Prevention, reduction and management of patient falls in hospital policy

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NHS Shetland Document Development Coversheet*

Name of document	Prevention, reduction and management of patient falls in hospital policy		
Document reference number	NAPOL011	**New or Review?**	**Review**
Author	Amanda McDermott, Acting Chief Nurse (Acute & Specialist Services) (Adapted from NHS Grampian and existing NHS Shetland policies, inpatients and A+E presentations)		
Executive lead	Kathleen Carolan, Director of NMAHP		
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Proposed groups to present document to:		
Falls group	Falls MCN	
ANMAC	Operational Clinical Governance group	

Date	Version	Group	Reason	Outcome
14/4/21	0.1	ANMAC	PO	AC&R
20/4/21	0.1	Falls MCN	PO	AC&R
1/7/21	0.2	Falls Group	PI	MR
18/8/21	0.2	ANMAC	PO	MR
7/12/21	0.2	CGC	FA	A

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)
• Final Approval (FA)	• Approved (A) or Not Approved, revisions required (NARR)

Please record details of any changes made to the document in the table below

Date	Record of changes made to document
25/01/21	Policy adapted from NHS Grampian policy Prevention, Reduction and Management of Patient Falls in Hospital Policy December 2017. Policy content from NHS Shetland inpatient falls policy and A+E presentation following falls also added. Local context and governance arrangements amended.
16/07/2021	Stratify risk assessment tool in Appendix 2 replaced with the Falls Risk Assessment and Falls Prevention Care Plan. Saved as version 0.2

Contents

1. Introduction

“A fall is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground, or an object below knee level” (NICE, 2017).

All patients, of all ages, have a heightened risk of falling when admitted to hospital, either due to their past medical history, their current condition or by the very fact that they are within an unfamiliar environment.

The purpose of this policy is to ensure that all patients admitted to hospital are systematically assessed for ‘falls risk’, and effective preventative strategies are put in place to reduce the risk of an initial or further fall, whilst promoting enablement. Prevention, reduction and management of falls within hospital are complex and change according to individual circumstances, clinical specialties and clinical environments. It requires strong leadership, a will to identify those at risk, and contributing factors, individual assessment of need and access to evidence based interventions and plan of care.

The Health and Safety at Work Act 1974, requires employers to ensure the health and safety of all employees and anyone affected by their work, so far as is reasonably practicable, which means balancing the level of risk against the measures needed. This includes taking steps to control slip and trip risks.

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 multifactorial in origin and by undertaking a collaborative multidisciplinary approach, the risk of falling can be reduced. It is recognised that there is a requirement for patient safety to be balanced with the promotion of recovery, independence, with the ultimate aim of successful discharge for our patients to an appropriate setting or end of life care.

Falls and fragility fractures continue to place a significant burden upon our older population, leading to fear, pain, social isolation, loss of independence and identity. The Prevention, Reduction and Management of Patient Falls in Hospital Policy (2021) provides staff with comprehensive, up-to-date and a specific management framework to safeguard patients. The policy is specific to the prevention, reduction and management of falls within the hospital setting, management of presentations to accident and emergency post fall and should be read in conjunction with the Safe and Effective Use of Bed Rails Policy (2021) see NHS Shetland Intranet.

NHS Shetland will ensure that as per the Falls Pathway (Appendix 1):

- Every patient over 65 (or those with risk factors as defined in section 1.3) admitted is assessed using Falls Risk assessment (Appendix 2).
- Effective processes are in place for assessing patients and planning care, therefore recognising those at risk of falls
- Care which minimises the risk of falls but promotes enablement with the ultimate aim of successful discharge to an appropriate setting or end of life care
- There is a recognised, systematic approach to responding to someone who has experienced a fall (post fall bundle -Appendix 3) including reporting and the implementation of measures to reduce secondary complications

