Patient Falls Prevention Policy

1. Indications

1.1 Background

Patient Falls are one of the top reported patient safety incidents reported in this Trust each month and this reflects the national picture.

The definition of a fall is an

''Unexpected event in which a person comes to the ground or other lower level with or without loss of consciousness"

(World Health Organisation/ Lamb 2005)

The National Institute for Health and Care Excellence (NICE) published a new Quality Standard in March 2015 which highlights that falls and fall-related injuries are a common and serious problem for older people, particularly those who have underlying pathologies or conditions. An in addition NICE state that falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged 75 and older in the UK.

The human cost of falling includes pain, distress, injury, loss of confidence, loss of independence and occasionally can be fatal. Falls also affect the carers and families of those who fall and have a significant financial impact on the NHS each year.

Due to the nature of the multifactorial causes of falls, they can never be eliminated, but robust assessment and preventative measures can reduce both the consequence and likelihood of falls.

1.2 Aim/purpose

To ensure appropriate identification, assessment and care of all patients at risk of falling thus decreasing the incidence of falls and improving patient safety.

To ensure the appropriate assessment and management of patients following falls.

This policy must be read in conjunction with the Slips Trips and Falls Policy (non patient) which is available via the Trust's Intranet. It outlines general preventative measures applicable to all areas including housekeeping, maintenance, health and safety legislation/responsibilities and how to conduct a general risk assessment.

1.3 Patient/client group

All in-patients over the age of 16 who are being cared for in an adult ward

1.4 Exceptions/ contraindications

Whilst the risk of falls to persons working or visiting Salisbury District Hospital is acknowledged, this policy relates to the management of the falls risk of in-patients. For guidance relating to managing the risks of persons working or visiting the hospital site, please refer to the Slips, Trips and Falls Policy (Non Patient) which is available on the Trust's intranet.

1.5 Options

The approved assessment documentation for the risk of falls and use of bedrails described in this policy must be used for all adult in-patients. This documentation can be obtained from the following sources:

- included in the generic Trust nursing assessment documentation
- incorporated into some care pathways where appropriate / possible
- as appendices to this policy

2. Clinical Management

2.1 Staff & equipment

2.1.1 Staff Responsibilities:

Patient Falls Group:

The Trust has a Patient Falls Group, which is multi-professional and follows an agreed action plan. The action plan is reviewed at each meeting and new items added as required. The group reviews themes and trends relating to patient falls recorded via Datixweb, (the Trust's electronic incident reporting and management system) and aggregate Root Cause Analysis reports from falls which result in serious harm. The group currently meets every other month and reports to the Trust's Clinical Risk Group quarterly.

Medical Staff:

Medical Staff are responsible for reviewing patients who have fallen in a timely manner Refer to Appendix 3: Management of the collapsed / fallen person flowchart. Immediate review must occur for patients identified with serious or potentially life threatening injuries or within 1 hour for head injuries with normal GCS/ patients on anticoagulants, when pain with suspected injury including fracture is present or an injury has occurred that requires medical treatment. Patients with no obvious injury or who have minor cuts or bruising and have stable observations should be reviewed within 12 hours for a routine post fall examination. Reviews and assessments must be documented in the patient's healthcare record. Medical staff should also explore potential physiological and pharmacological reasons for the fall, but unless immediate action is required, this can be carried out as part of the next routine review by the patient's own team. If there is a patient who is at a high risk of falls on discharge, and has not had a recent admission under a Care of the Elderly Consultant, the risk of falls should also be included on the discharge letter to the GP to ensure the risk is highlighted to them and enable appropriate follow up arrangements to be made once discharged.

Nursing Staff:

Nursing Staff are responsible for ensuring a Falls Risk Assessment (Appendix 1) is undertaken on each patient within 6 hours of admission to a ward, within 24 hours of transfer to another clinical area or immediately after a fall (except where the patients clinical condition, due to injuries sustained, takes priority where it should be completed as soon as possible and within 6 hours). It should be repeated following a change in clinical condition but otherwise a minimum of weekly. The outcome of the assessment must be documented in the patient's medical records, the appropriate falls prevention measures implemented (relevant to their identified level of risk) and the information shared with the patient and their family. It must be noted that the falls assessment is only a tool to guide staff and where staff are concerned about a patient, they should use their professional judgement and take action to minimise the risk of falling, regardless of the risk level identified by the tool. In the event a patient needs to be transferred to another ward, any information regarding the patient's history of falls, their falls risk and prevention measures in place/required, must be handed over to the receiving ward. Nursing staff must ensure patients who have fallen receive a medical review within a timely manner (refer to Appendix 3: Management of the collapsed / fallen person flowchart).

