York Teaching Hospital NHS
NHS Foundation Trust

Slips, Trips and Falls Policy

Hospital Inpatients (Adults)

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Owner:	Beverley Geary, Chief Nurse
Publisher:	Compliance Unit
Date of first issue:	May 2008
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Approved by:	Organisational Falls Steering Group
Date approved:	5 August 2014
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Target audience:	Trust Wide
Relevant Regulations and Standards	CQC Essential Standards of Quality & Safety

Executive Summary

This policy sets out the process to reduce the risk of patients falling in hospital, so far as is reasonably practicable. This policy also indicates the immediate care which should be given if a patient has a fall whilst in hospital.

This is a controlled document. Whilst this document may be printed, the electronic version is maintained on the Q-Pulse system under version and configuration control. Please consider the resource and environmental implications before printing this document.

Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
2	March 2010	Becky Hoskins		New template. Policy separated to include patients only.
3	August 2014	Darren Fletcher		New Template. To include NICE 2013 guidelines. Integrated document

Contents

Guideline I	Podiatry Referral Criteria
Guideline J	COMFE Rounds (Intentional Rounding)
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Guideline P	Equality Analysis
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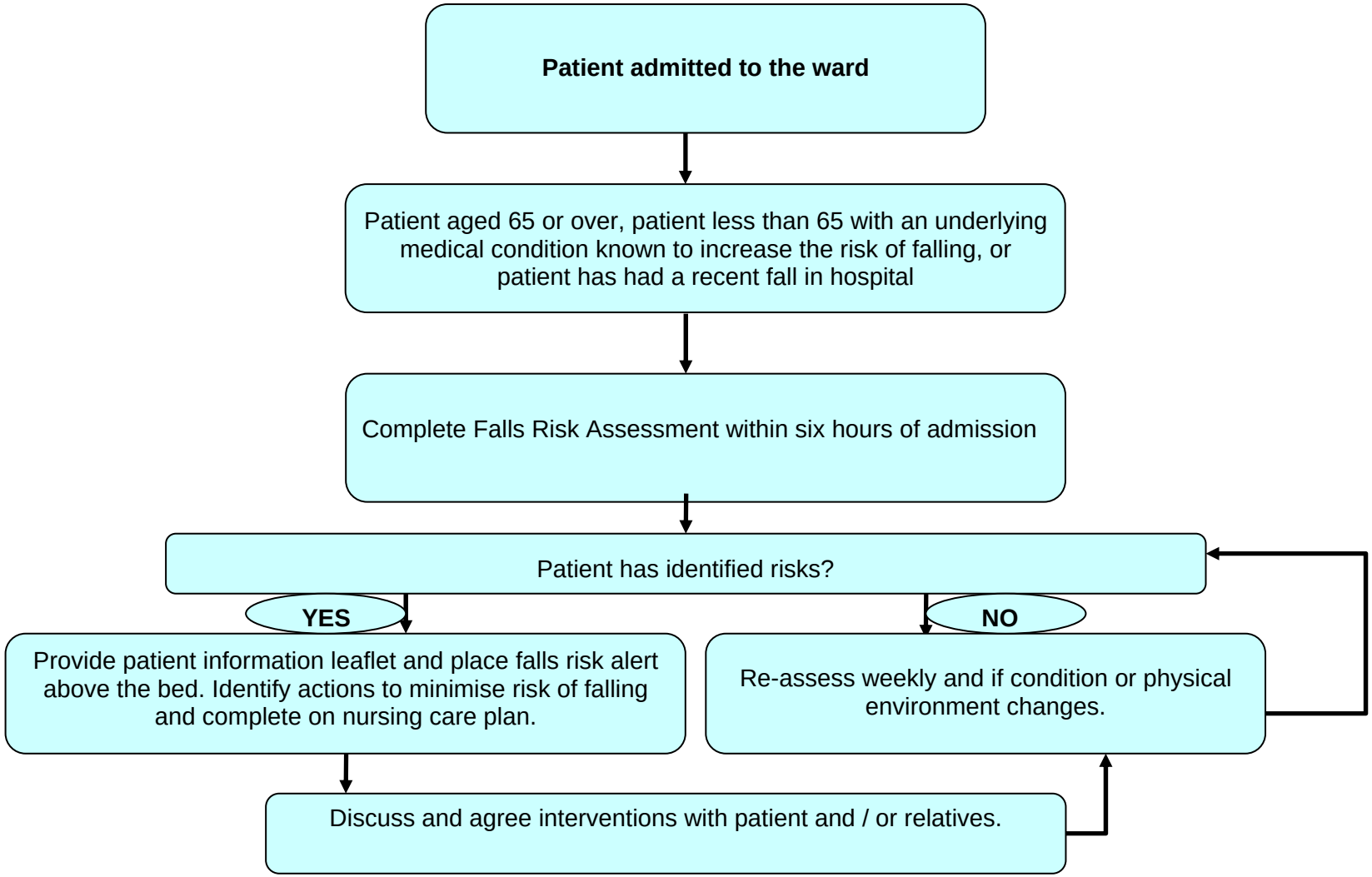
Guideline R	Plan for dissemination of policy

York Teaching Hospital NHS
NHS Foundation Trust

Patient Falls Prevention Pathway



1 Introduction and purpose

Falls and falls related injuries are a common and serious problem (NICE 2013) for patients in hospital, particularly older patients. People aged 65 and older have an increased risk of falling and in the hospital setting, they are particularly vulnerable due to acute illness, chronic illness and the associated frailty and anxiety.

The purpose of this policy is to provide guidance on assessment and interventions to minimise harm to patients at risk of falling in hospital. This policy provides a consistent approach to preventing falls in hospital, based on best practice and clinical evidence of effectiveness.

Some patients may continue to fall and incur harm even when best practice is followed. In such cases we must ensure vigilant monitoring, re-assessment and where necessary, modifications to the plan of care and actions to minimise the risk of harm.

2 Definitions / Terms used in policy

Slip – the slipping of one or both feet when the grip between the shoe and floor is too low

Trip – the sudden arrest of movement of the foot with a continued motion of the body

Fall - an event whereby an individual unintentionally comes to rest on the ground or another lower level, with or without loss of consciousness

Hazard – anything that has the potential to cause harm.

Risk – likelihood that somebody or something will be harmed by a hazard (calculated by multiplying the probability of the incident occurring by the likely severity of the outcome).

Interventions – steps taken that either eliminate or reduce/mitigate the potential to cause harm, and/or reduce the likelihood of that harm being realised.

Risk Assessment – process for the systemic identification of hazards and evaluating (assessing) their risk levels, along with the control measures in place to ensure that the risk of harm to

patients is either eliminated or reduced to the lowest level that is reasonably practicable.

3 Policy Statement

All staff has a responsibility to ensure that patients within our hospital are kept safe from harm. The impact of sustaining a fall whilst in hospital has potential catastrophic and even fatal consequences for patients, and therefore risk must be assessed and interventions put into place to reduce the likelihood of patients falling and sustaining injury.

This policy should be read in conjunction with the Policy and Procedure for the Safe Use of Bedrails.

3.1 Risk factors for falling in hospital (NICE 2013)

- Cognitive impairment
- Continence problems
- Falls history
- Footwear that is unsuitable or missing
- Health problems which may increase the risk of falling
- Medication
- Postural instability, mobility and / or balance problems
- Syncope syndrome
- Visual impairment.