- Falls are reported accurately and promptly on the Adverse Event Management Reporting System (Datix)
- Systems, processes and policies are in place to minimise the number of falls within hospitals
- The hospital environment is safe and does not contribute to the risk of a patient falling whilst in the care of NHS Shetland
- There is a robust communication system to highlight those at risk including safety brief, referral pathways from hospital and handover information

  The organisation monitors its performance in the prevention and management of falls e.g. through speciality, division and sector level. There is a no blame culture of shared learning in relation to the prevention reduction and management of falls e.g. local, divisional and sector level governance arrangements
- Staff have the knowledge, skills, and competence in relation to the prevention reduction and management of falls

1.1. Objectives

To support the provision of safe, effective, evidence based, person centred care in the prevention, reduction and management of falls within the Gilbert Bain hospital. This policy will support the requirements of the following drivers, programmes and standards including:

- Falls and Fracture prevention strategy for Scotland 2019-2024 (Scottish Government, 2019)
- Excellence in Care, Inpatient fall measure development document (EiC, 2020)
- Scottish Patient Safety Programme (Healthcare Improvement Scotland, 2018)
- Care of Older People in Hospital Standards (Healthcare Improvement Scotland, 2015)
- Falls in Older People (National Institute for Health and Care Excellence, 2015)
- Person Centred Care Health and Care Programme (Healthcare Improvement Scotland, 2012)
- Health and Safety at Work Act (1974)

1.2. Clinical situations

This policy applies to all staff permanent and temporary including students and volunteers who work within the hospital setting in NHS Shetland.

It provides information on the expectations of the organisation, and provides key information for staff about the standards of care expected for those people within our hospitals who are identified as being at risk of experiencing a fall. It is expected that all staff will be familiar with the NHS Shetlands approach to the prevention, reduction and management of falls within hospital. The organisation is committed to supporting staff to achieve these expectations through the delivery of education and the provision of information.

1.3. Patient groups to which this document applies

This policy applies to all patients admitted to hospital who are under the care of NHS Shetland.

Patients who would be expected to be at greater risk include those with:

- History of previous falls
- Impaired mobility
- A requirement for assistance with bowel and bladder management
- Cognitive impairment
- Sensory deficit – visual and/ or auditory impairment
- Neurological deficit
- Polypharmacy
- 65 years of age and over
- 50-64 years of age who are judged by a healthcare professional to be at higher risk of falls because of an underlying condition.
- Stressed or distressed behaviour

1.4. Patient groups to which this document does not apply

While Neonates are not at risk of falling in the general sense, they are at risk of falls from cots or being dropped. Paediatric inpatients require special consideration due to normal developmental milestones. Exceptions include delayed development and underlying conditions which increase their risk of falling. These risks are considered in addition to this policy by the service.

2. Assessment and management of patients – duties and responsibilities

2.1. Interventions for all

The use of the Falls Pathway, for the prevention, reduction and management of falls.

There will be an emphasis on the following:

- The patient's bed and chair are of a suitable height
- If appropriate, a suitable walking aid is provided and within reach
- Suitable footwear is available and worn
- Glasses and/ or hearing aid is available and worn
- The call buzzer is available and the patient is able to use it appropriately
- Adequate hydration
- Suitable equipment will be provided to all patients as required

Staff should encourage the involvement of family and carers in informing care and supporting the person during their stay. There is a range of equipment to reduce the risk of patient falls, see Appendix 4 for more details.

2.2. Process of identifying those patients at risk of falls

On admission initial assessments based on professional judgement is undertaken and recorded in the Inpatient pathway document as soon as reasonably practical.