Falls prevention measures that can help reduce falls include:

- Use of measures identified in the falls assessment within the nursing and therapy integrated assessment record.
- Consider if high/extreme risk patients can be charted into a bay to make observation of these patients easier.
- Ask the patient what side of the bed they get out of at home and ensure aids, lockers and footwear etc. are kept on this side.
- Ensure patients have appropriate footwear (even if not mobile at the time). Provide hospital footwear if not.
- Speak to the patient and family to identify key information about the patient's mobility/falls history to help tailor their care.
- Consider use of sensor mats for patients with delirium.

Nursing Staff are also responsible for ensuring a Bedrails Assessment (Appendix 2) is undertaken on each patient within 6 hours of admission to a ward, within 24 hours of transfer to another clinical area or immediately after a fall (except where the patients clinical condition, due to injuries sustained, takes

priority where it should be completed as soon as possible and within 6 hours). It should be repeated following a change in clinical condition but otherwise a minimum of weekly. The outcome of the assessment must be documented in the patient's medical records and a clinical judgement made as to the most appropriate course of action to take in view of the assessment outcome. If a patient or their relative/carer independently requests the use of bedrails where they have not previously been identified or considered, a full assessment must be undertaken prior to a decision being made. If bedrails are identified as not being appropriate for the patient, the rationale behind this decision should be explained to the patient and their relative/carer and an alternative plan explored and agreed which must be documented in the healthcare record.

Departmental/Ward Managers

Departmental/Ward Managers are responsible for ensuring that all staff within their areas are familiar with this policy and complete the required documentation. They should ensure all staff have attended the Trust Induction programme (Health and Safety session) for generic advice relating to the prevention and management of slips, trips and falls. Their staff must also be aware of the specific care needs for their group of patients and where to obtain further advice if required. Managers should provide appropriate support to new staff until they are confident they can fulfil the requirements laid out in this policy. Where areas have a high number of patients at risk of falling, a departmental risk assessment should be completed (as per the Trust Risk Management Policy and Procedure) by the Manager of that area. A risk assessment should also be undertaken for areas where patients have the potential to fall from height (e.g. upper floor windows etc.) and appropriate measures to reduce these risks must be made.

All staff

All staff are responsible for the completion of Incident Reports via Datixweb, the Trust's electronic incident management system. The reports should give details of circumstances surrounding a fall, injuries sustained and any immediate action taken. Departmental / Ward Managers are responsible for investigating the fall and updating Datixweb with the incident outcome, medical teams opinion where appropriate, results of investigations and patient's current condition/status. The actions put in place to reduce the risk of further falls must also be stated. Any falls resulting in serious harm, for example head injury or fracture, must be escalated to the Risk Management Team as soon as possible and the Directorate Senior Nurse for that ward or department informed.

Pharmacy staff

Pharmacy staff are responsible for highlighting to medical teams any medicines prescribed for the patient which increase their risk of falling and for providing advice on alternative medicines.

Therapy staff

Therapy staff are responsible for working alongside clinical teams, patients and carers, if referred, to put into place treatment programmes to increase functional ability and minimise the risk of falls both whilst in hospital and following discharge. Therapy staff must complete appropriate assessment documentation if equipment is required to facilitate discharge to ensure it is available and discharge is safe. Referral to the community services may also be initiated where appropriate.

Housekeeping staff

Housekeeping staff are responsible for assisting in reducing the risk of falls by ensuring a high standard of cleanliness in all patient areas and ensuring appropriate Health and Safety guidance is followed relating to equipment used, signage etc.

Patients, their family and carers

The prevention of falls requires co-operation from the patient (and their family / carers where applicable) and their responsibilities are outlined below:

Patients and carers are responsible for highlighting to clinical staff any factors that may increase the risk of falling, participate in treatment plans prescribed or suggested and follow advice given to reduce their risk of falling both whilst in hospital and following discharge. Patients should also be informed of the increased risk of falling that occurs if they do not adhere to the action plan implemented following the completion of falls assessment.

Patients and carers are also responsible for actively participating in the discussion surrounding the use of bedrails and obtaining consent for their use.

2.1.2: Equipment:

Bedrails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of a bed. Bedrails will not prevent a patient from leaving their bed and falling elsewhere and should not be used for this purpose, however patients who fall from a bed without bedrails are more likely to be injured (NPSA 2007). Bedrails are not suitable for all patients and the risk of injury or entrapment from the bedrails must be assessed alongside the need for using them. The assessment documentation in Appendix 2 is the approved documentation for this Trust. Bedrails are not intended as a moving and handling aid. Padded bed rail covers are available to order by wards for their own use via the Oracle system.