3.2 Falls from height/windows

A place ‘is at height’ if a person could be injured falling from it, even if it is at or below ground level. The severity of injury increases with the height of the fall, but also depends on body and surface features and the manner the body impacts on the surface. For some people, even a fall from standing position to flat ground may cause serious injury.

All windows that patients have reasonable access to must be fitted with window restrictors to ensure that the window does not open more than 100mm (DH 1998).

Any faults with window restrictors must be reported to the Facilities Helpdesk (or the Shift Engineer via Switchboard if out of hours).

4 Accountability

Operational implementation, delivery and monitoring of this policy reside with the Chief Nurse.

All staff has responsibility for ensuring a safe working environment. The Chief Executive has overall responsibility for ensuring that all staff complies with this policy.

All nursing & midwifery staff are responsible for ensuring that patients' risk of falls is assessed as indicated within this policy and interventions planned and acted upon according to the individual patients needs.

The consultant / clinician in charge of the patients' care is responsible for ensuring that the patients' medical condition is monitored and reviewed in accordance with the treatment plan.

4.1 Duties:

Chief Nurse:

Will have the overall responsibility to ensure that:

- slips, trips and falls are reduced to the lowest level that is reasonably practicable
- training on recognition of patients at risk of falling and actions to minimise the risk of falling in hospital is provided
- this policy is implemented and complied with by all staff
- adequate resources are made available to ensure effective implementation of this policy.

Director of Facilities and Estates:

Will ensure that:

- environmental adaptations to reduce the risk of falls and injuries, particularly in older people are considered and actioned as appropriate.

All Clinical Staff

Will ensure that:

- they undertake patient risk assessments on all in-patients aged 65 and over within six hours of them being admitted to hospital (Guideline A)
- they undertake falls risk assessments on all in-patients under 65 years of age who are judged by a clinician to be at risk of falling due to an underlying condition (Guideline A)
- all patients have their risk of falls re-assessed if their condition or environment changes or at least every 7 days or if they are transferred to another ward
- actions identified from these risk assessments are implemented
- local induction of temporary staff includes awareness of patients at risk of slips, trips and falls and the actions planned to prevent injury
- slips, trips or falls are reported, investigated and where necessary that actions as a result of injury or to prevent recurrence are implemented
- incidents which result in severe injury are reported and investigated in accordance with the Serious Incident Policy.

Matrons/Ward Sisters/Charge Nurses

Will ensure that:

- training in completion of the Falls Risk Assessment Tool is undertaken by all registered nurses
- nursing staff undertake patient risk assessments on all adult in-patients aged 65 and over within six hours of the patient being admitted to hospital
- nursing staff undertake falls risk assessments on all in-patients under 65 years of age who are judged by a clinician to be at higher risk of falling due to an underlying condition
- all patients will have their risk of falls re-assessed, if their condition or environment changes or at least every 7 days or if they are transferred to another ward

- actions indicated from the Falls Risk Assessment should be recorded on the patients care plan
- patients are falls risk (re-)assessed following a fall in hospital.

All employees:

Will ensure that:

- comply with this policy, regardless of grade or occupation, and follow any instruction, procedure or policy provided to them with regards to health and safety management

- co-operate with their managers in ensuring that they operate in a safe environment following safe practices. Employees are required to bring to the attention of their manager any shortcomings in health and safety in their immediate working conditions, including policies, procedures, guidelines, training and supervision

- report hazards such as unsafe environments, unsafe flooring (internal and external), spillages etc to the Estates Helpdesk at the earliest opportunity (or the Shift Engineer via Switchboard if out of hours)

- ensure that they undertake their work in a way that does not cause any slip, trip or fall hazard (e.g. locating wires and cables safely, not blocking walkways, clearing spillages immediately, using wet floor signage appropriately).

4.2 Legal Requirements

The Health and Safety at Work Act (1974) requires employers to ensure the health and safety of all employees and anyone who may be affected by their work, including patients.

Management of Health and Safety at Work Regulations (1999) include duties for employers to formally undertake suitable and sufficient risk assessments of anything that may cause harm or ill-health (including slips, trips and falls); and for effective risk control measures to be planned, organised, implemented, controlled, monitored and reviewed (Guideline B).

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (1995) require employers and others to report accidents and some diseases that arise out of or in connection with work. Some injuries resulting from slip, trip or fall incidents may be reportable to the Health & Safety Executive under RIDDOR. These include incidents that result in a major injury such as a fracture that would require hospital treatment.

5 Multifactorial Interventions

A multifactorial approach to actions preventing falls in hospital has been shown to be more effective than single interventions for preventing falls and associated injuries for people in hospital.

There are a number of risk factors for falling in the hospital setting and these are increased in elderly patients.

Factors associated with the risk of falling in the hospital setting have been incorporated into the Trust Falls Risk Assessment for Adult Inpatients, which also identifies interventions (actions) targeting risks to prevent falls or to reduce the associated injuries (Guideline A). The individualised falls prevention action plan of care based on the findings of the assessment should systematically address the identified risk factors.

The following falls prevention interventions should be considered in the plan of care:

- Discuss falls risk and prevention strategies with the patient and family / carers and provide them with the “Reduce Your Risk of Falling” leaflet (Guideline B)
- Identify patients at risk of falling by placing the falls alert card above the bed (Guideline C)
- Measurement of lying and standing blood pressure (Guideline E)
- Review of medications (Guideline F)
- Appropriate equipment (Guideline G)
- Review of footwear (Guideline H)
- Podiatry review (Guideline I)

- COMFE Rounds (Guideline J)
- Review of bed height (Guideline K)
- Use of bed and / or chair sensors (Guideline L).

Where patients are identified at risk of falling and are nursed in isolation, in certain situations the door may be left open to aid observation. Refer to the Trust's Isolation Policy in this instance.

6 Actions Following a Fall in Hospital

If a patient slips, trips or falls whilst on hospital premises, staff are required to:

- complete a Datix incident reporting form immediately following the incident
- follow the guidance on the Post Falls Flow Chart, which must be displayed on all nurses stations in accordance with recommendations from the NPSA Rapid Response Report "Essential care following an in-patient fall" (Guideline M)
- complete all checks outlined in the Post Falls Checklist sticker and insert this into the medical notes (Guideline N)
- re-assess the falls risk and associated interventions
- inform the relative or carer that the patient has fallen, in line with the Being Open Policy and advise of actions as a result.

If the fall results in severe harm, injury or death, then the incident should be investigated using the RCA form (Guideline O) in accordance with the Serious Incident Policy.

7 Consultation, Assurance and Approval Process

The following groups were consulted as part of the policy approval process:

- Patient Safety Group
- Organisational Falls Steering Group
- Clinical Commissioning Group (CCG).

8 Equality Impact Assessment

The Trust's statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.
A copy of the Equality Impact Assessment for this policy is at Guideline P.

9 Review and Revision Arrangements

The date of review is given on the front coversheet.
Persons or group responsible for review are:

- Chief Nurse.

The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified in Section 7 will be consulted as per the Trust's Stakeholder policy. Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

This policy has been reviewed in accordance with the Trust Checklist for Review and Approval (Guideline Q).

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the **Policy for Development and Management of Policies.**

10 Dissemination and Implementation

10.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, Section 8 and Guideline R, Plan for Dissemination.

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

10.2 Implementation of Policies

The policy will be implemented throughout the Trust by managers and employees identified in Section 5 above; all managers will ensure the day to day adherence of the policy.

11 Document Control including Archiving

The register and archiving arrangements for policies will be managed by the Compliance Unit. To retrieve a former version of this policy the Compliance Unit should be contacted.

