls Prevention Care Plan as delegated to them within the scope of their competence.
• Documenting the care delivered as part of the Prevention of Falls Care Plan.
• Informing the RN of any changes to the patient’s condition immediately.
• Reporting on Datix falls and near misses

6. Standards and Practice

6.1 Falls Risk Assessment

6.1.1 Early identification of those at risk within Admission nursing care record (CHA3831) is the first stage in falls prevention. For all patients the following four questions should be answered:

- Have they had a fall in the last 12 months?
- Do they have a cognitive impairment or had recent change in their cognition?
- Has their mobility deteriorated from a normal level?
- Are they on medication that increases risk of falls?

If the answer is ‘Yes’ to any of the above then assessor should commence Prevention of Falls Care Plan.

6.1.2 The Holistic Risk Assessment (CHA3897) must be completed for all patients within 12 hours of being admitted to RCHT. Assessing for the risk of falling must include discussions with the patient and, where appropriate, carers.

6.1.3 The outcome of cognitive and delirium assessments, found in the Adult Inpatient Admission Record (CHA2638), must be taken into account when undertaking the falls risk assessment.

6.1.4 The risk assessment must include the completion of a lying and standing blood pressure, assessment of medications associated with the risk of falls, and assessment of vision.

6.1.5 Patients’ must be reassessed following a fall or if there has been a change in their condition. Otherwise the re-assessment has to be completed every 72 hours.

6.1.6 Patient’ identified to be at high risk of falling should be handed over between shifts during safety brief and to the MDT during rapid round.
6.1.7 Each clinical area, following thematic review, should determine ward specific characteristics of high falls risk patient and for those that meet the criteria the red non slip socks should be issued.

6.1.8 Following each internal move between wards all patients should have their falls risk reassessed.

6.2. Individualised Falls Intervention Plan

6.2.1 Interventions for reducing the risk of a patient falling must be documented on an Individualised Prevention of Falls Care Plan (found within the Nursing Care Record document CHA3897). An intervention plan must be completed for all patients identified as a risk of falling. Implementation of plans must include discussions with the patient and, where appropriate, carers.

6.2.2 The intervention plan must include consideration of assessment by a relevant healthcare professional such as Physiotherapist, Occupational Therapist or Podiatrist.

6.2.3 The intervention plan must include a review of medication associated with the risk of falls by the medical team, as well as individualised interventions aimed at reducing the risk of falls associated with vision, postural changes in blood pressure (Appendix 3), cognitive behavior, presence of delirium, mobility, continence, the environment (Appendix 4) and footwear (Appendix 6).

6.2.4 Where patients are identified as being at risk of falls, written, as well as oral information must be provided about falls prevention, to the patient and carers. It must be recorded on the care plan that this information has been given.

6.2.5 Patients identified as in an imminent risk of falls, sensor alarms systems might be considered as part of patient’ care plan; these will alert staff when a patient attempts to get up from their chair or bed. Staff must balance the use of this equipment as a safety tool against other important factors such as the dignity, privacy and the rights of the patient. It must be used as a falls preventative and must not be used to restrict patient movement. See the clinical guidance for use of bed and chair sensor alarm mats for preventing falls in adult patients.

6.2.6 Consideration must be given to heightened levels of observations when a patient has been identified as in an imminent risk of falls, such as implementing ‘care rounding’ (CHA 3061) or enhanced care, please see the RCHT Enhanced Care and Meaningful Activities Policy for further information.
6.2.7 Where there is a high number of patients requiring Enhanced Care, and it is deemed appropriate, co-horting of patient should be used to manage safety of patients and available resources effectively. Please refer to RCHT Enhance Care and Meaningful Activity Policy for more information.

6.2.8 Interventions must be evaluated following a fall or if there has been change to patient’s condition.

6.3. Bedrail Assessment and Care Plan

6.3.1 Decision and rational for use of bedrails should be documented in Prevention of Falls Care Plan section. See Appendix 7 for further guidance. If the patient is mobile and confused and is at risk of climbing over the bedrails, then please consider alternative methods for keeping the patient safe.

6.3.2 Patients’ must be reassessed if there is a change in their condition.

6.3.3 When considering the use of bedrails, it is important to remember that they are safety devices intended to reduce the risk of patients accidentally slipping, sliding, rolling or falling from bed. They may also be used to reassure patients who are anxious about falling from bed. Bedrails should NOT be used as a manual handling aid, as a hanging point for call bells or other equipment, or as a means to prevent a patient from getting out of bed.

6.3.4 The use of bedrails could be perceived as a form of restraint if used in a manner to prevent a patient from leaving their bed. The Royal College of Nursing (2004) defines restraint as ‘restricting someone’s liberty, preventing them from doing something they want to do’. When bedrails are used correctly they are not classified as restraint.