- The Falls risk assessment will be completed as soon as reasonably practical but within 24 hours of admission for all patients over 65 or those identified as potentially having increased risk of falls due to underlying conditions (please see section 1.3).
- The Falls Care Plan (appendix 2) will be initiated for any patient who is identified as being at risk of falls from the Falls Risk assessment.
- For patients 65 years or with an underlying condition that are considered through professional judgement not to be at risk of falling, this must be documented in the Inpatient pathway document.
- The patient will be reviewed by registered healthcare professional as their condition changes/ deteriorates and/ or following a fall using falls risk assessment.
- Patient falls risk should be communicated on movement to and from departments
- The Falls Risk Assessment will be completed by the parent and receiving wards at times of intra wards and/ or intra hospital transfer and during the handover between services

2.3. Process of assessment and provision of intervention

The Falls Care Plan will be implemented for any patient who is identified as being at risk of falling following the Falls Risk Assessment.

Local referral will be undertaken for a further specialist assessment of need e.g. to Pharmacy or Allied Health Professional (AHP) services. Referral for further assessment should reflect the patient's individual requirement, based upon the findings and documented in the Inpatient pathway document. The following assessments should be considered:

- Cognition
- Continence
- Cardiovascular system, including the assessment of postural hypotension
- Medicine reconciliation
- Mobility, including the assessment of strength and balance
- Fracture risk
- Hearing, vision and other sensory assessments

Referrals should be responded to within 72 hours of being received, unless identified as urgent. A MDT assessment will be carried out as soon as it is reasonably practical to ensure appropriate management and safety of the patient. Individual professionals should communicate and document the findings of their assessment (including analysis of equipment required) in patient records. Multidisciplinary professionals are responsible for the provision of evidence based interventions (including equipment) and reviewing and documenting progress against their original findings.

If a patient requires supervision to mobilise, this means when the staff member is in close proximity to the patient but no hands on. When the patient moves the staff member moves with the patient but there is no physical contact. If the patient requires assistance, the staff member would be required to have hands on the patient. When the patient moves the staff member moves with the patient and is in physical contact with the patient to influence the patients' movement. Staff should describe the actual assistance in the patient's care plan.

2.4. People who present to accident and emergency as a result of a fall or fracture

A Falls Risk Assessment should be carried out on all patients known to have fallen. It should be clearly recorded on Trak that the patient has had a fall along with the details of the assessment, so that the information can be included in correspondence to other clinicians (e.g. Consultant if the patient is admitted or intermediate care team if the patient is discharged directly from the A&E department). The referral form for the intermediate care team can be found on the intranet under departments; intermediate care team.

2.4.1. Action to be taken by A+E nurse

- If a patient is assessed as high risk of fractures and/or falls then an onward referral needs to be made so that a MDT review can be carried out.
- Send a copy of the Falls Risk Assessment results to the intermediate care team advising that a community multifactorial falls risk screening is carried out.
- Refer the patient to the Occupational Therapy team for follow up and home assessment (regardless of the Falls Risk Assessment outputs).
- Refer to the Physiotherapy team for follow up if the Falls Risk Assessment indicates so.

2.5. People who present to A+E and may be at future risk of falls

A Falls Risk Assessment should be carried out on all patients over the age of 65 years and has at least one other risk factor. These tools allow the future risk of falls and fractures to be identified, and will allow appropriate action to be taken.

The details of the risk assessments should be clearly recorded on Trak, so that the information can be included in correspondence to other clinicians (e.g. Consultant if the patient is admitted or intermediate care team if the patient is discharged directly from the A&E department).

2.5.1. Action to be taken by A+E nurse

- If a patient is assessed as high risk of fractures and/or falls then an onward referral needs to be made so that a community multifactorial falls risk screening can be carried out, the patients consent must be gained before referral.
- Refer the patient to the intermediate care team for a community multifactorial falls risk assessment (regardless of the Falls Risk Assessment outputs).

Precise and timely communication between healthcare professionals, at key times during the patient's journey is vital. It is the responsibility of all staff, including support services, to notice and report a change in a patient's condition, which may increase their risk of having a fall. Information on their risk of falls, level of observation and any special equipment and/ or interventions being used by the transferring ward must be documented.