12 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

12.1 Process for Monitoring Compliance and Effectiveness

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
a. Duties a. Duties (cont.)	Compliance with management duties related to the environment e.g., lighting, flooring, trip hazards etc will be monitored via the annual Health & Safety Audit Tool, which will be reported to the Board of Directors through the Annual Health & Safety Report. Compliance with staff duties will be	Health & Safety Group, Risk Review Group, Health and Safety Non-Clinical Risk Group.	Annual	Health & Safety Group, Risk Review Group, Clinical and Health and Safety Non-Clinical Risk Groups. Ward Managers, Matrons,	Ward Managers, Matrons, Directorate Managers, Community Locality managers. Ward	Ward Managers, Matrons, Directorate Managers, Community Locality managers. Ward

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
	monitored via • Datix forms • Falls Root Cause Analysis. Findings are reported in the *Risk Review Quarterly Report* which is reviewed by the Health Safety and Non Clinical Risk Group, Risk Review Group.	Risk Review Group, Health and Safety Non-Clinical Risk Group.	Quarterly	Directorate Managers, Community Locality managers.	Managers, Matrons, Directorate Managers, Community Locality managers.	Managers, Matrons, Directorate Managers, Community Locality managers.
b. Compliance with Patient Falls risk assessments	Serious Incident investigations into patient slip, trip or fall	Patient Safety Manager	Three monthly	Organisational Falls Steering Group	Organisational Falls Steering Group	Organisational Falls Steering Group

Minimum requirement to be monitored	Process for monitoring	Responsible Individual/ committee/ group	Frequency of monitoring	Responsible individual/ committee/ group for review of results	Responsible individual/ committee/ group for developing an action plan	Responsible individual/ committee/ group for monitoring of action plan
and interventional care plans	incidents.					

13 Training

See Section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

Any ward identified as a high risk area will be offered individualised Falls awareness training depending on identified need. Wards can be identified via a number of different routes.

- Trend analysis of Serious Incident Root Cause Analysis reports
- Falls Panel recommendation
- Early Warning Trigger Tool
- Safety Thermometer
- Patient Complaint

14 Trust Associated Policies

- Reporting of Incidents Policy.
- Health & Safety at Work Policy.
- Policy & Procedure for the Safe Use of Bed Rails.
- Serious Incident Policy.
- Being Open Policy.
- Isolation Policy.

15 References

Cameron L et al (2008) Interventions for preventing falls in older people in nursing care facilities and hospitals. Cochrane Database of Systematic Reviews (3) Art. No.:CD005465

DH (1998) HTM55, windows. Department of Health, London.

Gillespie LD et al (2009) Interventions for preventing falls in older people living in the community. Cochrane Database of Systematic Reviews (2) Art. No.:CD007146

Health and Safety at Work etc. Act (1974)

NICE (2013) Falls: assessment and prevention of falls in older people. National Institute for Health and Care Excellence, clinical guideline 161.

NPSA Rapid Response Report (2011) – Essential care following an inpatient fall NPSA/2011/RRR001

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013)

16 Plan for dissemination of policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	Slips, Trips and Falls Policy
Date finalised:	5 August 2014
Previous document in use?	Yes
Dissemination lead	Darren Fletcher, Patient Safety Manager
Which Strategy does it relate to?	Risk Management, Quality and Safety
If yes, in what format and where?	Via Staff Room. Paper copies may be available in some areas.
Proposed action to retrieve out of date copies of the document:	Compliance Unit will hold archive

Dissemination Grid

To be disseminated to:	1) Directorate managers, matrons, heads of service, ward sisters	2) All clinical staff
Method of dissemination	e-mail sent to all to request removal of paper copies and dissemination to all staff. Communicate via Staff Brief.	Statutory and Mandatory Training
who will do it?	Policy author	Patient Safety Team via CLAD
and when?	On approval	On approval
Format (i.e. paper or electronic)	Electronic	

Dissemination Record

Date put on register / library	**27 August 2014**
Review date	**31 July 2016**
Disseminated to	**Electronic**
Format (i.e. paper or electronic)	**As above**
Date Disseminated	**On approval**
No. of Copies Sent	**As above**
Contact Details / Comments	**Policy Author**

17 Equality Analysis

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy	Slips Trips and Falls
1.	**What are the intended outcomes of this work?** • The provision of a safe environment that is free from slip, trip and fall hazards, so far as is reasonably practicable • All potential slip, trip and fall hazards are identified • That any subsequent risk to a patient's safety is adequately assessed, controlled and reduced to the lowest level reasonably practicable.
2	**Who will be affected?** Directorate managers, matrons, heads of service, ward sisters and all clinical staff
3	**What evidence have you considered?** Best practice, NPSA 2007 PS03: Slips, trips and falls in hospital
a	**Disability -** The policy is inclusive
b	**Sex -** The policy is inclusive
c	**Race -** The policy is inclusive
d	**Age -** The policy applies to all adult inpatients
e	**Gender Reassignment -** The policy is inclusive
f	**Sexual Orientation -** The policy is inclusive
g	**Religion or Belief -** The policy is inclusive
h	**Pregnancy and Maternity**. **-** The policy is inclusive
i	**Carers -** The policy is inclusive

j	**Other Identified Groups** - None Identified	
4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	By discussion
c.	If so, how have you engaged stakeholders in constructing the policy	As above
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs: Organisational Falls Steering Group By circulation of draft policy for comments and inclusion into final document	
5.	**Consultation Outcome** The policy conforms to the requirements of the Policy for the Development and Management of Policies, relevant legislation and the requirements of the relevant CQC Outcomes	
a	Eliminate discrimination, harassment and victimisation	The policy is inclusive
b	Advance Equality of Opportunity	The policy is inclusive
c	Promote Good Relations Between Groups	The policy is inclusive
d	What is the overall impact?	The policy is inclusive
	Name of the Person who carried out this assessment: Darren Fletcher	
	Date Assessment Completed April 2014	
	Name of responsible Director Mrs Beverley Geary	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

18 Checklist for the Review and Approval

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Slips Trips and Falls Patient Policy	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or procedures?	Yes	
2	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3	**Development Process**		
	Is the method described in brief?	Yes	
	Are individuals involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Has an operational, manpower and financial resource assessment been undertaken?	Yes	
4	**Content**		
	Is the document linked to a strategy?	Yes	
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	

	Slips Trips and Falls Patient Policy	Yes/No/ Unsure	Comments
	Are the statements clear and unambiguous?	Yes	
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are local/organisational supporting documents referenced?	Yes	
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?	Yes	
	Has QA been completed and approved?		
6	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	N/A	
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	

	Slips Trips and Falls Patient Policy	Yes/No/ Unsure	Comments
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so, is it acceptable?	Yes	
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Mrs B Geary	Date	July 2014
Signature	*Beverley Geary*		
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Mrs B Geary	Date	5 August 2014
Signature	*Beverley Geary* Chair, Organisational Falls Steering Group		

GUIDELINES:

Guideline	Title
A	1 Patient Falls Risk Assessment Acute Inpatient 2 Patient Falls Risk Assessment Community Inpatient
B	Patient and family information leaflet
C	Falls Alert Card
D	Workplace Risk Assessment
E	Lying and Standing Blood Pressure Measurement
F	Drugs that increase the risk of falls
G	Appropriate Equipment
H	Footwear
I	Podiatry Referral Criteria
J	COMFE Rounds (Intentional Rounding) relating to falls risk
K	Guidance on the use of Low Profiling Beds
L	Bed / Chair Sensors
M	Post-Falls Flow Chart
N	Post Falls Checklist Sticker
O	Fall Root Cause Analysis Procedure

Guideline A: [1] Acute Inpatient

All adult in-patients aged 65 and over should have a falls risk assessment completed within six hours of being admitted to hospital. People under 65 years of age who are judged by a clinician to be at higher risk of falling due to an underlying condition should also have the assessment completed. The risk assessment should be repeated every seven days or whenever the patient's condition changes, or following a fall or transfer to another ward.