6.3.5 Consideration must be given to patients who lack capacity and staff must be guided by current RCHT policies regarding capacity and consent and seek further guidance from the relevant specialists, for example the acute learning disability nursing team.

6.3.6 Where a hospital bed has integral bedrails these cannot be removed from the bed itself and no other bedrail will be used on this bed. The integral bedrail is in four sections, two sections on each side of the bed. Precautions must be taken to prevent entrapment of limbs between the two side panels; this is a particular risk when the bed head is being raised electronically. The patient operated panel must be disabled for patients who are cognitively impaired to minimise risks.

6.3.7 For electric beds that have integral rails consisting of three bars which are manually operated, precautions must be taken to prevent risk of entrapment between the bars. The position of limbs must be checked prior to the rails being raised or lowered.
and prior to a change in bed position.

6.3.8 When a patient is assessed as not requiring bedrails, it is recommended that the patient is nursed in a bed without bedrails and not in a bed where they are stored in the lowered position, as there is a potential for patient injury caused by hitting against the lowered bedrail.

6.3.9 It is important that the bedrails are fitted properly and securely, incorrect fitting can result in patient injury through entrapment or can result in a fall from bed if the bedrails do not remain in the raised position.

6.3.10 All patient trolleys at RCHT are provided with integral safety rails. Patients must be assessed for potential risk of climbing over the safety rail. Unless there has been identified risk, safety rails should be placed in the raised position.

6.3.11 The use of overlay mattresses, which raise the height of the patient in bed can reduce the efficacy of bedrails in falls prevention and can increase the risk of asphyxiation and entrapment. Staff must exercise additional measures for caution and monitoring.

6.4. **Trust standard for toileting patients**

6.4.1 Where possible, all patients should be taken to the toilet in line with ‘Behind the door’ privacy and dignity principles.

6.4.2 Where patients have been risk assessed as needing to use a commode at the bedside the following standard should be applied:

- Patient should be turned with the commode to face the bed
- Call bell should be placed directly in front of the patient on the bed

6.4.3 Patient’ who have been assessed as having a higher risk, e.g. due to recent fall or signs of delirium (acute confessional state), must be supervised within arm’s length.

6.4.4 Commodes must not be routinely left at the bedside, the only exception being when this has been identified as part of patient’s reablement plan and has been risk assessed by the multidisciplinary team and documented.

6.5. **Environmental Assessment**

6.5.1 There must be documentation of immediate environmental hazards and action taken to minimise these. If an environmental hazard has caused or contributed to a
fracture or other significant injury, then the Health and Safety Advisor and Risk Co-
ordinators must be notified.

6.5.2 The score of 80% or below requires ward sister/ charge nurse to create an action
plan that is sheared with specialty matron. If a persistent score of 80% or below
continues for over 3 quarters then the action plan should be presented to the
specialty governance meeting and any unresolved problems reported on the
ward/specialty/care group risk register.

6.5.3 All patient care areas will undertake an environmental audit on a quarterly basis as a
minimum standard and record it on Quanta (audit form available in appendix 1) If a
clinical area has more than five falls in a month, related to environmental risk
factors, then an environmental audit must be carried out. The audit results will be
reported to the Specialty Matron and an action plan presented to the specialty
governance meeting. Unresolved problems reported on the ward/specialty/ care
group risk register.

6.6.  Assessment and Management of Patients who Fall in Hospital

6.6.1 If a patient should fall in hospital an immediate assessment must be carried out by
a registered nurse at the scene of the fall prior to moving the patient as per the
flowchart in Appendix 8.

6.6.2 The patient’s Airway, breathing, circulation and Glasgow Coma Scale (GCS)
must be assessed.

6.6.3 The patient must then be assessed for signs of serious injury, for example: obvious
fractures; including neck of femur and cervical spine, head injury, significant soft
tissue injuries and any change in neurological status. See section 6.7 of this policy
if any of these serious injuries are visible, reported or suspected.

6.6.4 If there is no serious injuries found patient should be assisted off the floor. Method
of moving/ assisting patient is available in the Appendix 11.

6.6.5 A set of observations must be completed and documented to detect any new acute
illness, or to detect any harm from the fall. Observations include temperature, heart
rate, respiratory rate, blood pressure, neurological observations, and blood glucose
level. Results need to be acted upon and repeated as the patient’s condition
requires.

6.6.6 If minor injuries are sustained, such as cuts or abrasions as a result of the fall
must be treated appropriately and on-going observations and management will be
dictated by the nature of the injury and the initial assessment. There are however,
certain injuries that require a more intensive and prolonged schedule of observation.

6.6.7 Haemodynamically stable patients without severe injury will be reviewed within 24 hours either by their own medical team or the on call team.

6.6.8 Following a fall, after patient’ safety is ensured, ward staff should undertake a post fall huddle to evaluate fall circumstances and preventative measures already in place (Appendix 12).

