University Hospitals of Morecambe Bay
NHS Foundation Trust

Document Type: **Policy**	**Unique Identifier:** CORP/POL/156
Document Title: **Prevention and Management of Patient Slips, Trips and Falls**	**Version Number:** 1 **Status:** Ratified
Scope: Trust wide	**Classification:** Organisational
Author / Title: Kim Wilson, Associate Director of Nursing	**Responsibility:** Corporate Nursing
Replaces: Version 9 Corp/Pol/025 Slips, Trips and Falls Policy remains in place for staff and visitors; this new policy is specifically for patients CPFT POL/001/048 is also replaced by this new policy	**Head of Department:** Lynne Wyre, Director of Nursing
Validated By: Corporate Cross Care Group Matrons Executive Nurse Accountable Care Team	**Date:** 15/08/2019 22/08/2019
Ratified By: Procedural Document and Information Leaflet Group	**Date:** 11/09/2019
Review dates may alter if any significant changes are made	**Review Date:** 01/08/2022

Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 1,2,3,4 Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 1,2,3,4,5,7 Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

Document for Public Display: Yes

Evidence search/reference check Joanne Phizacklea 19.8.19 (2019-2020/226)

To be completed by Library and Knowledge Services Staff

CONTENTS

BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

1. SUMMARY

Falls in hospitals are one of the most common patient safety incidents reported to the NLRS in England. The nature of the patients to whom acute and community services are provided and the philosophy which supports active rehabilitation and independence deems that the risk of the patient falling is ever present. However, it is important that the risk be maintained at a minimum level, whether the patient is admitted following a fall or assessed as being at risk of falling once admitted.

Whilst many falls result in no injury to patients, there is a small number who do come to harm which may increase their length of stay and have a negative effect on their confidence and their experience. For a small minority, the fall event may even lead to disability or death.

Patients who have fallen prior to admission or who present to hospital following a fall are at high risk of falling whilst an inpatient. Reducing the risks of these falls can be achieved by comprehensive and systematic risk identification and positive co-coordinated multidisciplinary management and intervention.

The evidence base and interventions contained in this policy are specific to patients 65 years and over. However, risk assessment and interventions may be applied to any group or setting and to any fall, including those from a height.

2. PURPOSE

This policy applies to inpatient settings under the control of UHMB and is to guide a multidisciplinary approach to the management of all patients who are at risk of falling or who have already fallen.

3. SCOPE

This policy is for the attention of all UHMB staff and is aimed at in-patient settings. It describes the expected assessments and interventions used to manage the risk of falling, prevent falls and manage a patient following a fall. There is reference where possible to community settings, with advice on the management of falls in non-inpatient settings.

4. POLICY

4.1 Duties

4.1.1 Chief Executive

The Chief Executive has overall responsibility for the implementation of this policy but employer's duties will be delegated down through Directors to Managers, staff and formal groups

4.1.2 Executive Chief Nurse

Hold responsibility for the strategic development and implementation of this policy and procedures relating to patient safety risks and governance

4.1.3 Care Group Management Teams

Ensure that responsibility for hazard identification and risk assessment is properly and clearly assigned and that the implementation of this policy along with any management and investigation of slips, trips and falls is effectively carried out or delegated.

4.1.4 Medical Staff and Community Advanced Care Practitioners (ACP)

- Are responsible for assessing the risk of falls and fractures on admission including carrying out a review of medications, blood pressure and sensory impairment
- Conducting a review of patients following a fall

4.1.5 Department Managers

- Ensure that patient risk assessments for slips, trips and falls including, where applicable, falls from height are carried out in their areas of responsibility and that appropriate actions are taken to reduce these risks so far as is reasonably practicable.
- Ensure that all investigations are completed and fed back to the appropriate groups.
- Report environmental defects to the Estate and Facilities Department Help Desk.
- Review all slips trips and falls within their area and cascade any lessons learned with action plans to other members of staff.

4.1.6 All Staff

- Ensure that they clear up any spillages and use the appropriate warning signs.
- Ensure that the environment is kept clear of clutter and that adequate housekeeping is maintained.
- Complete falls care plan within Lorenzo Electronic Patient Record for each patient and review every 7 days or as clinical condition changes, implementing relevant actions / referrals.
- For community patients, complete the Falls Risk Assessment and Management Plan (FRAMP) on EMIS Electronic Patient Record or complete a paper copy of FRAMP for those services required to use paper notes.
- Complete a Trust clinical incident form in the event of a slip, trip or fall incident.
- If a patient falls, staff must complete the post falls checklist, update the falls care plan. Review FRAMP for community patients and complete the rapid review or RCA associated with the Clinical Incident Report.

4.1.7 Corporate Matrons Group

- Keep up to date with latest information regarding falls and cascade this information to the departmental managers
- Ensure the lessons learned from adverse incidents, are considered and make recommendations to all areas as appropriate.