FALLS CARE PLAN TRIGGER	DATE								
	TIME								
Is there a history of falling in the last year or a near miss in the last month?	**Yes / No**								
Recent faints or dizzy spells, or orthostatic hypotension? *(Drop of 20mg or more between lying and standing systolic BP)*	**Yes / No**								
Is the patient or their relatives anxious about falling?	**Yes / No**								
Does the patient need assistance to mobilise (even if refuses)?	**Yes / No**								
Is there a background history of cognitive impairment? *(If yes, confirm with relatives/carers/GP and document in notes)*	**Yes / No**								
Are there any signs or evidence of delirium? *(Disorientated, failing to recognise relatives/situation, inattention, etc)*	**Yes / No**								
If answering 'YES' to any of the above, the patient is at risk of falling and a care plan must be completed.									
Clinical Judgement of risk (Low (L) Medium (M) High (H)									
Initials of RN performing assessment:									
Initials of RN if completed by student nurse:									

Guideline A – [2] Community Inpatient

All adult in-patients aged 65 and over should have a falls risk assessment completed within six hours of being admitted to hospital. People under 65 years of age who are judged by a clinician to be at higher risk of falling due to an underlying condition should also have the assessment completed. The risk assessment should be repeated every seven days or whenever the patient's condition changes, or following a fall or transfer to another ward.

Falls Risk Assessment for Adult Inpatients

To be completed for all patients aged 65 and over and adult patients less than 65 years of age with underlying medical conditions that increase the risk of falls. Complete within six hours of admission and following a fall in hospital.
Re-assess on patient transfer, after any fall, every seven days or as condition changes.

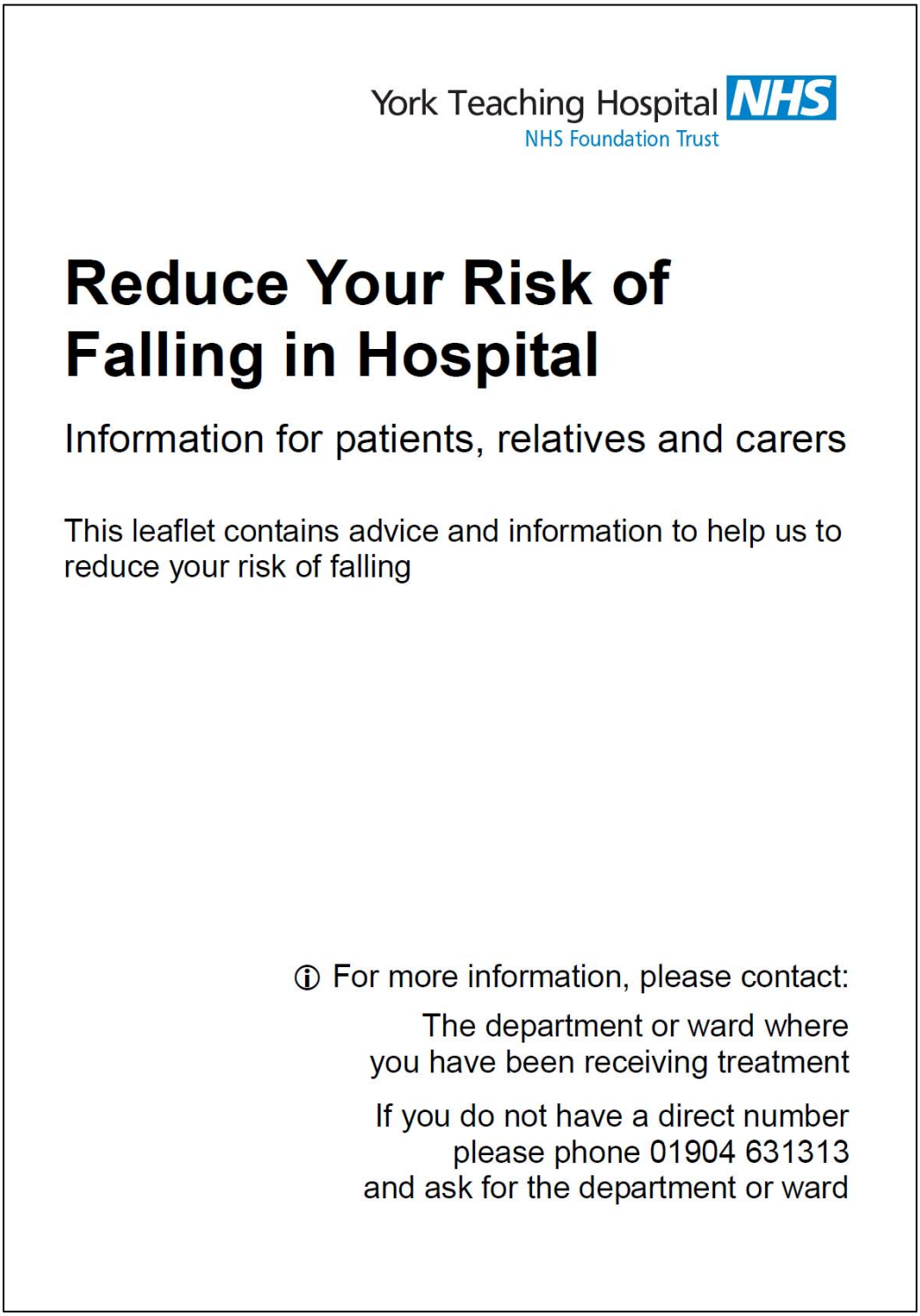
- *Patients with one or more identified risks will be deemed at risk of falls and must be provided with the patient information leaflet and falls alert sign placed above the bed*
- *All patients must be advised on the use of the Nurse Call Bell system*
- **Supplementary guidance will be available, either via hyperlink when electronic or appendix to policy*

Identified Risks	Action (s)	Date / Time							
1) Patient has a history of recent falls Admitted due to a fall, fall in hospital or any fall within the last 12 months. ❑ YES ❑ NO	a. Refered to Physiotherapy								
2) Dizziness / Postural Hypotension Experiences dizziness on standing or sitting up, experiences dizziness / vertigo on turning in bed or experiences any other dizziness / vertigo symptoms. ❑ YES ❑ NO	a. Lying and standing BP recorded *								
	b. Measures in place to ensure appropriate hydration. Fluid balance chart in place if appropriate								
3) Fainting episodes in the past year Complains of blackouts, loss of consciousness, unexplained fall or unable to recollect mechanism of fall (not due to cognitive issues). ❑ YES ❑ NO	a. ECG requested / performed if not done in past month or if patient complains of dizziness / blackouts								
	b. BM checked. Doctor informed if <4 or >18								
4) Experiences medication related drowsiness Taking 4 or more regular medications per day, taking drugs that can contribute to falls*, has symptoms of drowsiness or has difficulty with managing own medications. ❑ YES ❑ NO	a. Doctor / ACP requested to review medication								
	b. Night sedation minimised or avoided where possible								
5) Balance, Transfers and Walking Unsteady on their feet or unable to transfer from bed, chair or toilet independently. ❑ YES ❑ NO	a. Referred to Physiotherapy								
	b. Referred to Occupational Therapy								
	c. Appropriate aids / equipment provided *								
	d. Bed near nurses station								
	e. Bed near toilet								
	f. Cohort nursing in place								
	g. Supervised toileting in place								
6) Footwear / Foot care Difficulty with foot care affecting mobility, inappropriate footwear. ❑ YES ❑ NO	a. Patient has suitable footwear *								
	b. If appropriate footwear is not accessible, non-slip bed socks have been provided								
	c. Referred to Physiotherapy if appropriate								
	d. Condition of feet and nails have been checked e.g. overgrown / thickened toe nails, corns callus								
	e. Referred to podiatry if appropriate *								