In relation to the prevention and management of falls, engagement should be sought from patients, families and carers and included in continuous and open communication throughout a patients' hospital admission.

2.6. Management and reporting of a fall

A post fall bundle must be completed after every fall which includes first responder and nursing review, this may also require medical/AHP review. All of the details of the fall and potential causes must be documented.

2.6.1. Falls without harm

A fall without harm is an adverse event, as there was a potential to cause harm. A controlled lower to the floor could be identified as a near miss, both should be reported as such on Datix. Reviewing events without harm offers an opportunity to learn and improve.

2.6.2. Falls with harm

A fall where there is harm is required by Health and Safety legislation to be recorded and an adverse event report completed on Datix. The severity of harm recorded on Datix should be chosen from the NHS Scotland Risk Matrix which is available through the Datix report. For Moderate and above severity, such as a fracture, a minimum of a level 2 review should be commenced and appropriate actions taken and documented to reduce the likelihood of reoccurrence. The adverse event may require Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR, 2013) reporting, guidance can be given from the Health & Safety team.

If an injury is confirmed after the initial Datix report then the original Datix report must be updated to include the most recent information, this may require a review of the severity chosen and the level of review required. Where serious injury is diagnosed after reporting it is the responsibility of the SCN, their deputy or Silver command to update the Datix with the known harm and amended severity where necessary within 24 hours, this will then allow timely investigation, possible RIDDOR reporting and duty of candour considerations.

Details to be included in the adverse event report must include:

- Time, place (bay/ bed number/ area) where fall occurred
- Activity of the patient, whether the patient frequently falls
- Cognitive impairment
- Any injuries sustained; and where possible, the approximate height of the fall
- Status regarding use of bedrails/ or not when the fall has been from bed

Senior Charge Nurses or their deputies are responsible for investigating the circumstances around individual falls and taking action as appropriate. It is expected that teams will adopt an ethos of shared learning from all falls which have occurred within their area by the completion of the post fall bundle (Appendix 3) as soon as possible, but within 72 hours and the subsequent discussion within their teams and key actions are identified.

The Falls Risk Assessment and Care Plan will be reviewed and updated after every patient fall.

2.7. Staff education

NHS Shetland is committed to the development of its staff through opportunities for learning and development. It is the responsibility of the Senior Charge Nurse/ Department Manager to ensure that their staff have had access to, and completed, the training and education relevant to their duties. A range of educational resources are accessible to staff:

- The Prevention of Falls within Hospital – e-learning
- The Safe and Effective Use of Bed Rails – e-learning
- Moving and handling – e-learning
- Ward facilitated work based learning

2.8. Paediatric applications of policy

Falling is a normal part of the way a child develops – learning to walk, climb, run, jump and explore the physical environment. Fortunately, most falls are of little consequence and most children fall many times in their lives without sustaining much more than a few cuts and bruises. But some falls go beyond the resilience of a child's body, making them the fourth largest cause of unintentional injury death for children' (WHO 2008 page 101). All children are therefore a falls risk as they grow, develop co-ordination and acquire new skills, and are often unaware of their limitations. The following risk reduction plan reflects the distinction between falls that occur as natural occurrence during the child's development and falls that occur due to factors related to their hospital admission. The ward nurses and the hospital children's nurse share responsibility for identification of risks and subsequent plans.

2.8.1. Falls risk reduction plan

1. Identification and care planning for patients at risk of falls due to identifiable risk factors associated with the child's health and/ or reason for admission to hospital.
2. To maintain a safe environment and safety culture within the clinical setting to reduce injury risk to children as they develop new skills and explore their environment without awareness of danger and their limitations

2.8.2. Identification of falls risk factors in paediatrics

Falls risk assessment for paediatric patients should include;

1. Mobility
2. Mental State
3. Toileting
4. Medication
5. Other – including history of falls

The individual's ability to maintain a safe environment mobilise and use the bathroom should all be assessed. Assessment of patient's medications occurs at admission through completion of the standard admission documentation. Staff should be aware of risk factors associated with new medications that are prescribed during the patient's admission checking the British National Formulary (BNF) as part of administration process. Nursing staff assess the patient's mental

state through review of the medical history on admission document. Ongoing assessment of the child's mental state is captured through Alert Vocal Pain Unresponsive (AVPU) assessment as part of Paediatric Early Warning Score (PEWS) or the use of the Glasgow Coma Scale (GCS) where appropriate.