4.1.8 Estates and Facilities and Patient Environment Services Managers

- Maintain appropriate lighting in general areas to reduce the risks of slips, trips and falls.
- Ensure an appropriate cleaning regime is chosen for the type of floor
- Ensure that floor cleaning is scheduled to take place at suitable times to reduce the risks of slips, trips and falls
- Ensure that a system is in place to clean up spillages between scheduled floor cleaning
- Ensure that suitable warning signs are displayed during floor cleaning and that access is prevented to wet floors or contaminated areas.
- Where floors are found to be dangerous when wet ensure floors will be mopped to dry.

4.2 Assessing the Risk

Risk prediction tools will NOT be used as there is no evidence base (NICE, 2013)[1].

- Risk assessment for patient falls will be carried out through the fundamental care plan in the electronic patient record in accordance with the guidance which supports it. For community areas this is known as the FRAMP.
- In all cases where a falls risk is indicated, the falls care plan will be completed, this is found in the Lorenzo electronic patient record within the fundamental care plan or if the FRAMP is a paper copy this must be scanned into the patient's EMIS record on discharge
- Patients identified as at risk of falls will be given advice on falls prevention and self-management
- Where appropriate a bedrail assessment will also be carried out. Please refer to Using Bedrails Safely and Effectively (hospital inpatients) (see section 6). This document is also within the electronic patient record as above.
- No third-party demountable bedrails will be used on any bed. Only beds with integral bedrails and an appropriate mattress which ensures the bedrails remain compliant with HSE requirements will be used where patients are assessed as needing the benefit of bedrails to prevent a fall from bed.

4.3 Prevention Strategies

It is well recognised that one third of people over the age of 65 years and half of people over the age of 85 years fall each year. The in-patient population is comprised of a disproportionate number of those aged over 65years giving an increased likelihood of falls. Added to this increased background falls risk is the changes of medication, changes of health status, disorientation, lack of furniture normally used to steady oneself at home, and an abundance of equipment on wheels.

UHMB have a number of items of equipment and strategies to reduce or prevent falls or reduce the risk of harm when people fall. For those at increased risk of falling staff should consider the following

- A review of medication which may affect balance
- Use of electronic bed or chair sensors/alarms
- Availability of beds and chairs to meet the needs of each individual in terms of stability, support and height
- Use of low rise beds
- Use of crash mats
- One way cushion covers
- Use of grip socks
- Cohorting those who have fallen or are at risk of falling into supervision bays with enhanced staffing or place in a highly visible area.
- Increased comfort rounds for those at risk who may be visually impaired or have a learning disability or dementia
- The pathway to the toilet and bathroom areas must be clearly marked, lit and free from obstacles

General interventions include the following:

- All patients must be orientated to the bed, toilet, and bathroom and ward area on admission. Drinks, food, walking aid and belongings must be placed within easy reach of the patient whether in bed or sitting in the chair. There should be clear signs to make it easy for patients to see where bathrooms and toilets are.
- The ward environment must be clutter free and clear from obstacles. Floors should be even, clean and no slip. Reviewing the journey that a patient is required to make, for example from the bed to the toilet, avoiding obstacles such as trolleys, chairs and trailing wires are important measures in minimising risk of falls.
- Patients must be warned of the potential risk of tripping up over items of equipment e.g. catheters, drips and drains, when mobilising and request assistance if required
- Appropriate lighting, use of night lights, accessible toilets and bathrooms with handrails and space to stand and turn safely, availability of chairs and perching stools all contribute to an environment that reduces the risk of a patient falling
- All staff have responsibilities to take reasonable care for the health and safety of themselves and others. Spillages should be isolated and cleaned immediately and hazard signs should be displayed.
- Relatives and carers can provide vital information in helping prevention of falling. If a patient is at risk of falling, the plan of care should be discussed with the patient and relatives/or carers as appropriate.

Call Bell

- Every patient must be shown how to use the call bell system, and be able demonstrate how it works. The call bell must be in sight and in reach of the patient. Patients must be reassured and encouraged to use the call bell

Eyesight / hearing

- Patients have access to own, clean spectacles and hearing aids that work. ENT/optometry referrals made as required.

Footwear

- Patient's footwear must be assessed on admission as appropriately well-fitting and non-slip, Relatives/or carers should be encouraged to provide appropriate footwear and where that is not possible wards will supply grip socks.

Comfort rounds and observation

- For in-patients, as a minimum, every 2 hours a patient will be seen and needs met, for example toileting offered, providing drinks, ensuring all belongings are close by. Exceptions to this will be within the EPR. Rounds will be documented in Lorenzo EPR; for staff on EMIS the comfort round will be completed on paper and scanned into EMIS.
- Some patients may need to be positioned in a more observable bed. This may be in bay or a side room close to a nurse's observation station. If a patient needs to be moved to a side room for a clinical reason i.e. infection prevention, then a risk assessment should be undertaken to ensure the risk of falling is mitigated.
- In clinical areas where there are high number of patients who are at risk of falling, the department should consider cohorting falls patients into falls bays to provide enhanced supervision.

- Some patients who are confused, wandering and are unsteady will be at greater risk of falling, may even require enhanced observation. The level of supervision required and provided needs to be recorded in care plan documentation and handed over at each shift change. Any additional staffing requirements needed to meet this need should be escalated to the appropriate manager as soon as is possible.