7) Reduced confidence / coping strategies Fear of further falls, change of lifestyle due to falls, unable to get up from floor or summon help. ❑ YES ❑ NO	a. Referred to Occupational Therapy							
	b. Referred to Physiotherapy							
	c. Supervised mobility in place							
8) Delirium / Dementia Noticeably confused / forgetful or comprehension difficulties which may affect ability to follow advice. Alert doctors if recent change in levels of confusion, poor attention or apathy. ❑ YES ❑ NO	a. Non-slip socks worn when patient in bed							
	b. Bed near nurses station							
	c. Bed near toilet							
	d. Cohort nursing in place							
	e. Hourly COMFE frequency in place *							
	f. Low Bed in use *							
	g. Bed / chair sensors in place *							
9) Continence Experiences urgency, frequency, nocturia, frequent UTI's incontinence or stress incontinence. ❑ YES ❑ NO	a. Measures in place to ensure appropriate hydration							
	b. Night time drinks limited (where appropriate in nocturia)							
	c. Urinalysis checked							
	d. Doctor advised if urinalysis and / or temperature results are abnormal							
	e. Appropriate aids / equipment provided *							
	f. Appropriate COMFE frequency in place *							
	g. Supervised toileting in place							
10) Vision Does the patient wear glasses. ❑ YES ❑ NO	a. Checked patient has glasses with them if usually worn							
	b. Checked glasses are in a good clean condition							
	c. Appropriate COMFE frequency in place *							
11) Hearing Wears hearing aid, difficulty hearing conversational speech (with hearing aid if worn). ❑ YES ❑ NO	a. Checked patient has hearing aids with them if usually worn							
	b. Checked hearing aid is in full working order where applicable							
	c. Referred to audiology for assessment or if problems with hearing aid							
	d. Appropriate COMFE frequency in place *							
York Teaching Hospital NHS NHS Foundation Trust	Initials of RN Performing assessment							
	Initials of RN if completed by student nurse:							

Guideline B: Patient and family information leaflet

This leaflet should be given to any patient who is identified with a risk of falling in hospital. There should also be a discussion with the patient and their family/carer about the risk of falling and actions to minimise the risk of falling in hospital.



York Teaching Hospital NHS
NHS Foundation Trust

Reduce Your Risk of Falling in Hospital

Information for patients, relatives and carers

This leaflet contains advice and information to help us to reduce your risk of falling

ⓘ For more information, please contact:

The department or ward where you have been receiving treatment

If you do not have a direct number please phone 01904 631313 and ask for the department or ward

Contents **Page**

We want to make your stay in hospital as safe as possible but we need your help.

Who is at risk of falling?

You are more likely to have a fall if you;

- get dizzy or light headed when you stand or turn
- have difficulty walking or getting up from a low chair or bed
- have poor balance
- have fallen before
- take four or more medicines
- have a fear of falling
- suffer from depression or memory problems
- have poor eye-sight or hearing
- try to walk around a cluttered or dimly lit area or uneven surface

As a patient, you can help to reduce your risk of falling by following this advice:

- if you have a walking aid, use it when you are moving around
- ensure you wear your hearing aid or spectacles if you need them
- keep the nurse call bell where you can reach it and use it if you need assistance to move
- keep everything you need within easy reach
- avoid stretching or bending to reach things
- wear non-slip well fitting slippers or light weight shoes
- do not use the bed tables to help you stand up or to walk around
- get up slowly from the bed or chair. Remember that your blood pressure falls as you stand and it may take longer for your body to adjust causing you to feel dizzy
- do not walk alone if you are advised that you need assistance when walking

- drink plenty of fluids (preferably water) to keep hydrated unless advised otherwise by your doctor or nurse

- be honest with the nurses or doctors if you feel anxious about moving around or falling

- if any medication you are taking makes you feel unwell, light headed or dizzy, please tell the nurse or doctor.

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If you are a relative, carer or friend, you can help by doing the following:

- when you visit, please put your chair away before leaving
- make sure that the patient realises that you are leaving
- make sure the nurse call bell is near the patient as you leave
- if possible, ensure the patient has lightweight non-slip footwear (slippers or shoes) and well fitting clothing
- bring in spectacles / dentures / hearing aids and all medication
- if you are aware that your relative or friend has fallen in the past before being admitted to hospital, please inform the nursing staff
- let us know if you have any concerns.

If you are at risk of falling we may:

- review your medications as some combinations of medicines can cause drowsiness, dizziness, weakness and affect your balance
- check your footwear and offer advice on suitable alternatives
- regularly check and offer you assistance to the toilet
- provide you with a very low bed
- move your bed to an area where we can easily observe you
- use safety rails on the bed
- discuss with you whether you use any aid at home to walk with

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If you fall whilst in hospital

Some patients will still fall even when advice is followed and when we have tried to do the things mentioned in this leaflet. If you do fall then the nurses and doctor will quickly check you for signs of injury and give you treatment if necessary.

Following a fall, you will be re-assessed for and we may advise you of additional actions to keep you safe, as with all of these actions we need your cooperation.

Please advise the doctor or nurses if you have any concerns.

References and further information

NHS Choices: www.nhs.uk

Age UK have produced a range of free advice leaflets for older people.

For more information or contact Age UK on:
0800 169 6565 or visit www.ageuk.org.uk.

Tell us what you think

We hope that you found this leaflet helpful. If you would like to tell us what you think, please contact Darren Fletcher, Patient Safety Manager, The York Hospital, Wigginton Road, York, YO31 8HE or telephone 01904 721549.

Teaching, Training and Research

Our Trust is committed to teaching, training and research to support the development of staff and improve health and healthcare in our community. Staff or students in training may attend consultations for this purpose. You can opt-out if you do not want trainees to attend. Staff may also ask you to be involved in our research.

Patient Advice and Liaison Service (PALS)

The York based team can be contacted on 01904 726262, or via email at pals.york@york.nhs.uk

The Scarborough based team can be contacted on 01723 342434, or via email at pals.scarborough@york.nhs.uk

Answer phones are available out of hours.

Please telephone or email if you require this information in a different language or format

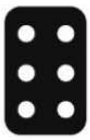
如果你要求本資訊是以不同的語言或版式提供，請致電或寫電郵

Jeżeli niniejsze informacje potrzebne są w innym języku lub formacie, należy zadzwonić lub wysłać wiadomość e-mail

Bu bilgileri değişik bir lisanda ya da formatta istiyorsanız lütfen telefon ediniz ya da e-posta gönderiniz

01904 725566

email: access@york.nhs.uk



Braille

Audio e.g. CD

Large print

Electronic

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Date first issued	July 2010
Review Date	August 2016
Version	4 (issued September 2014)
Approved by	Falls Steering Group
Document Reference	PI 581 v4

Guideline C: Falls Alert Card

This card should be placed above the bed of any patient who is identified with a risk of falling in hospital.