Nursing professional judgement should be used to consider the patients risk of falls on admission and if there are any changes in the patient's condition or treatment plan that may increase this risk.

2.8.3. Promoting falls risk reduction in hospital and at home

Staff within wards and the Paediatric team should promote strategies to reduce falls and injuries that will occur as children begin to mobilise and explore their environment without awareness of danger and their limitations.

Standard safety measures should be put place for all patients regardless of identified risk, these include:

- Patients are nursed in an appropriate bed and bed rails used in accordance with NHS Shetland policy: Safe Use of Bed Rails
- Orientate all patients, parents/ carers to room and ward
- Keep beds in low position with brakes on and bed ends in place
- Appropriate non slip footwear for ambulating patients
- Nurse call within reach, educate patients and families on its functionality
- Maintain adequate lighting in child's room; low level lighting at night
- Keep floors clear of clutter including equipment and toys
- Secure and supervise all children with a safety belt or harness in wheelchairs,
- highchairs, strollers, infant seats and any specialist seating

  Children on trolleys are always under the immediate and direct supervision of a staff member or a caregiver
- Assist unsteady patients with ambulation
- Place necessary items a patient may need within reach (drinking water, phone, etc)

  Patients who have received sedation or general anaesthetic may be unsteady and require supervision

  Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes)
- Parents/ carers are encouraged to adhere to the above safety measures at all times.

2.8.4. Maternity Unit

While babies within the maternity unit are not at risk of falling in the general sense, they are at risk of falls from cots or being dropped. Please refer to the Management of new-borns who fall or are dropped in hospital policy.

2.9. Roles and responsibilities

2.9.1. All staff

All staff are responsible for:

- Being aware of the Prevention, Reduction and Management of Patient Falls in Hospital Policy and adhere to the systems and strategies within this document
- Maintaining a safe environment, adopting safe systems of working, taking proactive measures to prevent and reduce the risk of falls and adverse events occurring
- Reporting falls/ near misses on Datix, and considering if the event is RIDDOR reportable
- Ensuring that there is learning from all falls, and ensuring that this learning is shared
- Completing and complying with the organisational documentation in the prevention and management of falls
- Ensuring that a person centred approach is applied, and that there is communication regarding prevention, reduction and management of falls with patients and families, including the provision of leaflets
- Evidencing their communication with patients, families and carers through documenting in the nursing documentation
- Ensuring patients receive care from the relevant member of the multidisciplinary team, with interventions based upon their clinical judgement and expertise, dependant on the patients presenting and current condition
- Identifying potential slips, trips and falls hazards within their area of responsibility and the precautions required to reduce the identified risk, ensuring that the equipment is provided to support the necessary measures
- Accessing the educational resources available in order to update their knowledge and skills
- Ensuring assessments are completed within agreed timescales, following a fall and/ or as the patient's condition changes
- Adhering to the Safe Use of Bed Rails Policy (2021) including bed rail risk assessment, at all times
- Taking reasonable care of their own safety and that of others who may be affected by their actions
- Making necessary referrals for a multidisciplinary team intervention based upon their professional judgement of the patient's current presenting condition
- Continually reviewing a patient's condition whilst considering the need for referral/re-referral to AHPs and updating Falls Risk Assessment and Falls Care Plan accordingly
- Contribute to the process of understanding the cause of a fall e.g. rapid root cause analysis
- Providing essential care for patients who have experienced a fall