Beds should be left in the lowest possible level when the patient is alone and only raised to allow staff to deliver care without compromising manual handling techniques. The Trust is undertaking a bed replacement project and therefore there are some older style beds are still in use which only lower to 16 inches from the floor. Should your patient require a lower level bed, contact Medical Device Management Services (MDMS) on extension 2872 or Bleep 1131 who can arrange one for you. MDMS can also access 'ultra-low' beds which lower to 6 inches from the floor and are suitable for patients who are a very high risk of falls from a bed. In addition, crash mats are available to order by wards for their own use via the Oracle system.

Mattresses will have an impact on the risk of falls for a patient. Pressure relieving mattresses are often more difficult for patients to stand unaided from and may also raise the bed height. Mattress overlay systems reduce the effectiveness of standard bedrails and mattress systems which replace the mattress should be requested rather than overlays. All mattresses can be requested from MDMS via extension 2872 or Bleep 1131. Further advice regarding pressure relieving systems can be sought from the Tissue Viability Service.

Movement Sensor Alarms are available for patients who are unsafe to mobilise without assistance but lack insight into their own safety so tend to attempt to mobilise without calling for help from staff. Some wards keep them as part of their usual stock equipment; other areas can access them from the Medical Equipment Loan Library. Please contact Medical Devices Management Services (MDMS) on extension 2872 or Bleep 1131 during normal working hours.

Patient Footwear must be well fitting and supportive with a good non-slip sole. Staff should ensure all patients are aware of the risks of mobilising in socks / stockings. Where a patient is admitted without appropriate footwear or slippers their carers should be asked to provide suitable footwear without delay as lack of footwear can delay the rehabilitation of patients. The Trust is able to provide some temporary footwear with non slip soles for short term use which wards and departments can order via Oracle. Please note that single use foam slippers should not be used.

Walking aids should be checked for wear & tear on a regular basis by all staff, including the ferrules on the base of walking sticks / crutches / gutter frames etc. Therapy staff should ensure that the equipment they give to patients is suitable for their requirements & fit for use.

2.2 Method/procedure

Minimum requirements are that falls and bedrails risk assessments must be completed on each patient within 6 hours of admission, within 24 hours of transfer to a new clinical area and immediately after a fall (except where the patients clinical condition, due to injuries sustained, takes priority where it should be completed as soon as possible and within 6 hours). They should be repeated following a change in clinical condition but routinely a minimum of weekly. It is acknowledged that patients may need to be reviewed more frequently than this where there is an obvious change in the patient's condition. For example, an alert, independent patient admitted for planned surgery will have an altered level of consciousness and mobility on return from theatre, even though this is a temporary alteration, and their risk assessment should be reviewed accordingly. Some patients may have fluctuating levels of confusion or compliance and again, their assessment should take this into account and any preventative interventions, for example the use of bedrails, adapted with corresponding frequency. Some patients may be safe to have bedrails raised during the day, but not be safe to be left with them raised at night where there will be less activity on the ward to observe them.

2.3 Potential complications / Risk Management

2.3.1 Bedrails:

All bedrails in use in this Trust comply with MHRA advice. Standard Trust beds are supplied with bedrails permanently attached, however older style beds there are some beds in use which have removable bedrails Should a patient require bedrails where there are none, they may be obtained

from ward stores or MDMS via extension 2872 or Bleep 1131. Please be aware that there is a known risk of entrapment and injury from inappropriate use of and/or ill-fitting bedrails. If a patient is found with injury from bedrail use or where there is increased likelihood of injury or entrapment (e.g. Limbs through the bedrails) immediate changes should be made to the plan of care which could include obtaining padded bedrail protectors or deciding not to use the bedrails. Where harm has occurred this must be reported as a patient safety incident via Datixweb, electronic incident reporting system, as per the Trust Adverse Events Reporting Policy (which is available via the intranet).

Patients who have been seen to climb (or attempt to climb) over the bedrails will have a significant risk of falling from an increased height and the appropriateness of bedrail use must be immediately re-assessed. Their use would generally not be advised, however it is not the purpose of this policy to provide strict guidance as each patient has individual needs and their risks must be balanced against these needs.

2.3.2 Patients under the influence of alcohol

Drinking alcohol can lead to loss of co-ordination and exaggerate the effects of some medicines. As levels of alcohol consumption increase so does the associated risk of illness, accident or injury. This can significantly increase the risk of a fall, particularly in older people.