6.6.9 Following a fall the Post Falls Checklist -Immediately Following a Fall (CHA3216) must be completed within four hours of the fall, and placed in the medical notes. Any recommendations identified must be actioned by the multi-disciplinary team.

6.6.10 All patients will have a multi-disciplinary and a full medical review to ascertain the reasons for falling. The interventions on the care plan must be reviewed and updated to ensure their effectiveness in fall prevention.

6.6.11 The relative or carer must be informed about patient' fall.

6.7. Management of a Patient with Visible, Reported or Suspected Severe Injury following a Fall

6.7.1 A doctor must be called immediately to assess the patient following a fall if any of the following injuries are suspected:

- Possible cervical / spinal injury. Injury to the cervical spine may be indicated by:-
  - Neck pain
  - Neurological deficit – limbs
  - Position / height of fall
- Possible Hip Fracture may be indicated by :
  - Hip/groin pain
  - Inability to move/lift/rotate leg
  - Leg shortening on the injured side
  - Injured leg positioned in external rotation (more than opposite side)
- Signs of other bony deformity
- Suspected or known knock to the head – head injury
- Change in neurological status – GCS Score
- Significant soft tissue injury
- Abnormality in the patient’s normal vital signs and National Early Warning Score (NEWS)

6.7.2 A patient falling from a significant height must be treated as an emergency. The
emergency department must be contacted and arrangement made for the immediate transfer of patient, or for Emergency Staff to attend the incident.

6.7.3 If there is evidence of a cervical spine injury, the patient’s head needs to be held still. The Emergency Department must be contacted so that the patient’s head can be immobilised using a hard collar and sand bags and advice taken regarding the movement of the patient.

6.7.4 It is important that safe retrieval of the patient who has fallen is managed correctly. Staff must know how to access and operate lifting equipment, and have the expertise to manage suspected cervical injury and hip fractures where immobilisation and flat-lifting is required. Hoist and fabric slings are not to be used for patients with suspected cervical injuries or suspected / clinically indicated hip fractures. Ensure pain relief is given before moving the patient if appropriate.

6.7.5 For patients where there is a reported or suspected head injury, and there is ANY drop in the patient’s GCS, or the patient presents with persistent vomiting, and/or severe or increasing headache this will trigger an immediate medical review (Appendix 9), and clinical diagnostics management (Appendix 10).

6.7.6 Anticoagulant therapy must be discontinued following a fall that results in head injury. All patients with a visible, reported or suspected head injury on anticoagulation or are coagulopathic must be reviewed by a doctor. The doctor will decide the risks and benefits of reversing anticoagulation, decide if a computerised tomography (CT) scan is required, and if/ when to restart the anticoagulants.

6.7.7 GCS and observations such as temperature, heart rate, respiratory rate blood pressure, and blood glucose level must be acted upon and repeated as the patient’s condition requires.

6.7.8 Only the 15-point version of neurological observation charts is to be used. Frequency of neurological observations must be as follows:

- Half-hourly neurological observations until the GCS = 15 and is maintained for 2 hours.
- Progress to hourly observations for 4 hours
- Then 2 hourly thereafter

6.7.9 An injury sustained as a result of the fall must be treated appropriately and ongoing observations and management will be dictated by the nature of the injury and the initial assessment.

6.8. Reporting Falls and Lessons Learned

6.8.1 All the details of the fall and potential causes must be documented in patient’ record, and in the incident report completed on Datix. If an injury is discovered after the initial Datix report then the original Datix report must be updated to
include the most recent information.

6.8.2 Description of the incident in the report must include details of:

- Date and time of the falls,
- Was the fall witnessed or unwitnessed,
- Place and activity leading to the fall,
- Where did the fall occur from (e.g. bed/chair/commode)
- Were the bedrails in use if fallen from the bed
- Whether the patient has a history of falls,
- Does patient have cognitive impairments,
- Any injuries sustained;

Datix entries must also include the immediate patient assessment and management post fall.

6.8.3 Ward sisters are responsible for investigating the circumstances around individual falls and taking action as appropriate. Ward managers can contact the Quality, Safety and Compliance Department if the actions identified require additional support or expert intervention.

6.8.4 Following a fall, ward staff should undertake a post fall huddle lead by nurse in charge to evaluate fall circumstances and preventative measures already in place to learn from the incident.

7. **Dissemination and Implementation**

7.1 This policy will be implemented and disseminated through the organisation immediately following ratification and will be published on the organisations intranet site (document library). Access to this document is open to all.

7.2 It is the responsibility of the ward / departmental managers to ensure all staff working in that clinical area remains aware of this policy.

7.3 Ward / departmental managers are responsible for ensuring staff undertakes training to support the implementation of this policy. All clinical staff will receive falls training as identified in the RCHT Core Training Policy.