2.9.2. Director of NMAHP

Has the overall accountability and responsibility for the implementation and review of this policy to ensure that:

- Systems and processes are in place to reduce the risk of slips, trips and falls
- All staff are aware of the policy and actions to be taken to prevent and reduce falls
- Service users, volunteers and contractors are made aware of the policy
- Patient safety and quality of care is being delivered to all patients by an educated and skilled workforce. This will be achieved through staff education and training and the safe use or purchase of appropriate equipment
- Has overall responsibility for Health and Safety.
- Ensuring that their area(s) of responsibility adhere to the policy and implement robust processes and systems
- Ensuring patient safety and quality of care is being delivered to all patients by an educated and skilled workforce. This will be achieved through staff education and training and the safe use or purchase of appropriate equipment

2.9.3. Chief Nurse Acute and Specialist Services/Chief Midwife

- Ensuring that their area(s) of responsibility adhere to the policy and implement robust processes and systems
- Measuring adherence to the policy for Prevention, Reduction and Management of Patient Falls in Hospital through assurance systems
- Ensuring patient safety and quality of care is being delivered to all patients by an educated and skilled workforce
- Enabling capacity within their teams to update staff's knowledge and training

2.9.4. Senior Charge Nurses/ Senior Charge Midwives/ Team Leaders

Senior Charge Nurses/ Senior Charge Midwives/ Team Leaders are responsible for:

- Identifying potential slips, trips, falls hazards within their area of responsibility and identifying the precautions required to reduce the identified risk, ensuring that the necessary equipment is provided to support the necessary measures
- Ensuring that the environment is safe and that all issues which contribute to the risk of falls are reported immediately, with warning notices clearly displayed e.g. wet floors
- Ensuring that all staff are suitably trained to reduce the risk of falls
- Monitoring compliance with the recommendations set out within this policy through care assurance processes
- Making available information regarding the prevention, reduction and management of falls to patients, families and carers, and be prepared to discuss any concerns
- Ensuring adequate levels and maintenance of equipment that assists in falls management and reduction, for example falls sensor pads.

- Ensure departmental membership of the falls group and falls prevention managed clinical network.

2.9.5. Registered Nurses

- Ensure training is up to date, where additional training is required this is highlighted to their manager.
- Ensure risk assessments, care plan and onwards referrals are completed within agreed policy timeframes, including the patient and their family/carers where indicated.
- Health care support workers are supported by registered nurses to achieve the aims of prevention, reduction and management of falls in hospital.
- Ensure all falls are reported on Datix as outlined in section 2.6

2.9.6. Health and Safety Team

The Health and Safety Team are responsible for:

- Supporting and advising the Director of NMHAP in minimising risk to the organisation
- Ensuring robust risk assessments in place, which can be utilised by clinical teams with their ongoing support
- Supporting clinical teams in undertaking root cause analysis