Attention should be placed on identifying the extent of alcohol use among people presenting to the Trust as part of the initial nursing falls assessment.

Previous research data on patients aged over 65 who present with falls suggests that over one third drink excessively (White et al 2002, Bell et al 2000).

Not only should be consideration be given to those presenting with a history of falls, but those who may be under 65 and are at risk of falls due to their detoxification programme or alcohol excess prior to admission to hospital. Support can be provided in the guidance for in order for the appropriate management of these patients to prevent mortality and morbidity.

2.3.3 Consent issues regarding use of equipment / falls prevention measures:

The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and, after discussion; the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making'; the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge. For more detailed information please refer to the Trust's Consent to Examination or Treatment Policy (which is available via ICID).

Where an adult patient lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, no-one else can give consent on their behalf unless they hold a registered Lasting Power of Attorney for Personal Welfare, or they are a Deputy appointed by the Court, with authority extending to healthcare decisions under the Mental Capacity Act 2005. The Act does however require that there is consultation with those closely involved with the patient in order to determine what might be in their best interests.

2.3.4: Reporting of safety incidents relating to patient falls:

All falls must be recorded in the patient's medical record. Falls should also be reported via Datixweb, the Trusts electronic incident management system, as per the Trust's Adverse Events Reporting Policy which is available via the Trust's intranet. The investigation section should clearly state any injuries sustained, any ongoing treatment required and all the actions being taken to minimise the risk of further falling. Where harm graded moderate or above has occurred, the incident report should also include details given to the patient and/or their family/carers as part of the Trusts commitment to fulfil its Duty of Candour requirements. See Duty of Candour and Being Open Policy available via the Trust's intranet for full details.

Incidents where serious harm has occurred as a result of a patient fall are reportable externally to the Clinical Commissioning Group, therefore it is important that any fall resulting in serious harm (i.e.

serious head injury or fracture requiring surgical repair) is escalated to the Directorate Senior Nurse and Risk Management Team as soon as possible to ensure action is taken without delay. This allows us, not only to ensure staff involved have sufficient support and guidance to deal with what can often be a complex situation, but also to meet our contractual requirements. See the Serious Incidents Requiring Investigation Policy available via the Trust Intranet for further details.

The Trust Patient Safety Facilitator is responsible for co-ordinating the investigation when serious harm has occurred as a result of a fall. Although the staff in the area concerned will be responsible for investigating the fall and liaising with the patient and their family/carers, the Patient Safety Facilitator will support them in completing the investigation and identifying learning points and any recommendations.

It is acknowledged, that some patients, due to their clinical condition, have the potential to suffer repeated minor falls or loss of balance. It is important that all their falls are documented in the healthcare record, and reported via Datixweb, the Trust's electronic incident management system. It is vital that steps are taken to minimise the potential for harm from future falls and that these steps are documented in the healthcare record. The patient and their family should be involved in planning the falls prevention strategies employed both whilst as an inpatient and to ensure preparation is in place for a safe discharge.

2.4 After care

If a fall occurs, the patient should be checked for any signs of injury before being moved. The nurse in charge of that area should be informed of the fall and Medical staff should be called to assess any patient who is thought to have suffered a significant injury, before they are moved. Staff may find it useful to display the Management of the fallen/collapsed person flowchart (appendix 3) in their area for ease of reference.

Patients who have not sustained injury and are able to stand themselves should be encouraged to do so. Appropriate hoists or the HoverJack system should be used for those unable to stand. Patients who have hit their head, or have an unwitnessed fall where hitting their head cannot be excluded, must be considered as sustaining a head injury until proven otherwise. Neurological observations must be recorded as per the guidance on the neurological observations chart, and escalated as required, please see the Neurological Observations and Escalation Policy (available via ICID) for more information.

The guidance on the Trust chart follows the recommendations set out in the NICE Guideline CG 176 (2014). Where there are concerns regarding a patients clinical status following a fall, especially where a head injury cannot be excluded and/or the patient is on any anticoagulation medication treatment or prophylactic dose, a CT scan should be undertaken without delay in order to obtain a definitive diagnosis and facilitate prompt specialist referral if required. Pre-existing confusion does not exclude new pathology and a low threshold for CT head scan is recommended. NICE CG 176 also offers guidance on investigations, in particular indications for CT scans, for people with head injuries.

The patient's relative / carer should be informed of the fall in a timely manner and must be informed of any fall resulting in harm graded moderate or above to meet the Duty of Candour requirements.