7.4 Monitoring of staff competence in falls assessment and management will form part of the individual’s annual performance review (appraisal) and where necessary, additional training provided.
8. Monitoring compliance and effectiveness

| Element to be monitored       | • Assurance of the effective implementation of the Falls Prevention and Management documents present within this policy.  
|                              | • Receive, analyse and benchmark patient falls data (from incidents, serious incidents, claims, safety alerts, safety thermometer, national confidential enquiries, complaints and other relevant sources) and reports/information, and use these to identify trends, risks and learning for RCHT. |
| Lead                         | • Deputy Director for Quality, Safety and Innovation, supported by Falls Prevention Practitioner |
| Tool                         | • Datix Incidents Reports  
|                              | • Ward to Board Report  
|                              | • Safety Thermometer |
| Frequency                    | Monthly |
| Reporting arrangements       | Key nursing quality indicators that focus on falls prevention are reviewed regularly by Clinical Matron’s and Ward Sisters / Charge Nurses and form part of the Performance Assurance Framework which is challenged at Divisional level. As part of the new Senior Nurse Meetings we have devised a monthly exception report that will now provide further assurance relating to this.  
|                              | Monthly exception is reported in the Integrated Performance Report (IPR) and ward to board report |
| Acting on recommendations and Lead(s) | Monitoring of the Trust work programme occurs at the Falls Work stream Group. |
| Change in practice and lessons to be shared | Monitoring of the Trust work programme occurs at the Patient Safety Group |
9. **Updating and Review**

9.1 The document review process is managed via the document library. Document review will be every three years unless best practice dictates otherwise. The author remains responsible for policy document review. Should they no longer work in the organisation or in the relevant practice area then an appropriate practitioner will be nominated to undertake the document review by the designated Director.

9.2 Revision activity will be recorded in the Versions Control Table to ensure robust document control measures are maintained.

9.3 This Policy replaces the V4.3 (July 2015)

10. **Equality and Diversity**

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

**10.2. Equality Impact Assessment**

The completed Equality Impact Assessment Screening Form is at Appendix 2.
Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>January 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>February 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>February 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Corporate Nursing Louise Dickinson Acting Director of Quality Safety and Innovation and Director of IPAC Magda Morgan Falls Prevention Practitioner</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 254993</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This policy provides staff with the organisation's expectations for the standard of care in preventing and managing falls in adult patients in hospital</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Patient falls, bed rails, falls assessment, head injury following falls</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Kim O’Keefe, Chief Nurse</td>
</tr>
<tr>
<td>Date revised:</td>
<td>January 2019</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Policy for Management and reduction of risk of falls in hospital care and the safe use of bedrails in adult patients, V4.3 (July 2015)</td>
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<tr>
<td>Approval route (names of committees) / consultation:</td>
<td>Falls Workstream Group (September 2018), Clinical Cabinet (Dec 2018), Quality Governance(Jan 2019)</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Director of Quality, Safety and Innovation</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Nursing Generic</td>
</tr>
</tbody>
</table>
| Links to key external standards | The National Service Framework for Older People (2001)  
NICE Falls in older people: assessment after a fall and preventing further falls (Quality Standard 86, 2015). |
• NICE Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults (2014)  
• NPSA Rapid Response Report: Essential care after an inpatient fall. (2011)  
• RCHT Policy to Manage Information and Records  
• RCHT Incident and Serious Incident Policy  
• RCHT Reporting of Injuries, Diseases and Dangerous Occurrences Policy and Guidance  
• RCHT Policy for Moving and Handling Patients and Inanimate Loads  
• RCHT Medical Devices and Equipment Management Policy  
• RCHT Enhanced Care and Meaningful Activities Policy  
• RCHT Guidance for staff providing Level 3 and Level 4 enhanced care |
| Training Need Identified? | Yes – This is supported by the Learning and Development Team. |
## Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul 10</td>
<td>V1.0</td>
<td>Reformat per NHSLA</td>
<td>Sandra Arnold, Matron Practice Development</td>
</tr>
<tr>
<td>Feb 11</td>
<td>V2.0</td>
<td>Amendment as per NPSA /2011/RRR001</td>
<td>Sandra Arnold, Matron Practice Development</td>
</tr>
<tr>
<td>Jul 11</td>
<td>V3.0</td>
<td>Reformat to revised RCHT document template</td>
<td>Sandra Arnold, Matron Practice Development</td>
</tr>
<tr>
<td>19 Jun 13</td>
<td>V3.1</td>
<td>Comfort Round Form replaced with Care Round Form – Appendix 9</td>
<td>P Prady Lead Nurse for Quality Safety and Innovation</td>
</tr>
<tr>
<td>9 Sep 13</td>
<td>V3.2</td>
<td>Falls Risk Assessment form updated</td>
<td>P Prady Lead Nurse for Quality Safety and Innovation</td>
</tr>
<tr>
<td>Jul 15</td>
<td>V4.3</td>
<td>Content updated and approved by RCHT Trust Falls Group Members</td>
<td>Lorrie Maltby Lead Nurse for Quality, Safety and Innovation</td>
</tr>
<tr>
<td>Nov 18</td>
<td>V5</td>
<td>Updated to reflect changes to core nursing documentation, the enhanced care process and Trust standard for toileting patients.</td>
<td>Magda Morgan Falls Prevention Practitioner</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description):</th>
<th>Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Quality and Safety</td>
</tr>
<tr>
<td>Name of individual completing assessment:</td>
<td>Lorraine Maltby</td>
</tr>
<tr>
<td>Telephone:</td>
<td>01872 25 3050</td>
</tr>
<tr>
<td>1. Policy Aim*</td>
<td>To provide clear framework for all staff in assessment and management of patients to reduce the risk of falls in hospital.</td>
</tr>
<tr>
<td>Who is the strategy / policy / proposal / service function aimed at?</td>
<td></td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
<td>The purpose of this document is to provide all staff regardless of grade or profession with clear practice guidelines when assessing, planning and managing patient care. The aim of the document is achieve a reduction of falls in patients identified at risk of falling and to promote staff awareness. The policy also addresses risks associated with bed rails and provides staff with an assessment</td>
</tr>
</tbody>
</table>
• Develop a culture where falls assessment is embedded in acute clinical inpatient areas.  
• To raise staff awareness, identify lessons learned and recommend action through policy audit. |
| 4. *How will you measure the outcome? | As per section 8 of the policy. |
| 5. Who is intended to benefit from the policy? | All patients |
| 6a Who did you consult with | Workforce | Patients | Local groups | External organisations | Other |
| b). Please identify the groups who have been consulted about this procedure. | X | X |  |
| Falls Workstream Group, Clinical Cabinet, Quality Governance |
What was the outcome of the consultation?
- Age criteria removed as a justification for falls risk assessment.
- Verification of appendix 4 - drugs associated with an increased risk of falls,
- Added role of pharmacist
- Clarification of information required within incident report
- Clarification of when to complete and where record environmental assessment
- Added Bed rail assessment matrix

