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

V4.3

August 2015
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1. Introduction

1.1 The Royal Cornwall Hospitals Trust (RCHT) Policy for Prevention and Management of Falls, and the Safe Use of Bedrails with Adult Patients, provides staff with comprehensive, up-to-date and specific management framework to safeguard patients.

1.2 Falls and associated fractures are a major cause of morbidity and mortality, especially for older people. Patients in hospital are at particular risk of falling and injuring themselves because of intercurrent illness, general frailty, confusion and the effects of the hospital environment.

1.3 The appropriate management of falls is of the utmost importance because of its effect on the person’s physical and psychological health. Falls are often multi-factorial in origin and by undertaking a collaborative multidisciplinary approach, the risk of falling can be reduced.

1.4 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.

- NHSLA 3.5 Slips, trips & falls requires organisations to produce documentation regarding the management of patients at risk of falling, as follows:

- ‘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

3.1 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

4.1 Fall
A fall is defined as “an unexpected event when the person 'falls' to the ground from any level, this also includes falling on the stairs and onto a piece of furniture, with or without a loss of consciousness” (National Institute Clinical Excellence 2004)

4.2 Bedrail
The term bedrails is used within this policy to describe rails attached to the sides of adult beds within the hospital setting. Bedrails may also be referred to as ‘side rails’, ‘bed guards’ or ‘safety rails’.

5. Ownership and Responsibilities

5.1. Chief Executive
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. **Trust Board**

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

5.3. **Governance Committee**

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. **Trust Management Committee (TMC) – Quality & Safety**

TMC – Quality & Safety, have responsibility for setting the clinical context in which this policy will be implemented.

5.5. **Patient Falls Work Programme**

Monitoring of the work programme will occur at the RCHT Safety Thermometer Group, who will ultimately provide assurance to the Senior Nurses and Midwives Committee and TMC Quality & Safety, of effective progress with implementation. The delivery of the work programme is supported through a network of agreed professionals in the Trust.

5.6. **Divisional Managers and Directors**

Divisional Managers and Directors are 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.

5.7. **All Clinical Staff**

All Clinical staff, including temporary and agency staff, are responsible for;-

- Compliance with the policy.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training / awareness sessions.
- Take every opportunity to identify those at risk of falling, assess their needs, and undertake simple interventions and signposting within their scope of practice.
6. Standards and Practice

6.1. Falls Risk Assessment

6.1.1 Notifying those at risk is the first stage in falls prevention. A Multifactorial Falls Risk Assessment must be undertaken for all patients admitted to RCHT, present within the Risk Assessment Pack (CHA2831). Assessing for the risk of falling must include discussions with the patient and, where appropriate, carers.

6.1.2 The outcome of cognitive and delirium assessments must be taken into account when undertaking the falls risk assessment.

6.1.3 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.

6.1.4 Patients’ must be reassessed if they have fallen or if there is a change in their condition.

6.2. Individualised Falls Intervention Plan

6.2.1 Interventions for reducing the risk of a patient falling must be documented on an Individualised Multifactorial Falls Intervention Plan (CHA3395). 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, as well as individualised interventions to reduce the risk of falls associated with vision, postural changes in blood pressure, cognitive behaviour, presence of delirium, mobility, continence and the environment.

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 in the intervention plan that this information has been given.

6.2.5 Identified as high risk of falls, Pressure Pads and Sensor Alarms might be considered for a patient as part of their plan of care; 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.

6.2.6 Consideration must be given to heightened levels of safe and supportive observations when a patient has been identified as at risk of falls, such as implementing ‘care rounding’ (CHA 3061) or ‘one to one nursing,’ please see the RCHT Safe and Supportive Observation Policy for further information.
6.2.7ventions must be reassessed every 48 hours; or if the patient has fallen or there is a change in their condition.

6.3. **Bedrail Assessment and Care Plan**

6.3.1 Bedrail assessment must be undertaken for all patients where bedrails are being considered. The Trust recommends that staff use both the risk balance questions and the risk matrix tool (CHA2677) to inform their decision. The risk matrix tool helps guide a decision on the use of bed rails based on the patient’s level of orientation and mobility. It is still necessary for staff to employ professional judgement, and ensure the outcome is clearly documented on the form.

6.3.2 Where appropriate, the care plan section must be completed on the form. Each patient will be re-assessed daily to determine if there have been any changes, a new care plan must be commenced if there is a change in patients’ condition, and/or the action taken has changed.

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 Ific 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 will be assessed for potential risk using the bed rail risk assessment and unless there has been identified risk, then then bedrails will 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. Professional Roles and Responsibilities in the Prevention and Management of Falls

6.4.1II staff are responsible for;-

- Ensuring interventions agreed through the care plan are undertaken and evaluated.
- Checking for sensory deficits.
- Communication across the multi-disciplinary teams and with patients, relatives and carers, including the handover of patients who are at high risk of falls between shifts/departments.
- Referring patients to community services as appropriate.

