SLIPS, TRIPS AND FALLS CLINICAL GUIDELINE

This procedural document sets out the guidelines for the organisation’s management of risks associated with slips, trips and falls involving, patients, staff and visitors.

The principles contained within this document will ensure that any incident is managed timely, effectively and appropriately in order to ensure the efficient management for all involved in such a safety incident.

The Trust monitors the implementation of and compliance with this clinical guideline in the following ways;

All slips, trips and falls (including near misses) will be reported through the Incident Reporting system. All incidents are investigated according to the severity of the incident and monitoring of this process will be undertaken by the Risk Management Team as outlined in Trust Adverse Incident including Serious Untoward Incident Policy.

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The Director responsible for monitoring and reviewing this Clinical Guideline is Executive Nurse.
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1.1 Essex Partnership University NHS Foundation Trust (EPUT) is committed to providing a safe and therapeutic environment for all patients having their care delivered in Trust managed premises and in supporting the reduction of falls in patients’ own homes in the community. In addition the Trust is committed to the provision of a safe place of work and a healthy working environment for all employees, visitors, contractors, volunteers and those affected by or involved in Trust activities.

1.2 Across England and Wales, over 36,000 falls are reported from mental health units and 28,000 from community hospitals. Approximately 30% of people over 65 years living in the community fall yearly; around 300,000 fragility fractures are sustained every year in the UK and there are 1,150 deaths every month as a result of hip fractures. Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged over 75 in the UK. Hip fracture is the most common serious injury related to falls in older people, resulting in an annual cost to the NHS of around £1.7 billion for England. Of this, 45% of the cost is for acute care, 50% for social care and long term hospitalisation, and 5% for drugs and follow up.

1.2.1 Most falls lead to minor injury but some can cause fractures, the need for surgery and other serious interventions, or even death. Such falls can cause severe morbidity in patients, restrict mobility, reducing independence, increase anxiety and create a fear of falling again. Many falls are avoidable and falls prevention has been identified as a way of making financial savings as well as improving the quality of life of the individual.

1.3 The Trust encourages the principle of good practice throughout all health-care staff teams. It is acknowledged that when an incident occurs resulting in the harm of anyone on Trust property, it is essential that communication between the health-care team, and others, is carried out in a timely and appropriate manner.

1.4 ‘Patient’ will be the terminology used throughout this document and will refer to a patient, resident or service user.

2.0 STATEMENT OF INTENT

2.1 The aim of this guideline is to promote the welfare and safety of patients, employees, visitors, contractors and volunteers by providing best practice guidance on the prevention and management of any slips, trips and falls within the Trust.
3.0 SCOPE

3.1 All staff working within Essex Partnership University NHS Foundation Trust (EPUT) must be alert to the possibility of falls associated with patients, other members of staff and visitors to the trust and to the potential consequence of such events. Falls prevention is a high priority in care delivery and in ward and unit management, and it is therefore the responsibility of every employee to report and/or address any event that may present as a hazard in this respect.

4.0 DEFINITIONS

4.1 A Patient Safety Incident is defined as any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS funded healthcare. The terms “patient safety incident” and “prevented patient safety incident” will be used to describe “adverse events” / “clinical errors” and “near misses”. “Patient Safety” is also used in some references and refers to service users, residents or patients.

4.2 A Fall is “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level” (WHO, 2007).

4.3 A Slip is a slide accidentally causing a person to lose their balance; this is either corrected or causes the person to fall.

4.4 A Trip is to stumble accidentally often over an obstacle, causing a person to lose their balance; this is either corrected or causes a person to fall.

5.0 RESPONSIBILITIES

5.1 The Trust Board is responsible for ensuring:
• That the principles of this policy, the related procedural guidelines and other associated policies are implemented across the organisation;
• The consideration of financial resources to support implementation of this procedural guideline.

5.2 The Director of Nursing, Executive Nurse will ensure
• Clinical Guidelines are embedded into clinical practice and updated regularly.