Both the falls risk assessment and the bed rails assessment should be repeated immediately following a fall (except where the patients clinical condition, due to injuries sustained, takes priority where it should be completed as soon as possible and within 6 hours). Any changes in management indicated by the reviewed assessments should be undertaken.

All patient falls need to be recorded in the healthcare record and an electronic incident report completed via Datixweb, electronic incident reporting system as per the Trust Adverse Events Reporting Policy

3. Patient Information

There are two patient information leaflets available (via ICID). One is written for inpatients and one is written for outpatients. Both are suitable to be given to patients and their carers, and staff should be encouraged to do so, to ensure the patients and their families understand the risks of falling and any measures we, and they, can take to reduce these risks.

Inpatients who are assessed as high risk of falling must be given an inpatient leaflet and discussions with themselves and/or their family/carers held to highlight our findings and explain what steps we are taking to keep the patient safe. It is worth emphasising however, that despite best intentions we cannot guarantee that the patient will not fall whilst under our care and encourage open discussions and updates about the success of any prevention measures introduced.

4. Audit

4.1 Standards

Some elements are captured as part of other Trust audits and the learning is fed back into the Patient Falls Group:

- The annual Nursing Documentation Audit captures assessment and re-assessment of both falls and bedrails. The results of this audit are shared with the Trusts Patient Safety Facilitator who chairs the Trusts Patient Falls Group.
- Safety measures such as the completion and accuracy of falls assessments as well as compliance with intentional rounding are captured as part of the Trusts commitments to participate in the national 'Sign up to Safety' campaign. The Trust's Patient Safety Facilitator leads on this workstream and the findings are shared with the Trusts Patient Falls Group.

4.2 Audit Indicators

All patients must have a falls risk assessment completed (and documented) within 6 hours of admission to hospital and within 24 hours of an internal ward transfer	100%	None
The falls risk must be re-assessed a minimum of weekly	100%	None
The falls risk must be re-assessed immediately following a fall	100%	Where the patients clinical condition, due to injuries sustained, takes priority it should be completed as soon as possible and within 6 hours
Appropriate falls prevention measures are implemented as per the outcome of the assessment	100%	Where there is clinical rationale, clearly documented.
All patients must have a bed rail assessment completed (and documented) within 6 hours of admission to hospital and within 24 hours of an internal ward transfer	100%	None
The use of bedrails must be re-assessed a minimum of weekly	100%	None
The use of bed rails must be re-assessed immediately following a fall and/or any attempt by a patient to climb over the bed rails.	100%	Where the patients clinical condition, due to injuries sustained, takes priority it should be completed as soon as possible and within 6 hours
Following assessment for the use of bedrails, appropriate action is taken	100%	Where there is clinical rationale, clearly documented
Each fall has been reported as a patient safety incident via Datixweb electronic reporting system.	100%	none

There is documented evidence that the patient was assessed for signs of injury after a fall and before being moved	100%	Where the patients clinical condition is life threatening (such as cardiac or respiratory arrest) and takes priority over physical injuries
All patients who have fallen have a documented medical assessment following their fall, either immediately or (where there is no harm) as part of a later routine review	100%	none
Any patient who has hit their head, or where a head injury cannot be excluded has neurological observations performed as per the guidelines on the neurological observation chart	100%	none

5. Evidence Base

5.1 Sources of information

Trust policies:

1. Consent to Examination or Treatment (2015)
2. Adverse Events Reporting Policy (2018)
3. Serious Incidents Requiring Investigation Policy (2018)
4. Duty of Candour and Being Open Policy (2018)
5. Slips, Trips and Falls Policy (Non Patient) (2014)
6. Risk Management Policy and Procedure (2017)

References

1. National Patient Safety Agency (NPSA), Safer practice notice 17 (issued 26th February 2007)
2. National Patient Safety Agency (NPSA) Rapid Response Alert; NPSA/2011/RRR001 (issued 13th January 2011)
3. National Institute for Health and Clinical Excellence (NICE) (2015) Falls in older people: assessment after a fall and preventing further falls, NICE quality standard 86
4. National Institute for Health and Clinical Excellence (NICE) (2014) Triage, assessment, investigation and early management of head injury in children, young people and adults, NICE Clinical Guideline 176
5. White IR, Altmann DR, Nanchahal K. Alcohol consumption and mortality: modelling risks for men and women at different ages. British Medical Journal 2002: 325: 191.
6. Bell AJ, Talbot-Stern JK, Hennessey A. Characteristics and outcomes of older patients presenting to the emergency department after a fall: retrospective analysis. Medical Journal of Australia 2000; 174:179 82