Appendix 1 – Falls Pathway

<table>
<tr><td>ADMISSION</td><td colspan="5">For ALL patients throughout their stay, ensure the following at ALL times;
Suitable footwear is worn
The call buzzer is available and within reach
If appropriate, a suitable walking aid is provided and within reach.
If appropriate, glasses and hearing aids are available and worn.</td></tr>
<tr><td rowspan="2">IDENTIFY</td><td colspan="5">Complete Falls Risk assessment as soon as possible but within 24 hours for those over 65 or those with risk factors as defined in section 1.3.</td></tr>
<tr><td colspan="3">Falls risk identified?
Complete falls care plan.</td><td colspan="2">No falls risk identified at this time?
Continue to observe and monitor.
Reassess if the patient’s condition changes or if the patient falls.</td></tr>
<tr><td rowspan="2">ASSESS</td><td colspan="5">Falls Care Plan</td></tr>
<tr><td>Cognitive impairment</td><td>Bladder/Bowel assessment</td><td>Postural hypotension/ syncope</td><td>Medication</td><td>Others-History of falls, strength, balance, risk of fracture, seizures etc</td></tr>
<tr><td>ACT</td><td>4AT.
Time Bundle.
Getting to know me.
Patient placement.
1:1 supervision</td><td>Exclude and treat urinary tract infection.
Relive urinary retention.
Minimise the impact of frequency or urgency.
Exclude and treat constipation</td><td>Monitor lying & standing blood pressure.
ECG.
Ensure adequate fluid intake.
Review medication.</td><td>Medication review and plan.</td><td>Consider:
Physio
OT
Strength and balance training
DEXA scan
Assessment of vision
Podiatry
Review environment
Professional judgement to be used at all times</td></tr>
<tr><td rowspan="2">MONITOR</td><td colspan="5">Communicate specific contributing factors and management plan at safety briefs including bed rail decisions.</td></tr>
<tr><td colspan="5">Review as patient’s condition changes- using falls risk assessment and falls care plan</td></tr>
<tr><td>DISCHARGE</td><td colspan="5">On patients transfer/discharge, falls specific interventions are communicated in the ward handover.
Onwards referrals for further assessment and interventions are made to community services using the local falls pathway.</td></tr>
</table>

Appendix 2 – Falls Risk Assessment and Falls Prevention Care Plan

Surname: First name: Hospital number: NHS number: DOB:	Affix patient label here

Falls Risk Assessment and Falls Prevention Care Plan

Falls risk assessment & care plan to be fully completed on all patients aged 65 years & over, or those patients whose clinical condition increases their risk of falling or any other patient considered at risk of a fall during this admission. The assessment of falls risks must be multi-factorial - to identify those factors which may increase a patient's risk of falling.

Falls Risk Assessment	Yes	No	Action
Part A (increased risk of falls)			If yes to any question ensure **ESSENTIAL** bundle of interventions implemented
Does the patient's clinical condition increase the risks of falling?			
Is the patient known to have a dementia?			
Has the patient developed delirium or become acutely confused?			
Does the patient have poor balance?			
Does the patient have an impaired gait?			
Does the patient usually use walking aids?			
Does the patient have poor vision?			
Is the patient on any medications associated with an increased risk of falling?			
PART B (serious harm from injury risk)			If patient has risk factors from **PART A and B** then implement **ESSENTIAL** AND **CONSIDER HIGH RISK** bundle
Is the patient on anti-coagulants or do they have a clotting impairment?			
Is the patient on treatment for osteoporosis or known to have a previous fragility fracture?			
PART C (History of falls)			Implement **ESSENTIAL AND CONSIDER HIGH RISK** bundle
Has the patient fallen in the past 12 months?			
Does the patient have a fear of falling?			

Risk Assessment Sign Off	
Signature of Registered Nurse	
Print name of Registered Nurse	
Date and time of assessment	

To record completed Interventions sign, date and time each intervention.

Essential Bundle of Interventions	Sign	Date	Time	Variances
Minimum of 2 hourly comfort rounding				
Record lying and standing blood pressure				
Assess for any continence issues especially urinary frequency.				
Ensure manual handling assessment and care plan are completed and accurate				
Ensure bedrail assessment completed				
Ensure any walking aids that the patient has been assessed to use are available and within reach				Document aids being used here
Ensure patient has appropriate footwear. If not available provide non slip socks.				Document footwear type here
Refer to physiotherapist for mobility and gait assessment				
Request a review of any medicines that are associated with an increased risk of falling or harm from falling.				
Provide patient and/or carer with falls prevention in hospital advice leaflet.				
Consider chair/bed sensor alarms / Check equipment in working order and correctly positioned if in use				
High Risk Bundle of interventions (assess if appropriate to use for the patient if not appropriate provide rationale in variances)	**Sign**	**Date**	**Time**	**Variances**
Increase comfort rounding to 1 hourly				
Nurse patient in observable bed space near to the nurses station				
Chair/bed sensor alarms in place Check equipment in working order and correctly positioned				
Low profile bed in place Check in working order and that the bed is used in its lowest position				
Consider 1:1 care				