7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>X</td>
<td></td>
<td>This policy is particularly focused on falls prevention for older patients.</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities / groups</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development
8. Please indicate if a full equality analysis is recommended. | Yes | No | X
9. If you are not recommending a Full Impact assessment please explain why.

No or neutral impact has been identified The Impact assessment above.

Signature of policy developer / lead manager / director
Magda Morgan/Lorrie Maltby

Date of completion and submission
January 2019

Names and signatures of members carrying out the Screening Assessment
1. Lorrie Maltby
2. Human Rights, Equality & Inclusion Lead

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the Human Rights, Equality & Inclusion Lead.

A summary of the results will be published on the Trust’s web site.

Signed __ Lorrie Maltby

Date _____ January 2019
## Appendix 3. Environmental Assessment for the Prevention of Patient Falls

### One + all | we care

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Date</th>
<th>Time</th>
<th>Name of Assessor</th>
<th>Designation</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Compliant</th>
<th>Actions to rectify</th>
<th>Action Complete Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Beds are at the correct height for each patient?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All chair heights are the correct height for patients?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All areas of the ward have effective lighting</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Areas are bright and easy to walk through</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All motion sensor lights are quick to respond</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All bulbs are working</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All call bells are within patients’ reach?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patient belongings are within easy reach?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The layout of the ward maximise observation of all patients, i.e. position of nurse station, positioning of medical notes trolleys?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patient bed spaces are free from clutter and obstacles?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All bed breaks are on?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all walkways clear from obstacles?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all bathrooms and toilets clearly sign posted?</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5

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The information gathered on this form should be inputted on to Quanta.
### Appendix 4. Drugs Associated with Increased Risk of Falls