Where a falls risk sign is displayed, all staff are expected to have a raised awareness of the risk of falls and intervene in a timely fashion where the patient is attempting to mobilise independently.

Guideline D: Workplace Risk Assessment

The Trust's Health & Safety at Work Policy gives guidance on the environmental/workplace risk assessment process.

Environmental risk assessments are reviewed on an annual basis, or following an incident/near miss, or change in legislation, equipment or an actual change in environment.

The environmental risk assessments are undertaken by staff that have attended the Trust's Workplace Risk Assessment course and/or are IOSH Managers & Risk Reviewers.

Appropriate control measures to mitigate significant risks are devised and then put in place to either prevent, or reduce the risk of slips, trips and falls to the lowest level reasonably practicable.

Significant risks should be identified on the local and/or corporate risk register and brought to the attention of the Estates Team.

Guideline E: Lying and Standing Blood Pressure Measurement

Why is this Important?

A fall in blood pressure on standing (Postural Hypotension or Orthostatic Hypotension) is common amongst older patients. The drop in blood pressure is often greater when;

- Patients are taking antihypertensive drugs and diuretics
- Patients have infections and a fever
- Patients are dehydrated.

All three of these added risk factors can be treated and the risk of falls lessened as a result.

When should Lying and Standing Blood Pressure be measured?

- First thing in the morning as more likely to be present.
- At least twice in the first two days of admission.
- Repeated (daily) measurement is useful in monitoring progress of treatment (rehydration, withdrawal of drugs and treatment of illness).

How is Lying and Standing Blood Pressure Measured?

1. Ask the patient to lie on the bed.
2. Wait at least 5 minutes.
3. Take blood pressure whilst the patient is lying down.
4. Ask or assist the patient to stand up
5. Take blood pressure immediately **AND** again after the patient has been standing for three minutes.

Abandon the procedure if the patient feels dizzy or about to fall.

What is Abnormal?

Postural hypotension is said to be present if:

- Systolic blood pressure falls by > 20mmHg on standing

OR

- Diastolic blood pressure falls by >10mmHg on standing.

Action to take on an abnormal result:

- Inform the medical team and ask them to review medications urgently
- Make sure the patient is well hydrated (by mouth if possible)
- Ensure the patient has easy access to the call button and advise them not to mobilise without assistance.

Guideline F : Drugs which increase the risk of Falls

Drugs Which May Increase the Risk of Falls

Never stop or withhold medication without agreement from the medical team

Group	Generic Drug Name	Contributing Factor	Suggested Action
Antidepressants	TCAs – amitriptyline, dosulepin (Dothiepin), imipramine, lofepramine. SSRIs – citalopram, fluoxetine. Other – trazodone, mirtazapine, venlafaxine.	Drowsiness, blurred vision, dizziness, postural hypotension, constipation, retention of urine.	• Review indication. • Stop if possible. May need to withdraw slowly. • Consider changing a tricyclic (TCA) to a Serotonin Specific Reuptake Inhibitor (SSRI) (eg citalopram). • Consider specialist referral if further advice needed.
Antipsychotics	Chlorpromazine, haloperidol, lithium, promazine, trifluoperazine, quetiapine, olanzapine, risperidone.	Postural hypotension, confusion, drowsiness, Parkinsonian symptoms.	• Review indication for use. • In long term use do not stop without specialist opinion.
Sedative and hypnotics	Temazepam, diazepam, lorazepam, nitrazepam, zopiclone, chlordiazepoxide, chloral betaine (Welldorm), clomethiazole.	Drowsiness which can last into the next day, light headedness, confusion, loss of memory.	• Stop if possible. • Long term use will need slow withdrawal. • No new initiation on TTOs.
Drugs for Parkinson's Disease	Co-beneldopa, co-careldopa, rotigotine, amantadine, entacapone, selegiline, rivastigmine.	Sudden daytime sleepiness, dizziness, insomnia, confusion, low blood pressure, blurred vision.	• May not be possible to change. • Do not change without specialist opinion. • Check for postural hypotension.
Drugs with anti-cholinergic side effects	Procyclidine, trihexyphenidyl (Benzhexol), prochlorperazine, oxybutynin, tolterodine.	Dizziness, blurred vision, retention of urine, confusion, drowsiness, hallucinations.	• Review indication. • Reduce dose or stop if possible.
Cardiovascular drugs	**ACE inhibitors / Angiotensin-II antagonists** Ramipril, lisinopril, captopril / irbesartan, candesartan. **Vasodilators** Hydralazine. **Diuretics** bendroflumethiazide, bumetanide, indapamide, furosemide, amiloride, spironolactone, metolazone. **Beta-blockers** Atenolol, bisoprolol, carvedilol, propranolol, sotalol. **Alpha-blockers** Doxazosin, alfuzosin, terazosin, (tamsulosin). **Calcium Antagonists** Nifedipine, diltiazem.	Low blood pressure, postural hypotension, dizziness, tiredness, sleepiness, confusion.	• Check lying and standing BP. • Review indication (alpha-blockers also used for benign prostatic hyperplasia). • Review dose. • May not be possible to stop. • Consider alternative to alpha-blocker.
Analgesics	Codeine, tramadol. Opiates – morphine, oxycodone, fentanyl.	Drowsiness, confusion, hallucinations, postural hypotension.	• Review dose. • Use analgesic pain ladder to avoid excess use. • In elderly start low and go slow.
Anti-epileptics	Carbamazepine*, sodium valproate*, gabapentin, pregabalin, lamotrigine, clonazepam, phenytoin*, phenobarbitone*, primidone*.	Drowsiness, dizziness, blurred vision.	• Consider indication (some are also used for pain control or mood stabilisation). • May need specialist review in problem cases. • *Consider Vitamin D supplements for at risk patients on long-term treatment with these drugs.

Guideline G : Appropriate Equipment

Chairs

Ensure chairs are at a suitable height and appropriate for the patient. Recliner chairs or specialist chairs are available for patients with complex needs and may be requested via the equipment coordinators. Physiotherapists can provide advice on the suitability of chairs.

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

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

Toilets

The provision of a “Toilet Seat Raise” or toilet frame may make toilet transfers safer and easier. Where used, ensure that these position the patient at a suitable height, allowing them to rest their feet flat on the floor when sitting down but high enough to facilitate safe transfer.

Check that the patient can safely manoeuvre any walking aids they have within the confined space and that they can balance long enough whilst standing and adjusting their clothing. Provide supervision or support when necessary.

Walking Aids

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

Consider if it is safer to walk the patient between two staff until they have had a physiotherapist assessment and appropriate walking aid supplied.

Guideline H: Footwear

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

Sports or walking shoes may be ideal for daily wear. Slippers generally provide poor foot support and may only be appropriate when sitting.

Temporary Footwear

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

Suitable Footwear

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

- Have a low heel (less than 2.5 cm) to ensure stability. A straight-through sole is also recommended
- Have a broad and firm heel with good ground contact and support
- Have a cushioned, flexible, non-slip sole
- Be lightweight
- Have non-trailing laces, buckles, elastic or Velcro
- Protect feet from injury.