5.3 Directors and Senior Managers will
• Monitor the implementation of this clinical guideline via clinical audit and supervision.
• Ensure that the Risk Management Team and Health and Safety Team are appropriately notified on all incidents.
• Be able to evidence that EPUT policies are followed.
5.4 **The Falls Group** will:
- Monitor and review falls incidents and trends.
- Provide a forum for discussion and exception reporting to improve reporting, analysis and learning from falls incidents.
- Oversee implementation of this guidance.
- Oversee partnership and joint working projects in relation to falls prevention focusing on areas of vulnerability and risk.
- Monitor and evaluate falls prevention actions required from frontline staff working in clinical areas.
- Ensure compliance/assurance with national and local standards and guidelines.

5.5 **Ward Managers/Nursing Homes Managers/Team leaders** will:
- Ensure the procedures and principles associated with this clinical guideline are followed.
- Ensure that all patient safety incidents including those regarding slips, trips and falls are recorded on relevant Trust documentation. Respond to all Datix reports and if a serious incident has occurred, undertake a root cause analysis.
- Be responsible for ensuring that the Being Open and Duty of Candour principles have been upheld if a serious incident occurs.
- Ensure that all staff are fully trained in safe working procedures including Codes of Practice detailed within Trust Corporate Health and Safety Policy.
- Monitor and ensure that all relevant staff adhere to mandatory training requirements.
- Ensure general workplace risk assessments are undertaken annually.

5.6 **Clinical Staff (Medical staff, nurses, pharmacists and allied health professionals)** will:
- Assess patients and participate in completing risk assessment tools and development of individual patient care plans. Recommend any specific interventions (depending on individual risk assessments) and support any required escalation of care.
- Optimise patient care to prevent a fall.
- Optimise patient care following a fall.
- Undertake falls prevention training offered by the Trust (e-learning).

5.7 **All employees** will:
- Ensure a risk assessment is undertaken once a falls risk is identified.
- Ensure that they report all incidents including those regarding slips, trips and falls to their line manager immediately and a Datix report is completed.
- Report any potential risks of slips, trips or falls to their line manager immediately.
- Adhere to EPUT clinical guidelines.
- Adhere to Trust Mandatory Training requirements.
5.8 **The Workforce, Planning Education and Training Department is**
- Responsible for ensuring that training in falls prevention and management is rolled out across the Trust.

### 6.0 ENVIRONMENTAL RISK ASSESSMENT

6.1 To ensure that the risk of slips, trips and falls is reduced in an environment, General Workplace Risk Assessments must be undertaken by each Team Manager, annually, in line with the General Workplace Risk Assessment Policy.

6.2 All staff are responsible for identifying any potential areas at high risk of slips, trips or falls.

6.3 Where a risk area has been identified a risk assessment must be undertaken for example if there was damage to the floor identified, if a paving slab was damaged etc. A task would then need to be put on 3i for estates to action and address measures that need to be put in place.

6.4 When an incident/accident occurs this must be reported on the Datix incident reporting system described within Trust policy.

6.5 The Corporate Health and Safety Policy states managers are responsible for ensuring that risks are minimised in their areas by monthly inspections as well as an annual inspection of environments. Should any risks be identified this must be reported and measures taken to reduce risks.

6.6 Following an incident where a person (patient visitor or staff member) has slipped, tripped or fallen (this includes falls from heights greater than 1m) or a near miss occurred the manager of that area is responsible for identifying if action is required to avoid the incident happening again. If the manager identifies a potential risk a risk assessment must be completed.

**Clinical Risk Assessment / Care Plan:**

6.7 Assessment of risk of falling must be completed in collaboration with the individual, relatives/carers in order to obtain accurate, important information and to develop a person centred care plan. For **inpatient areas including nursing homes all people over the age of 65** must have a falls risk assessment known as a Guide to Action For Falls Prevention Tool (GtA), completed (Appendix 1) on admission. For patients aged 50-64 years, considered to be at risk of falls, a GtA should also be completed.

Please be aware that any patient aged 18-64 years with balance/and or mobility problems, physical disabilities, recent falls or has a fear of falling, should have a falls risk assessment.

6.8 The GtA (falls risk assessment) should be undertaken within 24 hours of admission. Where this is not possible, it should be undertaken at the earliest possible opportunity and the reason documented in the clinical record.
6.9 **Postural Hypotension** can increase the risk of falls and integral to the falls risk assessment is the recording of a lying and standing blood pressure (Appendix 3). Postural hypotension describes a drop in systolic blood pressure of 20mmHg or more or a drop in diastolic blood pressure of 10mmHg (with symptoms) within three minutes of standing.