Record of Care Plan Review (Every 3 days or if patient falls or condition changes)					
Date/Time					
Is this a review post fall? (yes or no)					
RN Signature					
RN Print Name					

Appendix 3 – Post falls bundle

Bundle measures		Outcome	Sign, date and time
1	Look for signs and symptoms of fracture or potential spinal injury before patient is moved.		
2	Appropriate manual handling methods for patients with signs and symptoms of fracture or potential for spinal injury.		
3	Record neurological observations for all patients where head injury has occurred or cannot be excluded (e.g. un-witnessed falls) based on local guidance.		
4	Adhere to agreed timescales for medical examination following a fall, as per local policy (within 24 hours).		
5	Conduct a post fall review/rapid root cause analysis (to learn how further falls can be prevented for the patient and annotate during report of incident for wider learning).	**Please tick the appropriate box:** 6. Lighting condition? Dark ☐ Night light ☐ Day light ☐ 7. Appropriate footwear worn? Yes ☐ No ☐ 8. Were bed rails in use? Yes ☐ No ☐ 9. Medication review undertaken? Yes ☐ No ☐ 10. Record any other contributing factors:	
6	Complete Datix and consider if RIDDOR reportable.		
7	Consider onward referral to Multi-Disciplinary Team.		

Appendix 4 – Falls management equipment

NHS Shetland uses a range of equipment to reduce the risk of patient falls. The selection, provision, access and use of all such equipment is subject to individual patient assessment by a range of healthcare professionals. Assessment starts from admission into the healthcare environment and throughout the patient's journey.

Equipment is subject to Health and Safety Regulations which includes the Lifting Operations Lifting Equipment Regulations 1998 (LOLER) and the Provision and Use of Work Equipment Regulations 1998 (PUWER).

NHS Shetland has the following equipment in place, staff must be trained in the use of the equipment and comply with the manufacturer's instructions:

Slipper Socks

The provision of slipper socks is for single patient use only. They are not a substitute for well-fitting slippers or shoes and so should only be used as an interim measure. These are available via PECOS order in various sizes.

Beds

A range of low level beds are available across NHS Shetland. These have been allocated through a strategic assessment of need for patients in a high risk category for falls. Estates team are responsible for statutory maintenance and repair of these beds.

Bedside Fall Safety Mats (crash mat)

An individual patient needs assessment is required for the use of bedside fall safety mats. Such items are held in ward locations that have the highest potential need. Responsibility for safe storage, condition of equipment, cleaning and safe use with a patient, lies with the manager/ senior nurse on location.

Falls Pressure Monitoring Systems

An individual patient needs assessment is required to identify a requirement for Falls Pressure Monitoring Systems. Such systems are located in ward areas that have the highest potential need. Responsibility for safe storage, pre use safety checks and cleaning of the equipment is with the manager/ senior nurse on location. All staff using the equipment must have had appropriate training prior to use.

The provision of walking aids is for single patient use only.

Most patients or their carers will be able to inform the ward of the correct walking aid to issue. If there are concerns regarding the suitability or safety of the patient and/ or the walking aid a referral can be made to the physiotherapist.

Patient Lifting Equipment and Slings

The management of a fall may require the use of patient lifting equipment (passive lifter / full body hoist) and an appropriately sized compatible sling (loop or clip system) to safely lift the patient from the floor to a suitable surface. Patient lifting equipment is found in all wards across NHS Shetland. Ward staff are responsible for ensuring that all equipment safety checks are performed prior to use. If the hoist is out with its annual statutory maintenance and certification check (LOLER), it should be removed from service and reported appropriately.