Never stop or withhold medication without agreement from the medical team

<table>
<thead>
<tr>
<th>Group</th>
<th>Generic Drug Name</th>
<th>Possible Side effects</th>
<th>Suggested Action</th>
</tr>
</thead>
</table>
| Antidepressants               | TCAs- amitriptyline, dosulepin, imipramine, doxepin, clomipramine, lofepramine, nortriptyline, trimipramine. Other- trazodone, mirtazapine, phenelzine, venlafaxine, duloxetine | Drowsiness, blurred vision, dizziness, postural hypotension, constipation, retention of urine | • Review indication  
• Stop if possible. May need to withdraw slowly.  
• Consider changing a tricyclic(TCA) to a Serotonin Specific Reuptake inhibitor (SSRI) (eg citalopram).  
• Consider specialist referral if further advice needed. |
• In long term use do not stop without specialist opinion |
| Sedatives and hypnotics       | Temazepam, diazepam, lorazepam, nitrazepam, clonazepam, oxazepam, zopiclone, zolpidem, | Drowsiness which can last in to the next day, light headedness, confusion, loss of memory | • Stop if possible  
• Long term use will need slow withdrawal.  
• No new initiation on TTOs |
| Drugs for Parkinson's Disease | Pramipexole, ropinirole, selegiline, | 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 |
| Cardiovascular Drugs          | ACE inhibitors/ Angiotensin-II antagonists  
Ramipril, lisinopril, enalapril, captopril, perindopril, fosinopril, trandolapril, quinapril  
Antianginals Gliceryl trinitrate (GTN), Isosorbid mononitrate, nicorandil  
Diuretics Bendroflumethiazide, metolazone.  
Beta-blockers Atenolol, sotalol , bisoprolol, carvedilol, propranolol, metoprolol, timolol eye drops  
Alpha-blockers Doxazosin, alfuzosin, terazosin, Indoramin, prazosin, tamsulosin, clonidine, moxonidine | Low blood pressure,  
postural hypotension, dizziness, tiredness, sleepiness, confusion | • Check lying and standing BP.  
• Review indication (alpha-blockers also used for benign prostatic hyperplasia).  
• Review dose.  
• May not be possible to stop  
• Consider alternative to alpha-blocker. |
| Analgesics                    | All opiate and related analgesics – Codeine, morphine, tramadol.                 | Drowsiness, confusion, hallucinations, postural hypotension                            | • Review dose.  
• Use analgesic pain ladder to avoid excess use.  
• In elderly start low and go slow |
| Anti-epileptics               | Carbamazepine*, phenytoin*, phenobarbitone*.                                   | Drowsiness, dizziness, unsteadiness, ataxia                                           | • 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. |
Table above highlights High Risk Medication only. To view full list of medication associated with falls refer to: ‘Guidance sheet: Medication and Falls in Hospital’ available on Royall College of Physicians website: https://www.rcplondon.ac.uk/file/933/download?token=drzlaAJ2
Appendix 5. Lying and Standing Blood Pressure Monitoring

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

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

**Lying**

0 min
- Ask the patient to lie down for at least five minutes.

5 mins
- Measure the BP.

0 - 1 mins
- Ask the patient to stand up (assist if needed).
  - Measure BP after standing in the first minute.

3 mins
- Measure BP again after patient has been standing for three minutes.

**Standing**

- Repeat recording if BP is still dropping.
- In the instance of positive results, repeat regularly until resolved.
- If symptoms change, repeat the test.
Notice and document **symptoms** of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.

Advise patient of results and if the result is positive:
- inform the medical and nursing team.
- take immediate actions to prevent falls and/or unsteadiness.

**A positive result is:**
- A drop in systolic BP of 20mmHg or more (with or without symptoms).
- A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms).
- A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP).
Appendix 6. Environment

Chairs

Ensure chairs are at a suitable height and appropriate for the patient. Patient with poor sitting balance may require specialist or recliner chair. Physiotherapists can provide advice on the suitability of chairs.

If a chair is raised, provide a foot rest for comfort when sitting but ensure that the patient is safe in using this when independently standing from the chair. Check that the chair has suitable arm rests to enable patients to push themselves up from the chair.

Remember to take into account any pressure relieving equipment that may be required.

Beds

Agitation and confusion combined with limited mobility or acute illness are particular risk factors for patients falling from their bed. To prevent injuries, consideration should be given to the use of the extra low position of beds or a specialist low profiling bed.

Both ArjoHuntleigh Enterprise 5000 and 8000 bed models have the ability to be lowered to an extra low position. When the bed is set to its lowest level, the bed can be lowered by a further 8cm to reach the extra low position providing a mattress platform height of 30cm. The extra low position can be achieved by;

- Pressing and holding the Mattress Platform Height Function Key (1)
- Whilst holding this button, press and hold the Down Direction key (2)
- Keep holding both buttons until the mattress platform stops moving
Appendix 7. Walking Aids

A walking aid may facilitate safe mobilisation but may also increase the risk of falling if the wrong piece of equipment is used. Where walking aids are required, patients should be referred to physiotherapy who will assess them and walking aid they are using ensuring it is appropriate for the patient’s height and level of independence.

If patient present with their own walking aid, make sure you check its condition including the ferrules (rubber ending of sticks/crutches/frames) and inform therapist if it needs replacing.
Appendix 8. Footwear

Footwear influences balance and the subsequent risk of slips, trips, and falls. The requirement for safe, well-fitting shoes varies, depending on the individual and their level of activity. Current opinion is that well-fitting footwear is key to aiding balance and postural stability.

Temporary Footwear

If a patient does not have suitable footwear, temporary provision of an alternative is recommended. If feet / ankles / lower legs are swollen or have bandaging in situ, the patient may also require alternative footwear. This can usually be sought through the Orthotic Department and Physiotherapists can advise on what is appropriate.

Suitable Footwear

The features outlined below may help in the selection of suitable footwear. The shoe should:

- Have a broad and firm heel with good ground contact and support
- Have a cushioned, flexible, non-slip sole
- Be lightweight
- Have non-trailing laces, buckles, elastic or Velcro
- Protect feet from injury.