- Clinical symptoms include: Dizziness, light-headiness, visual disturbance, palpitations, pallor and syncope when a patient stands up from sitting or lying down.
- A lying and standing blood pressure should be recorded on the GtA and also on the patient’s MEWS/NEWS chart.
- To ensure compliance, the Ward manager/Sister/Matron should keep a record at the front of the MEWS/NEWS chart (Appendix 4).
- Nursing staff should inform the doctor immediately if a patient has postural hypotension.
- Patients should be advised to sleep with the head of the bed elevated and to move from supine to standing or sit to standing very slowly to prevent falls.
- Patients should be instructed to do calf pump exercises before standing to reduce postural hypotension.

6.10 If a patient refuses to have a lying and standing blood pressure taken on admission, nursing staff should document this and try again at least once a week to see if the patient will comply. A patient may also need to have their lying and standing blood taken more than once if there is a change in their medical condition or medication and have clinical symptoms.

6.11 **Medication Review for Falls Risk:** Patients identified as being at risk of falls or have been admitted with a fall should have a formal review of medicines on admission by the admitting doctor or pharmacist and consideration should be given to reducing or stopping high risk medications.

- **Documentation:** A doctor or pharmacist should date and sign in the notes box on the front of the medication chart when they have reviewed a patient’s medication for falls risk.

- **High Risk Medications:** Many medications are known to increase the risk of falls from a variety of mechanisms, but commonly those that affect blood pressure or have a sedating effect are particularly problematic. Careful consideration should be given when prescribing any drugs known to increase the risk of falls (Appendix 7).

- **Night Sedation:** Should be used with caution, particularly in frail, elderly patients and reviewed regularly. Staff should be aware of the high risk of falls associated with starting or increasing doses of night sedation and measures such as falls sensor equipment should be considered if the patient is in an unobserved bed.
6.12 Where a patient is admitted with a fall or is found to be at high risk of falls, the multi-disciplinary team may need to do further tests/assessments and investigations to include:

- An assessment of cognitive impairment
- Testing for delirium
- Visual assessment (a bedside check of ability to recognise objects from the end of the bed as a screen for eyesight problems and a fuller assessment where required).
- Cardiovascular examination including ECG.
- Continence assessment and Urinalysis (if appropriate).
- Bone health review and assessment for Osteoporosis
- Physiotherapy assessment: Gait, balance, mobility and muscle weakness.
- Occupational Therapy assessment of performance and function (including activities of daily living) to reduce falls.
- An assessment of footwear/foot health (refer to guidelines in Appendix 5)

6.13 On inpatient/Nursing Home areas when a falls risk has been identified staff should refer to the suggested actions on the GtA and implement a falls care plan which must be reviewed as necessary on a scheduled basis or when there is a change in the patient’s condition (and especially following a fall).

6.14 If bedrails are considered to be necessary, refer to the Clinical Guidelines on the use of Bedrails.

6.15 In the community when a fall has occurred or a falls risk has been identified by the visiting clinician, the short FRAT (Appendix 8) should be completed and referral made to the Falls Prevention Service or relevant specific service.

6.16 Procedural pathways for falls prevention within in-patient/nursing homes and community dwellings follow this page.
Falls Prevention and Management Procedural Pathway for In-Patients / Nursing Homes (All people over 65 and those between the age of 50-64 thought to be at risk of falling)

Involve individual’s carers/relatives as appropriate regarding falls risk and any existing coping strategies

Complete Guide to Action for Falls Prevention Tool (GtA) or FRAT and document within 24 hours of admission

IS RISK OF FALLING IDENTIFIED?

YES

FORMULATE CARE PLAN
Multi-factorial interventions

NO

HAS A RISK OF FALLING FROM BED BEEN IDENTIFIED

YES

Complete bed Rails Risk Assessment (if appropriate) and Plan
Incorporate into Falls Prevention Care Plan

NO

REVIEW

Change in need identified/ following clinical incident

REVIEW AND UPDATE

Following change in identified need/ following clinical incident

REVIEW AND UPDATE
Falls Prevention and Management Procedural Pathway for Community

Assess for risk in relation to falls and document within 48 hours of admission to service
Involves individual’s carers/relatives as appropriate regarding falls risk and any existing coping strategies

IS A FALLS RISK IDENTIFIED

YES

Complete FRAT within 48 hours of identification of Risk

NO

Falls risk identified and being addressed by other agency?