6.4.2Medical staff are responsible for;-

- Taking a comprehensive falls history and arranging appropriate investigations and treatment such as 24 hour tapes, carotid sinus massage and tilt testing.
- Reviewing medication in a timely manner (especially sedatives, anti-psychotics, anti-hypertensives and anti-dysrhythmics).
- Considering investigation and treatment for osteoporosis.
- Considering referral to specialist falls services.

6.4.3Nursing staff are responsible for;-

- Ensuring a falls risk assessment is completed for each patient on or prior to admission.
- Ensuring a bedrails risk assessment is completed for all patients where the use of bedrails is being considered.
- Where applicable, ensuring that appropriate interventions are undertaken as per the care plan.
- Checking lying and standing blood pressure
- Evaluating daily the interventions taken to reduce the risk of falls.

6.4.4Therapists are responsible for;-

- General assessment, which will be continuous throughout the patients’ stay, to include:
• Ensuring that the necessary interventions and treatments identified are taken. This will be continuous though out the patients’ stay.
• Assessment of cognitive function where appropriate.
• Gait re-education.
• Assessment of the need for a walking aid and provision of specialist equipment.
• Advising on suitable foot wear.
• Advice to other members of the multi-disciplinary team on the best methods of patient movement and mobility.
• Assessment of home environment prior to discharge.

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 Coordinators must be notified.

6.5.2 All patient care areas will undertake an environmental audit (Appendix One) on a quarterly basis as a minimum standard. If a clinical area has more than five falls per month then a monthly audit must be carried out. The audit results will be reported to the Specialty Matron and unresolved problems reported on the divisional risk register.

6.6. Assessment and Management of Patients who Fall in Hospital

6.6.1 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 Two.

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 serious injury is visible, reported or suspected then the patient can then be assisted in getting up or assisted into bed using appropriate supervision/manual handling aids (refer to RCHT Manual Handling Policy and RCHT Medical Devices Policy).

6.6.5 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 minor injuries 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 Haemodynamiically 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 patient fall the Post Falls Checklist - Immediately Following a Fall (CHA3216) must be completed within four hours of the fall, and any recommendations identified must be actioned by the multi-disciplinary team.

6.6.9 ll patients will have a multi-disciplinary and a full medical review to ascertain the reasons for falling. The Multifactorial Falls Risk Assessment, Individualised Multifactorial Falls Intervention Plan and Bed Rail Assessment must be reviewed.

**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
- 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 arrangements 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 or 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 Three), and clinical diagnostics management (Appendix Four).

6.7.6 Coagulant 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 anti-coagulants.

6.7.7 CS 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 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 four hours
- Then 2 hourly thereafter

6.7.9 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 If the details of the fall and potential causes must be documented in the nursing and medical notes, and an 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 The incident report must include details of the time, place and activity of the patient, whether the patient is a frequent faller, has cognitive impairments, any injuries sustained; and where possible, the approximate height of the fall, and the use of bedrails when the fall has been from bed. Datix entries must also include the immediate patient assessment and management.

6.8.3 Ward managers 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 The Patient Falls Work Programme supports the identifying of trends through the Datix system, facilitating actions needed, identifying and sharing good practice.
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 undertake 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

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Assumptions of the effective implementation of the Falls Protection and Management documents present within this policy.</th>
</tr>
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<tbody>
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<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

| Lead | Deputy Director of Nursing, supported by the Lead Nurse for Quality, Safety and Innovation |

| Tool | Datix Incidents Reports |
|      | Test Your Care |
|      | Safety Thermometer |

| Frequency | The Safety Thermometer group produces a monthly report to the Senior Nurse and Midwife Committee, prepared by the Lead Nurse for Quality, Safety and Innovation on behalf of the group. |
|           | Trust Management Committee receive monthly exception reports relating to the four harm work programmes. |

| Reporting arrangements | Monitoring of the work programme will occur at the RCHT Safety Thermometer Group, who will ultimately provide assurance to the Senior Nurses and Midwives Committee and TMC Patient Safety and Quality of effective progress with implementation. |

| Acting on recommendations and Lead(s) | The Safety Thermometer Group will provide a systematic link between Operational Services and the Services supporting Patient Safety. |

| Change in practice and lessons to be shared | The Safety Thermometer Group will provide a systematic link between Operational Services and the Services supporting Patient Safety. |
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 V3.2 (9th September 2013)

10. Equality and Diversity

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.