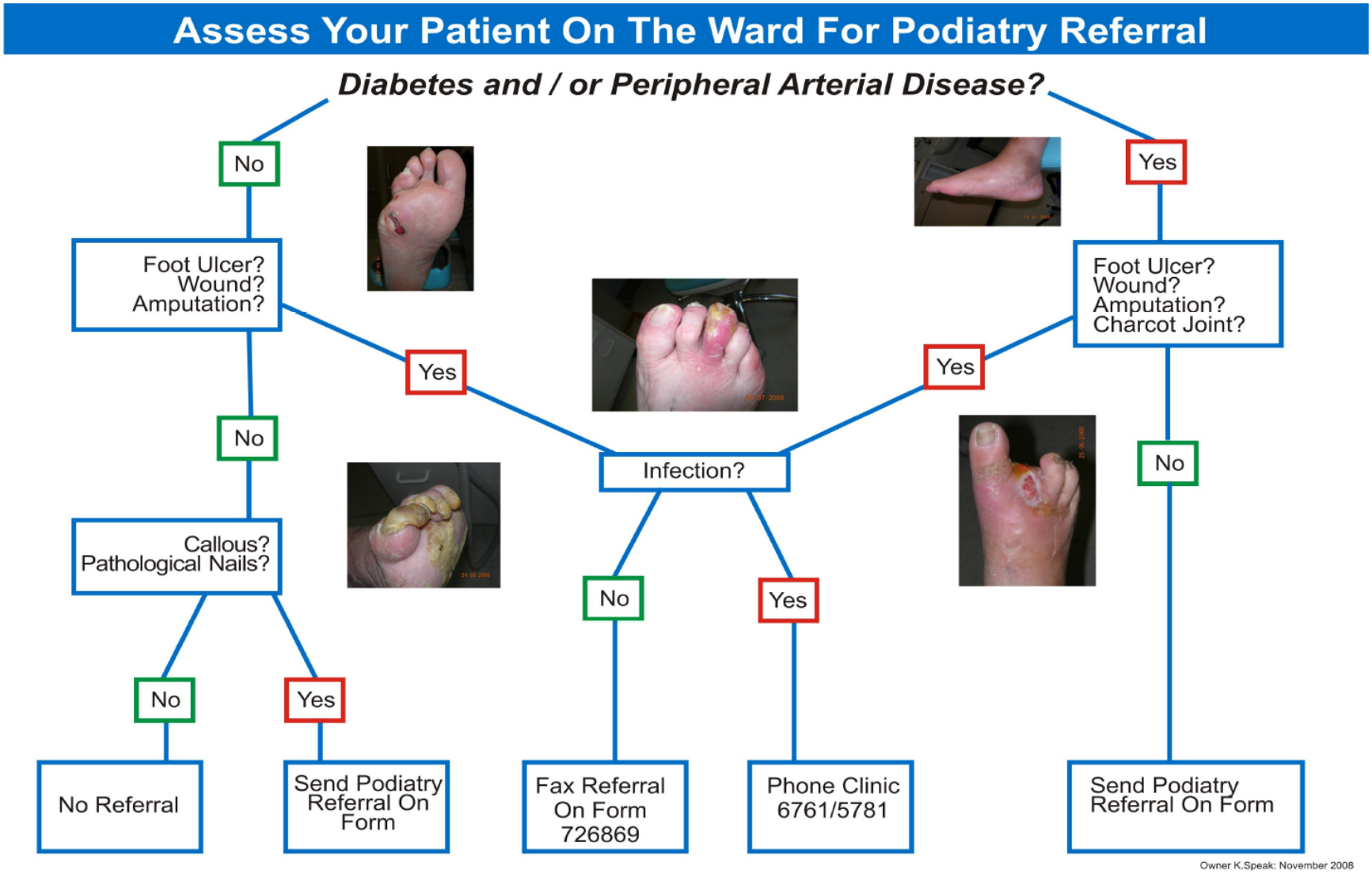
Non-slip Bed Socks

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

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

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

Guideline I: Podiatry Referral Criteria



How To Refer

Ward referrals are accepted from any member of the medical or nursing staff and AHPs.

Complete the “Podiatry Inpatient Request Form”. (Version dated Nov 2006)

Copies should be kept on the ward and photocopied for staff use.

This should then be sent by internal post to:-

Podiatry Clinic Centre
for Diabetes and Endocrinology

Urgent referrals can be made by fax or by phone.
(Please note:- calls come straight to the clinic and interrupt patient treatments).

If you leave a message on the ansaphone please leave contact name and number to help us return the call.

Please see flow chart overleaf for guidance.

Owner K.Speak: November 2008

Contact Details

Katharine Speak,
Clinical Lead Podiatrist
Katharine.Speak@nyypct.nhs.uk

Paul Burland,
Specialist Podiatrist

Pat Lomax, Podiatry Assistant

Hospital Podiatry Clinic	(72)6761 (72)5781
Diabetes Reception	(72)6510
Fax	726869

North Yorkshire and York NHS
Primary Care Trust

Podiatry Services At York Hospital

Information For Staff

Podiatry Ward Visits

Tues pm

Weds pm

Podiatry Assistant Ward visits

Weds all day

Guideline J: COMFE Rounds (Intentional Rounding)

Every in-patient will receive intentional rounding, depending on their level of dependency and support required. Each round will consist of a review of the following:

- Level of pain / discomfort
- Need for a drink or snack
- Mouth care
- Position of mobility aids
- Position of other aids such as spectacles and call bells
- Provision of footwear
- Bed or chair height
- Patients general position
- Skin checks
- Personal hygiene
- Toilet frequency
- Needs the patient may express
- Check that the patient knows where the toilet is situated or how to summon assistance to the toilet
- Change in condition.

The frequency of the rounds will depend on the condition of the patient. Some patients may need to be woken from sleep to change their position or to take them to the toilet, and this will require an individualised assessment depending on risk of pressure ulcer development and risk of incontinence.

Frequency for patients at risk of falling:	
Hourly	• Where the patient is identified as displaying agitation and confusion.
Two hourly	• Where the patient has recognised continence problems, overnight support is particularly important to prevent a patient attempting to walk to the toilet without assistance. • If the patient has no aids and has significant hearing problems.
Four hourly	• Where the patient has hearing problems but has no other risk factors and has aids to assist with hearing. • Where the patient has vision problems but no other risk factors.

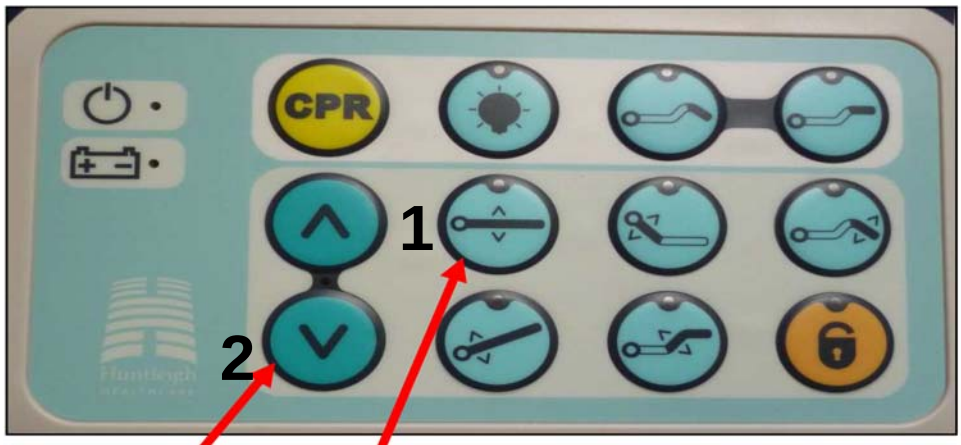
Guideline K: Guidance on the use of Low Profiling Beds

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

ArjoHuntleigh Beds - Enterprise 5000 / 8000 beds:

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

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



Attendant Control Panel (ACP)

Further Information can be obtained from:

Keith Underwood
Scarborough
(771) 2633

Wendy Marshall
York
(772) 6292

Specialist Low Profiling Beds

Specialist low profiling beds are completely height adjustable and can be raised to allow clinical interventions to be undertaken, to facilitate a sit to stand transfer to take place and to ensure the safe use of mobile hoists or other transfer aids. The minimum mattress platform height that can be reached is 15cm.