YES

Obtain copy of Assessment and Plan

NO

Make appropriate referrals.

Review

Change in need identified following clinical incident

FORMULATE CARE PLAN

REVIEW CARE PLAN

Change in need identified following clinical incident

Contribute to Review as appropriate
7.0 FACTORS TO TAKE INTO CONSIDERATION WHEN ASSESSING RISK:

7.1 PERIODS OF HIGHER RISK-There are a number of factors that may interact to cause a person to fall and particular hazards and circumstances within a period of hospitalisation to inpatient area or Nursing Home that may increase risk further.

- Standing up from a sitting or lying down position (postural hypotension)
- Medication initiation and/or change
- Personal care – toileting/dressing and undressing/washing etc.
- Agitation/restlessness/suspicion
- Poor or altered sleep pattern
- Post TI/CVA/post-activity/procedure (including post-ECT)
- Post medication administration
- Meal times
- Independent toileting/self-care
- Night time (often association with need to void)
- Reduced staffing levels or observation
- Floor cleaning periods/maintenance work
- Application of Bed Rails
- Handover periods

7.2 All care plans must identify areas and/or times of risk in any patient’s pattern of behaviour. This must outline interventions and observation levels that must be implemented to address such issues.

7.3 All patients at high risk of falls should be reviewed in the daily safety huddle in order to discuss fall prevention strategies and review supportive observations.

7.4 Possible interventions for patients at risk of falls:

- Some patients may require enhanced observation in the form of cohort nursing or 1-1 supervision (See Appendix 11 – Falls: Safe & Supportive Observation Guidelines)
- Ensuring that patients know how to use the call bell system which must be in sight and reach of the patient (if applicable).
- Patients have access to their own spectacles and hearing aids that work.
- Fall safety alarms (Bed, chair and floor sensor mats).
- Commodes should be made available where appropriate ensuring the equipment is sound and making sure that brakes are applied.
- Beds are to be adjusted to the lowest level when in use and the brakes applied.
- Use of low profiling beds (See Appendix 13 – Guidance on the use of Ultra-low Beds)
- Bed rails (Refer to CG86 Clinical Guidelines on the Use of Bedrails)
• Hip protectors
• All staff to ensure that prior to mobilising, patients are wearing appropriate footwear and/or splints as required (See guidelines Appendix 5).

7.5 Where any patient is at risk of falling, relatives/carers are to be made aware of the risk at the earliest opportunity, and whilst every step will be taken to reduce the risk; it may not be possible for this to be eliminated completely.

If a patient has been assessed and issued with a walking aid by a Physiotherapist in the community, then they should be encouraged to bring their walking aid into the ward.

7.6 Patients at high risk of falls must have a joint Physiotherapy/OT home assessment prior to discharge.

7.7 Patients with a history of falls on discharge if possible, should be referred locally to a specialist community falls prevention service

8.0 FALLS PROCEDURE

8.1 Staff should be aware that many older people have higher potential for fracture than younger adults, and fractures can be induced with minimal impact or force – this includes patients at risk from ‘spontaneous’ fracture.

8.2 It is also significant to bear in mind that falls may cause fractures which are not immediately apparent, in that the fracture has not displaced. In this instance, the patient may not complain of pain at the time of injury, but may do so some days later.

8.3 Following a fall when a fracture or other injury is suspected, the patient must be reviewed by a registered nurse or Physiotherapist. They should notify the doctor as soon as practicable. Information relating to the fall and condition of the patient should be relayed to the doctor and a decision will be made on further action to be taken; SBARD (Situation, Background, Assessment, Recommendation and Decision) who will make a decision on further action.

On CHS inpatient wards, a competent nurse or physiotherapist may review the patient and decide on further action.