10.1. Equality Impact Assessment

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

<table>
<thead>
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<th>Document Title</th>
<th>Policy for Prevention and Management of Falls in Hospital, and the Safe Use of Bedrails with Adult Patients</th>
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<tr>
<td>Date Issued/Approved:</td>
<td>July 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>August 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>August 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Kim O'Keefe, Deputy Director of Nursing</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253026</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>
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<tr>
<td>Target Audience</td>
<td>RCHT, PCH, CFT, KCCG</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>July 2015</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, V3.2 (9th September 2013)</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Patient Falls Work programme Links (March 2015) Trust Management Committee (Date)</td>
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<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Head of Quality, Safety and Compliance</td>
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<tr>
<td>Name and Post Title of additional signatories</td>
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<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
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<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet, Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Nursing Generic</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>Care Quality Commission;</td>
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<td></td>
<td>• Outcome 4 (Care and Welfare of People Who Use Services)</td>
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### Related Documents:

- RCHT Standards of Record Keeping
- RCHT Incident Reporting Policy
- RCHT Policy on Slips, Trips and Falls Prevention
- RCHT Health and Safety Policy on Manual Handling including Bariatric Policy
- RCHT Medical Devices and Equipment Management Policy
- RCHT Procedure for Safe and Supportive Observations in Adults

### Training Need Identified?
Yes – This is supported by the Learning and Development Team.

### Version Control Table

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<th>Summary of Changes</th>
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<td>Jul 10</td>
<td>V1.0</td>
<td>Reformat per NHSLA</td>
<td>Sandra Arnold, Matron Practice Development</td>
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<tr>
<td>Feb 11</td>
<td>V2.0</td>
<td>Amendment as per NPSA /2011/RRR001</td>
<td>Sandra Arnold, Matron Practice Development</td>
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<tr>
<td>Jul 11</td>
<td>V3.0</td>
<td>Reformat to revised RCHT document template</td>
<td>Sandra Arnold, Matron Practice Development</td>
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<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>
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<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>
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<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>
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<td>Aug 18</td>
<td>V4.3</td>
<td>Policy currently under review</td>
<td>Magda Morgan, Falls Lead</td>
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**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. Environmental Assessment for the Prevention of Patient Falls

**One + all | we care**

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Name of Assessor</th>
<th>Date</th>
<th>Designation</th>
<th>Time</th>
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<td>All chair heights are the correct height for patients?</td>
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<td></td>
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<td></td>
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<tr>
<td>All areas of the ward have effective lighting:</td>
<td>Yes</td>
<td></td>
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<tr>
<td>• Areas are bright and easy to walk through</td>
<td>No</td>
<td></td>
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<tr>
<td>• All motion sensor lights are quick to respond</td>
<td></td>
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<tr>
<td>• All bulbs are working</td>
<td></td>
<td></td>
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<tr>
<td>All call bells are within patients’ reach?</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>All patient belongings are within easy reach?</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>The layout of the ward maximise observation of all patients, i.e.</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td>position of nurse station, positioning of medical notes trolleys?</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>
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<tr>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>All bed breaks are on?</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Are all walkways clear from obstacles?</td>
<td>Yes</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Are all bathrooms and toilets clearly sign posted?</td>
<td>Yes</td>
<td></td>
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<td></td>
<td>No</td>
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</tbody>
</table>

RCHT Prevention and Management of Falls Policy
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all areas of the floor safe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Even</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Free from wear and tear</td>
<td></td>
<td></td>
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<tr>
<td>• Dry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients have got appropriate footwear?</td>
<td></td>
<td></td>
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<tr>
<td>Are all commodes in good working order?</td>
<td></td>
<td></td>
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<tr>
<td>Do all sinks have a bin adjacent to it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where Falls Prevention Equipment in use, is it in good working order and being used as per instructions?</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix 3. Immediate Assessment Following a Fall

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

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

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.

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

RCHT Prevention and Management of Falls Policy
Appendix 4. Patient Changes Requiring 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

No  

Change confirmed?

Yes  

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

No  

Continue with observations according to schedule

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
Appendix 5. 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  No

Any amnesia or loss of consciousness since the injury?

Yes  No

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  No

Request CT scan immediately  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 6. Initial Equality Impact Assessment Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy)  | (Provide brief description): RCHT Prevention and Management of Falls Policy |
| Directorate and service area: Quality and Safety | Is this a new or existing Policy? Existing |
| Name of individual completing assessment: Lorraine Maltby | Telephone: 01872 25 3050 |
| 1. Policy Aim* | To provide clear framework for all staff in assessment and management of patients to reduce the risk of falls in hospital. |
| Who is the strategy / policy / proposal / service function aimed at? | |
| 2. Policy Objectives* | 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 framework. |
• 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) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? | No |
| b) If yes, have these *groups been consulted? | |
| C). Please list any groups who have been consulted about this procedure. | |

### 7. The Impact

Please complete the following table.

Are there concerns that the policy **could** have differential impact on:

RCHT Prevention and Management of Falls Policy
<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability -</td>
<td>✓</td>
<td></td>
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<tr>
<td>Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✓</td>
<td></td>
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</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✓</td>
<td></td>
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<tr>
<td>Marriage and civil partnership</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✓</td>
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<tr>
<td>Sexual Orientation,</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Bisexual, Gay, heterosexual, Lesbian</td>
<td>✓</td>
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</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 service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No | ✓ |

9. If you are not recommending a Full Impact assessment please explain why.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
</table>

Names and signatures of members carrying out the Screening Assessment
1. Lorrie Maltby
2. Kim O’Keefe

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

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

Signed ________________

Date ________________