Nimbus mattresses are not compatible and must not be used with the Ultra Low bed. Other models of specialist low profiling beds may be used with Nimbus mattresses.

Transferring patients to other departments should not take place on specialist low profiling beds due to the danger of transport bar entrapment and increased weight of the bed, posing a manual handling risk to staff.

The decision to use a specialist low profiling bed must be recorded in the nursing notes and communicated to all members of the ward (multidisciplinary) team. The patient's family and/or carers should also be informed of the decision.

The use of specialist low profiling beds must be reviewed and documented on a daily basis

Obtaining a specialist low profiling bed

Acute Services:

- In hours, contact the Equipment Coordinators to request a specialist low profiling bed. If none are available, you will be advised of the process to obtain a rented bed.
- Out of hours, contact the Porters to request a low bed. If none are available, contact the Bed Managers who can organise for a rented bed to be delivered.

Assess your ward area for patients that may be on a low bed that can be de-escalated.

Where a low bed is not available and a rental is being arranged, aim to nurse the patient on an Enterprise 5000 or 8000 bed and set to the lowest level. Crash mats may be requested where appropriate to be used with the Enterprise beds.

Guideline L: Bed / Chair Sensors

Bed sensors will alert staff to movement but will not prevent a patient from falling. All nursing staff should be aware that sensors are in use, and react to the alarms as quickly as possible.

If the patient is repeatedly standing up when unsafe to do so, try and deal with the issue rather than simply asking the patient to sit down again. Constant alarms on bed sensors will reduce the effects on the reactions of staff.

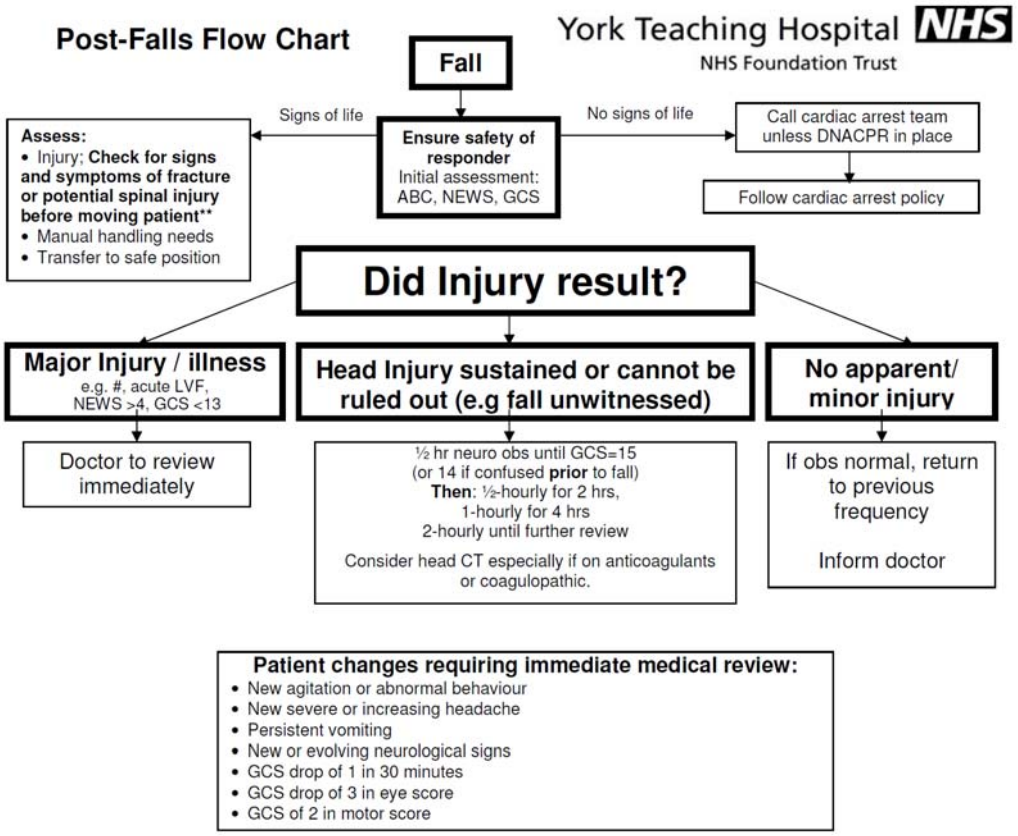
Before requesting bed sensors;

- Ensure the bed / chair is appropriate for the patient and can support having sensors in place
- Ensure that any pressure relieving equipment that may be required is compatible with placement / use of the sensor pads
- Ensure any other actions have been implemented as far as possible to reduce the risk of falls.

TABS bed and chair falls sensors can be obtained via the Equipment Co-ordinators or via the Porters out of hours.

Guideline M: Post-Falls Flow Chart

This process must be followed in the event of any patient fall. A copy of the Post-Falls Flow chart must be laminated and displayed on all nurses' stations.



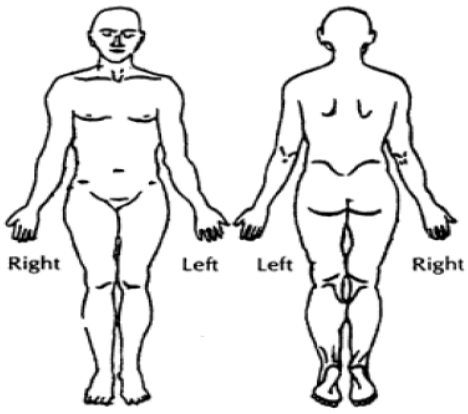
Guideline N: Post Falls Checklist Sticker

This sticker must be completed and placed in the medical notes following any patient fall incident.

This patient had a fall / found on floor on: Date: Time:

Nursing Checklist	
Immediate Actions	
❑ Re-assess moving and handling	❑ Complete Datix form
❑ Inform Doctor Dr's Name:	❑ Inform family / carer / NoK
❑ Complete a full set of observations including GCS where appropriate	
Any loss of consciousness?	
Recurrent faller?	
Falls leaflet given to;	
❑ Patient	❑ Family / carer
Completed by:	
Sign:	Date:
Print:	Time:
Give summary of events below	
Continue in medical notes if needed	

Doctors Checklist	
History – Tick and document in notes	
❑ Time and circumstances	❑ On warfarin / fully anticoagulated
Examination – Tick and document in notes	
❑ Review Obs (inc GCS)	❑ Other relevant systems
❑ Orientation	❑ Medication review
❑ Cardiovascular	❑ Hip examination
❑ Neurological (inc pupils, vision, speech, power)	❑ Likely cause of fall
Injury Sustained	



Include head, c-spine, hips, wrists
*Mark image with **X** or tick;* ❑ *No injury*

Start neuro obs if head injury risk

Investigations requested	
❑ ECG	❑ Complete AMT score
❑ X-ray	❑ Bloods

Guideline O

Fall Root Cause Analysis Procedure

This Root Cause Analysis tool should be used to investigate all serious incidents of patients falling in hospital

To be added once reviewed