Vital signs, including an assessment of the patient’s neurological condition must be recorded and must include use of the Glasgow Coma Scale (GCS) to determine whether any neurological impairment has resulted from the fall. GCS must be recorded by a qualified member of staff and recorded on the appropriate neurological chart. In patients whose condition may be difficult to assess using the GCS (such as in advanced dementia) the patient’s response level must be assessed using the ACVPU scale. See Appendix 10 for details of neurological observation frequency.

If a head, neck or spinal injury is suspected do not move the patient, wait for the paramedics to arrive and they can use specialised manual handling equipment. If the patient has a possible lower limb fracture or hip fracture
(limb is shortened and leg externally rotated) and the patient is complaining of pain, do not hoist patient from the floor, wait for the paramedics. Hoisting a patient with a fractured hip could cause severe pain and may displace the fracture further.

8.4 If the response from the ambulance service is delayed staff should report this via the Datix Incident Reporting system.

8.5 At all times the patient will require reassurance and observation, and every attempt should be made to keep the person comfortable and pain assessed, managed & controlled.

8.6 The appropriate recording of information should take place and the next of kin informed at the most convenient/appropriate opportunity. Liaison with the patient’s next of kin and/or relatives should take place during on-going care following a fall.

8.7 Nursing and medical staff must be constantly alert to the potential for the patient’s physical and psychological presentation. This includes review of medication that may increase the risk of falling. This should be identified in the care plan and monitored regularly.

8.8 All falls must be recorded in the nursing notes and care plans updated, including the amendment form for the GtA to be completed (Appendix 2). Falls are to be reported using the Trust wide incident reporting system (Datix).

8.9 Where the patient is found on the floor this MUST be reported as a fall and the Rapid response protocol followed to include neuro-observations (GCS) if patient has a suspected head injury or fall was unwitnessed. A laminated copy of the post-fall protocol flow chart for nurse’s actions to be displayed in all clinical areas.

**NB: This includes times when no injury is apparent at the time of the incident.**

8.10 A Root Cause Analysis (Appendix 6) should be undertaken in the event of a fracture which meets Serious Incident Reporting criteria and the Serious Incident reporting procedure must be followed.
The Glasgow Coma Scale (GCS).
The Glasgow Coma Scale is a comprehensive tool to estimate levels of consciousness following any fall. It will provide staff with indicators of the impaired level of consciousness as described below. Each criterion is assessed separately and the total of the three scores provides the GCS result. This will be recorded on the observation chart.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Best eye response</th>
<th>Score</th>
<th>Description</th>
<th>Best verbal response</th>
<th>Score</th>
<th>Description</th>
<th>Best motor response</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Spontaneous</td>
<td></td>
<td>5</td>
<td>Orientated</td>
<td></td>
<td>6</td>
<td>Obey commands</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>To sound</td>
<td></td>
<td>4</td>
<td>Confused</td>
<td></td>
<td>5</td>
<td>Localising</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>To pressure</td>
<td></td>
<td>3</td>
<td>Words</td>
<td></td>
<td>4</td>
<td>Normal flexion</td>
<td></td>
</tr>
<tr>
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<td>None</td>
<td></td>
<td>2</td>
<td>Sounds</td>
<td></td>
<td>3</td>
<td>Abnormal flexion</td>
<td></td>
</tr>
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<td>NT</td>
<td>Non testable</td>
<td></td>
<td>1</td>
<td>None</td>
<td></td>
<td>2</td>
<td>Extension</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>NT</td>
<td>Non testable</td>
<td></td>
<td>1</td>
<td>None</td>
<td></td>
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</table>

**Score** | **Description** | **Action**
--- | --- | ---
3–8 | Indication of a severe head injury. The patient’s airway will not be self-maintained and will require airway management. The patient may have no signs of life, be unconscious or show abnormal signs of raised intracranial pressure. | Call for immediate help and commence post falls protocol. Call emergency services (9)999 as GCS indicates severe head injury. Commence CPR if there are no signs of life; continue until emergency services arrive and take over resuscitation. If there are signs of life: manage patient’s airway and their safe environment; commence EWS observations and neurological observations in accordance with NICE CG176 every 30 minutes until the emergency services arrive.

9–12 | Indication of a moderate head injury. The patient may be conscious but restless, agitated or confused | Call for immediate help and commence post falls protocol – call emergency services (9)999 as GCS indicates moderate head injury. Manage patient’s safe environment, commence EWS observations and neurological observations in accordance with NICE CG176 every 30 minutes until the emergency services arrive.