Non-slip Bed Socks

Non-slip bed socks can be issued to patients that do not have suitable footwear available provided these can be worn comfortably. This should be a temporary arrangement until suitable footwear is available.

Patients slipping when not wearing footwear, patients that suffer from cognitive impairment and mobilise frequently should wear non-slip bed socks. These socks can also be worn during the night whilst patients are sleeping.

Where non-slip bed socks are being worn, it is important that regular skin checks are undertaken by removing the socks frequently and inspecting feet and ankles for signs of swelling or pressure damage.
### Appendix 9. Bed rail assessment matrix

<table>
<thead>
<tr>
<th>Mental state</th>
<th>Risk Matrix Tool</th>
<th>Mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is confused and disorientated</td>
<td>Consider other interventions / Use bedrails with care</td>
<td>Patient is immobile (never leaves bed or is hoist dependent)</td>
</tr>
<tr>
<td>Patient is drowsy</td>
<td>Bedrails recommended</td>
<td>Patient requires physical help with mobility</td>
</tr>
<tr>
<td>Patient is orientated and alert</td>
<td>Bedrails recommended</td>
<td>Patient mobilises without help from staff</td>
</tr>
<tr>
<td>Patient is unconscious</td>
<td>Bedrails recommended</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Not applicable**
Appendix 10. Immediate Assessment Following a Fall

Immediate Assessment for Potential Injury

Immediate assessment should be carried out by a registered nurse at the scene of the fall prior to moving the patient.

Assess:
- Airway
- Breathing
- Circulation
- Glasgow Coma Scale (GCS)

Document in the patient’s notes

Assess for signs of:
- Fractures; deformity, pain, loss of sensation. (Consider neck of femur).
- Spinal Injuries; including cervical spine
- Soft tissue injuries
- Cuts and abrasions
- Head Injury; Change in neurological status

Document in the patient’s notes

If NO evidence of a spinal injury/other fractures:
- Assist the patient to get up AND/OR
- Assist to bed

Take observations, including:
- Heart Rate, Blood Pressure, Respiratory Rate, Temperature, O₂ Saturation Rate, NEWS Score, Blood Glucose Level.
- Head injuries/ suspected head injuries must have neurological observations including pupil size, pupil reactivity, limb movements, GCS Score.
- ½ hourly neurological observations until GCS=15 is achieved for 2 hours. Progress to hourly observations for 4 hours, and then 2 hourly thereafter.

Injury to the cervical spine may be indicated by:
- Neck pain, neurological deficit in limbs and position of fall. If there is evidence of a cervical spine injury the patient head and neck must be held still.

The Emergency Department must be contacted for appropriate equipment and patient management. Other fractures should be immobilised to minimise patient pain/discomfort.

DO NOT USE STANDARD SLING HOIST to move patient with suspected spine/hip injuries

A doctor should be called to assess the patient immediately if any of the following criteria are met:
- Possible cervical spine/spinal injury
- Signs of bony deformity/fracture
- Suspected of known head injury
- Change in neurological status (see Patient changes requiring review following a head injury flowchart)
- Significant soft tissue injury
- Abnormality in NEWS score/GCS
- Hypoglycaemia

ALL PATIENTS TO BE MEDICALLY REVIEWED WITHIN 24 HOURS OF FALL

- Ensure all falls, interventions and management plans are accurately documented in the patient’s notes
- Report fall of Datix

Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5

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Appendix 11. Patient Changes Required Following a Head Injury

Patient changes requiring review following a head injury

Have any of the following happened?
- Agitation or abnormal behaviour developed
- GCS dropped by 1 point and lasted for at least 30 minutes (give greater weight to a drop of 1 point in the motor response score)
- Any drop of 3 or more points in the eye-opening or verbal response scores, or 2 or more points in the motor response score
- Severe or increasing headache developed or persistent vomiting
- New or evolving neurological symptoms or signs, such as pupil inequality or asymmetry of limb or facial movement

Yes

Is a second member of staff competent to perform observation available immediately?

No

Yes

Change confirmed?

Yes

Urgent reappraisal by supervising doctor

Change confirmed?

No

Yes

Consider immediate CT scan, re-assess patient’s clinical condition and manage appropriately

If GCS 15 not achieved after 24 hours’ observation, but CT scan normal: consider further CT imaging or MRI scanning and discuss with radiology department

No

Continue with observations according to schedule

Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5

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Appendix 12. Investigation for Clinically Important Brain Injury

Investigation for clinically important brain injury

CT imaging of the head is the primary investigation of choice.

Are any of the following present?