13–15 | Indication of a mild head injury. The patient will be conscious, may be fully alert and orientated but may also have confusion or may require to be roused to undertake the assessment. | Call for immediate help and commence post falls protocol, manage patient’s safe environment, commence EWS observations and neurological observations in accordance with NICE CG176 every 30 minutes. Call a doctor for immediate assessment. Follow post falls plan of care.

**Caution** | Any deterioration in the GCS by 2 points | Seek immediate medical assessment and increase neurological observation in accordance with NICE CG176 recommencing half hourly
The minimum frequency of observations for a patient with a GCS equal to 15 is shown below (for more details see appendix 10)

- Half-hourly for 2 hours.
- Then 1-hourly for 4 hours.
- Then 2-hourly thereafter for 24 hours
- If it is not possible to perform GCS assessment on a patient because of refusal or because of existing neurological deficit making GCS assessment difficult, a full description of level of alertness using ACVPU scale and a description of behaviour and limb movements is required at the above frequency

**NB** Patients with cognitive decline or dementia may have a GCS of less than 15. Distinct changes in usual behaviour/level of agitation, restlessness, listlessness will require immediate medical review.
Post Falls Protocol
Stay with the person and summon help immediately

Is the patient stable?
Assess ABC, EWS, GCS, AVPU

No
Follow your local cardiac arrest protocol or deteriorating patient protocol as appropriate

Yes
Check BEFORE moving off floor: Are there any signs or symptoms of injury?

Spinal Injury
e.g. struck spine or neck, pins & needles, tingling, numbness, weakness, back or neck pain, loss of sensation

Hold patient still
Call doctor immediately. Dial (9) 999. Inform nurse in charge. Consider pain relief.

Fracture Injury
e.g. lower or upper limb fracture, joint/limb pain, limb deformity, loss of sensation, numbness, weakness

Immobilise spine and/or limb
Retrieve patient from floor using standard manual handling methods if appropriate (if in doubt seek expert advice)

Head Injury
e.g. struck head or face, lumps, grazes or lacerations on scalp or face, black eye, head pain, nosebleed, vomiting, reduced consciousness or new confusion

Is there EITHER signs of head injury as above OR was there no reliable witness to the fall?

YES
There are no indications of head injury, but there was NO RELIABLE WITNESS to the fall

There is a reliable witness to the fall who can confirm the patient DID NOT strike their head

Take and act on neurological observations for the frequency and duration stated on the neuro obs chart

Consider how best to prevent the patient falling again (refer to slips trips and falls clinical guidelines). Report the fall and inform family/friends (as appropriate).

Any other significant injury
e.g. haemorrhage, large skin tears or lacerations

Only minor injury
e.g. grazes, bruises

No signs of injury

MH: Following a fall, the patient should be reviewed by a registered nurse or Physiotherapist. They should notify the doctor as soon as practicable. Information relating to the fall and condition of the patient should be relayed to the doctor. Decision will be made on further action to be taken; SBARD (Situation, Background, Assessment, Recommendation and Decision).

CHS Wards and nursing homes (out-of-hours): A competent nurse or Physiotherapist may assess & decide on further action.

Production Date: Jan 2018; amended Jan 2020

EP0325
FALLS AT HOME Reassurance/Support needs to be given throughout this process.

WITNESSED FALL OR ARRIVE TO FIND PATIENT FALLEN

- **Obvious physical Injury?**
  - YES
  - **ABLE TO GAIN ACCESS**
    - YES
    - **Assessment of physical condition (record whilst individual is on floor)**
      - NO
      - **No evidence of injury**
    - NO
    - Contact Emergency Services to gain entry
  - NO
  - Contact Next of Kin as appropriate

- **Evidence/suspect injury during/following assessment**
  - YES
  - **Individual able to be safely assisted from the floor or rise independently**
    - NO
    - Verbal and physical prompts can be used to assist individual from floor, in line with moving & handling best practice
  - NO
  - Contact Next of Kin as appropriate

- **Staff member to remain with individual until ambulance arrives**

- **Assessment of injury**
  - (record whilst individual is on floor)

- **FOLLOWING THE INCIDENT**
  - Incident form must be completed
  - Notify GP
  - Falls risk assessments and associated care plan must be reviewed
9.0 ENVIRONMENTAL CONSIDERATIONS

9.1 Liquid spills on non-porous flooring must be cleared immediately. In the event of a significant spillage/flood, the area affected is secured and all patients, visitors/personnel diverted away from that area until it is completely dry.

9.2 Hazard warning signs are clearly displayed and left in place whilst the area continues to be wet. Once dried, the signs are removed and re-stored at the earliest opportunity.

9.3 Food spillages are cleaned up immediately and the dining floor swept as soon as possible after every meal.

9.4 Flexes / extension cables do not cross open areas, and are not left near a walkway. If necessary, permanent cabling must be secured to the wall / fittings to reduce the likelihood of it causing someone to trip.

9.5 Portable electrical equipment is connected to the mains at the nearest socket adjacent to areas of use. Flex is not allowed to stretch across corridors / walkways. In the event of this being unavoidable, a member of staff must be available within the vicinity to direct people away from the cable, until the procedure / work are complete and the flex can be removed.

9.6 Furniture is placed in positions that leave walkways clear.

9.7 Lighting is appropriate and fully functioning. Any light that is malfunctioning is reported immediately and repaired as a matter of urgency.

9.8 Worn or damaged floor covering is reported and repaired immediately.

9.9 Where immediate repair cannot be made and/or a hazard cannot be removed a risk assessment must be undertaken to identify control measures to reduce the risk of injury, harm or damage. The Trust approved Risk Assessment Tool should be used please see Risk Management Policy RM11 Appendix 2A. A copy of the Risk Assessment is to be sent to the Risk Management Department.

9.10 All aids to mobility are clearly marked for individual patient use, and checked for appropriateness.

10.0 OTHER FALLS

10.1 If a member of staff sustains an injury as a result of a fall, during duty time they will need to assess their own ability to continue working.

10.2 If they consider that as a result of the fall they need medical assistance, appropriate services should be summoned.

10.3 Wherever possible the manager or senior member of the team must be informed at the earliest opportunity about the incident and an incident form completed.
10.4 If a member of the public or staff falls:

• Reassure the person and render first aid / 9-999 if required
• Advise/support the person to seek further medical advice if needed at GP/A&E/Occupational Health.
• Complete the incident report and circulate as form describes (consider RIDDOR & SOVA)
• Environmental risk should be considered and any faults reported to Estates and Facilities
• Consider any predisposing factors for the fall

11.0 ACTION TO BE TAKEN IF A FRACTURE SUSPECTED

11.1 Where a person, other than a patient falls and a fracture is suspected the person must be advised to attend the local emergency Department. This information must be recorded on the incident form and follow up should be undertaken by the area manager to ascertain if a fracture did occur. All possible assistance must be given to the person.

12.0 TRAINING

12.1 Staff training needs regarding slips, trips and falls have been identified as part of a trust-wide training needs analysis. The training will include monitoring the patient who has fallen and the use of the Glasgow Coma Scale for observation in order to detect and minimize any risk of complications or further injury.

12.2 All nursing staff, Occupational Therapists and Physiotherapists working on older peoples wards will need to complete the OLM 000 preventing falls in hospital. Medical staff will undertake Carefall training. In addition, falls risk assessment and the use of the risk assessment tool forms part of the annual mandatory clinical risk training for qualified staff.

12.3 Senior Clinical Staff are responsible for nursing home/ward based training and ensuring on-going competency of staff in falls prevention awareness. Each area must ensure staff are informed about current policy / guideline requirements, through ward/nursing home based induction, preceptorship and supervision. Specific training for falls prevention will be provided through a number of routes including face to face training and mandatory e-learning packages.

12.4 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training.

12.5 The ward manager/nursing home manager/team leader should check which training has been undertaken by a member of staff through:

• The Training Tracker, which will be validated to confirm training has taken place
• Supervision

12.6 Staff who are booked on mandatory training and are, for whatever reason, unable to attend, MUST inform their relevant Director of their reasons.
12.7 If an employee fails to attend on the second occasion, the service director will be notified and the conduct procedures will be initiated if appropriate.