- GCS < 13 when first assessed in emergency department
- GCS < 15 when assessed in emergency department 2 hours after the injury
- Suspected open or depressed skull fracture
- Sign of fracture at skull base (haemotympanum, ‘panda’ eyes, cerebrospinal fluid leakage from ears or nose, Battle’s sign)
- Post-traumatic seizure
- Focal neurological deficit
- >1 episode of vomiting

▲ Amnesia of events > 30 minutes before impact

Yes

Any amnesia or loss of consciousness since the injury?

Yes

Are any of the following present?

▲ Age ≥ 65 years

- Coagulopathy (history of bleeding, clotting disorder, current treatment with warfarin)

▲ Dangerous mechanism of injury
- Pedestrian or cyclist struck by a motor vehicle
- Occupant ejected from a motor vehicle
- Fall from > 1 m or 5 stairs

Yes

Request CT scan immediately

No

No imaging required now

▲ Imaging should be carried out and results analysed within 1 hour of request being received by radiology department

▲ Imaging should be carried out within 8 hours of injury, or immediately if patient presents 8 hours or more after the injury

*If patient presents out of hours and is ≥ 65, has amnesia for events more than 30 minutes before impact or there was a dangerous mechanism of injury, it is acceptable to admit for overnight observation, with CT imaging the next morning, unless CT result is required within 1 hour because of the presence of additional clinical findings listed above.

NICE 2007
Appendix 13. Method of Moving/Assisting Patient Following a Fall

Check for Injuries prior to moving patient.

Assess patient for any injuries. If no severe injuries found continue to the next step.

Encourage patient and assist to roll on to his/her side. Place two sturdy chairs, one near patient’s head and one near their feet. Walk your hands pushing yourself up into the sitting position.

Ask patient to keep his/hers knees bent, pushing their bottom up into 4 point kneeling position. Assist patient with achieving this position.

Ask the patient to lean on the chair in front of them, bring one leg forward and put that foot flat on the floor. Curl toes of the other leg underneath.

Place a second chair behind patient then ask them to push up with their arms and legs, and once they are up, to sit down in the chair behind them. Guide them into the seat. Do not lift them.

If patient is not able to perform this then hoist should be used to assist patient off the floor. For spinal and hip fractures flat lifting equipment must be used.
## Intervention Review Post Fall

**Guide:** Designed for use by NIC/Senior Nurse and Nurse allocated to patient to review the falls prevention interventions pre and post fall.

- Complete following fall, **after is patient safe and post falls bundle completed.**
- Give completed form to Sister or deputy.

<table>
<thead>
<tr>
<th>Datix ID</th>
<th>Ward / Dept</th>
<th>Date completed</th>
<th>Witnessed by staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Pre-fall Risks

**Falls Risk Assessment Outcome**
- No risk
- At risk

**Known Risk Factors**

### Pre-Fall Prevention in place

<table>
<thead>
<tr>
<th>Bedrails</th>
<th>Assessed as</th>
<th>Required</th>
<th>Not required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footwear**
- Anti-slip socks
- Shoes/slippers
- Well-fitting and on feet
- Not used

**Patient able to follow instructions**
- Yes
- No

**Patient able to use callbell**
- Yes
- No

**Mobility aids needed**
- Yes
- No

**List:**

### Safe & Supportive Observations

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2 Care Rounds</th>
<th>Frequency</th>
<th>Level 3</th>
<th>Level 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>mins</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In your clinical judgement – does the pre-fall prevention in place meet the care needs and minimise falls risk in this individual patient with the information known prior to the fall?

- Yes
- No

If answering No, please explain why and what intervention is missing?
## Fall Review

<table>
<thead>
<tr>
<th>Exact location</th>
<th>Date &amp; Time of fall</th>
<th>Time Patient last seen</th>
<th>Environment Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there was a delay in care round intervention – why was this?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Environmental Risks

<table>
<thead>
<tr>
<th>Lighting</th>
<th>Flooring</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication – is the patient on meds that may increase the risk of falls?</td>
<td>Was this medication involved in this fall?</td>
<td>Bedrails</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Footwear</td>
<td>Anti-slip socks</td>
<td>Shoes/slippers</td>
</tr>
<tr>
<td>Did the Patient follow instructions from staff?</td>
<td>YES / NO</td>
<td>Was the Patient call-bell within reach?</td>
</tr>
<tr>
<td>Did the Patient use Mobility aids as needed?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other prevention in place</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Why did the fall occur?

### Post Fall Prevention in place

| List below any intervention different from pre-fall prevention | |
| Are fall prevention risk assessments and care plans up to date? | Yes | No |
| In your clinical judgement – does the post-fall prevention in place meet the care needs and minimise falls risk in this individual patient with the information known following this fall? | Yes | No |
| If answering No, please explain why and what intervention is missing? | |
| Confirmation that all identified falls prevention intervention are in place and that this has been discussed with the Nurse in Charge/Nurse allocated | YES / NO |

Comments:

Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients Policy V5

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<table>
<thead>
<tr>
<th>Signature</th>
<th>Role</th>
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Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients
Policy V5

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