<p>| MANDATORY | STAFF | UPDATE | DELIVERY |</p>
<table>
<thead>
<tr>
<th>TRAINING</th>
<th>CATEGORY</th>
<th>INTERVAL</th>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit for Work- Slips / Trips and Falls for patients &amp; Staff</td>
<td>(A) All staff on inpatient areas</td>
<td>annually</td>
<td>E-learning</td>
</tr>
<tr>
<td>OLM 000 preventing falls in hospitals.</td>
<td>(B) Nursing staff, OT’s and PT’s working in older inpatient service areas/ nursing homes</td>
<td>3 yearly</td>
<td>E-learning</td>
</tr>
<tr>
<td>Carefall OLM training.</td>
<td>(C) Medical staff</td>
<td>3 yearly</td>
<td>E-learning</td>
</tr>
<tr>
<td>Basic Back Care (People Handlers)</td>
<td>(A) All staff requiring training must complete theory prior to practical sessions. Occupational therapy staff (Head OT staff, OT staff adult community resource teams OT staff rehabilitation team &amp; adult in-patient areas, including Nursing Homes. E-learning theory)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(B) All areas with link workers on site training On site</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(C) In patient nursing staff, Nursing Home staff, Physiotherapists and day hospital services, All other occupational therapy staff. (all areas without a link worker). Allied health professionals as identified by service leads.</td>
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<td></td>
<td>2 hours</td>
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<tr>
<td>Hoisting</td>
<td>(A) All staff that require hoist training must complete theory prior to practical sessions. E-learning theory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(B) All areas with link workers receive onsite training On site</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(C) Nursing staff older adult in-patient/Nursing Home areas, All basic grade (band 5) occupational therapy staff occupational therapy staff in learning disabilities &amp; older adult services &amp; physio’s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.5 hours</td>
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</tbody>
</table>
13.0 RAISING AWARENESS

13.1 Awareness of any key risks highlighted through risk assessment, audit or trend analysis will be shared through staff training and team meetings.

13.2 Awareness of issues will be advertised within Trust publications at regular intervals (a minimum of 6 monthly). The Trust Falls Group will be responsible for reviewing this as appropriate.

14.0 MONITORING OF IMPLEMENTATION AND EFFECTIVENESS OF THESE CLINICAL GUIDELINES

14.1 This clinical guideline will be disseminated across the organisation via the Trust Intranet and is found within Policies and Procedures.

14.2 All slips, trips and falls (including near misses) will be reported through the Incident Reporting system. All incidents are investigated according to the severity of the incident and monitoring of this process will be undertaken by the Risk Management Team as outlined in Trust Adverse Incident including Serious Untoward Incident Policy.

14.3 Slips, trips and falls trends are analysed and shared through the Trust’s Health and Safety report and disseminated through the Falls Group, the Health, Safety and Security Committee and the Health and Safety sub-groups for each area.

14.4 Patients who experience repeated falls are reported to the Falls Prevention Coordinator on a weekly basis. Trends are reviewed and any actions required reported to the appropriate service lead with timescales for implementation.

15.0 ASSOCIATED DOCUMENTS

- Adverse Incident including Serious Untoward Incident Policy
- Corporate Health & Safety Policy
- Moving and Handling Procedure
- Clinical Guidelines for the Assessment and Management of Clinical Risk
- Freedom of Information Act 2004
- NPSA/2005/010- Safer Practice Notice
- Clinical Guidelines for Engagement and Formal Observation
- Clinical Risk Assessment & Safety Management Policy
- General Workplace Risk Assessment Policy
16.0 REFERENCE INFORMATION


Health & Safety Executive. (2003). *Preventing Slips and Trips at Work*. HSE. Available at: www.hse.gov.uk

Health & Safety Executive. (2003). *Slips and Trips in the Health Services*. Health Services Sheet Number 2. HSE Books. Available at: www.hse.gov.uk/


Management of Health and Safety at Work Regulations SI 1999/3242. Available at: www.hse.gov.uk


Royal College of Physicians (2012) The FallSafe Project

Royal College of Physicians (2012) *FallSafe prevention resources available at* www.rcplondon.ac.uk

Royal College of Physicians (2015) *National Audit of Inpatient Falls audit report*. Available at www.rcplondon.ac.uk