Pressure Sensor Equipment

- The use of pressure sensor equipment as a falls prevention strategy can potentially reduce the risk of a patient falling, if trying to move from the bed or chair without requesting assistance. A chair and/or bed sensor is used to alert staff when a patient is mobilising independently but has been assessed as unsafe to do so. An alarm is emitted when the patient moves from the bed or chair. However, it must be highlighted that there is no guarantee that by using these sensors that a patient will still not fall
- NICE (2015)[2] currently does not include the use of pressure sensor equipment in their guidance as there is currently not a sufficient evidence base to encourage/discourage their use. The use of this type of equipment needs to be assessed on an individual patient basis and the use of such equipment does not negate the need for frequent checks on patients. If in use and then removed(for example if causing distress) document the reason and/or mitigating factors and compensatory strategies

Low Profile Beds and Crash Mats

- Low profile beds can be used if a patient is assessed as being at risk of falling from a bed but when bedrails are inappropriate/or unsafe.
- Consideration should be given to the use of low profile beds and patients should be assessed individually to ensure that this is the safest and appropriate method of preventing a patient potentially falling from their bed
- Crash mats may also be considered on the floor next to the bed to cushion anyone rolling from a bed, but care must be taken to not introduce a trip hazard

Cognitive Impairment and delirium

- Clinical staff should assess patients for any acute changes in cognitive function by carrying out cognitive tests. Routinely assessing at admission will aid this process. Recent changes or fluctuating cognitive problems can indicate delirium that requires medical attention. (NICE guidance on delirium CG 103)[3]
- Patients who are confused and wandering in ward areas can be at risk of falls, so it is important that sources of delirium (such as infection) are identified and treatment commenced. An MSU must be performed in patients who are either confused or have urinary symptoms during admission, to rule out the possibility of urinary infection causing falls and delirium

Medication and Blood Pressure

- All patients aged 65 years and above will require completion of a lying and standing blood pressure[7]. See Appendix 1. (This can be done at any time during their stay.)
- Patients can be at risk of falling if they are on certain medications which may be sedating, induce confusion or continence problems, slow reaction times, cause symptomatic hypotension or systolic drop on standing. Non-medical prescribers, ACPs, pharmacy staff or medical staff can be used to review medication likely to increase the risk of falling.
- A drop of 20mmHg systolic or 10mmHg diastolic may indicate the need for further

review of medication and consideration of referral to specialist if symptoms persist
Continence

- Patients can be more at risk of falls if they have urgency or incontinence. A full assessment including urinalysis needs to be undertaken and referral to continence service as appropriate
- A patient who is assisted to use the commode or taken to the toilet, must be risk assessed if left alone for any length of time. The risk assessment must include reviewing a patient's ability to use the call bell to request assistance and balancing this with privacy, dignity and autonomy of the patient

Mobility and balance

- On admission, all patients receive a moving and handling assessment and a mobility assessment which is reviewed weekly during the patient journey (or if the patient's condition changes or if the patient falls.
- Levels of mobility and whether the patient uses mobility aids and whether supervision is required should be recorded in the EPR
- Mobility aids will be provided as appropriate and advice given to both patients and relatives/carers of plans to reduce the risk of falls
- Physiotherapy staff will review patients who require balance, mobility and strength assessment.

4.4 In the Event of a Fall

- Following a patient fall, if a spinal injury is considered then the patient should not be moved until specialist equipment is available (See Appendix 2 for Guidance for suspected spinal injury) and the doctor has reviewed
- Following assessment for spinal injury and appropriate decisions for care, a Post Falls Checklist (Appendix 3) will be completed by the nurse responsible for the patient at the time and all relevant actions will be completed. The Post Falls checklist is found within the electronic patient record.
- Where a hip fracture cannot be ruled out, the hoverjack (Appendix 4) should be used instead of a hoist and sling
- There is a separate SOP for patients in their home setting when they fall (Appendix 5)
- Any patient who has been transferred from another clinical area or who has fallen must have a review of their falls risk assessment, care plan and frequency of comfort rounding/intentional rounding.
- All slip, trip and fall incidents will be reported on the clinical incident reporting system in accordance with the Policy for Reporting and Management of Incidents including Serious Incidents which is found on the Trust Procedural documents library.
- Investigations of moderate, severe and catastrophic harms will require a root cause analysis and may be requested by the SIRI panel (or where it is evident that a theme or pattern is emerging from scrutiny of investigations).
- Investigations of minor harm will require a rapid review.

STOP and CONSIDER

Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy are at an increased risk of intracranial, intrathoracic, intraabdominal haemorrhage

There may be late manifestations of head injury up to 72 hours[4]

4.5 Incident Reporting, Learning Lessons and Raising Awareness

- All patient slips, trips and falls, including bedrail incidents must be reported on the Ulysses reporting system. A record of the fall must be documented in the patient record and a note made of the incident number.
- At the point of discharge or transfer incidents should be shared with the new department or care provider
- In the event of moderate, severe or fatal harm resulting from an inpatient fall, the incident must be escalated by the ward or department where the fall happened to ensure that a root cause analysis investigation is undertaken, Duty of Candour (CQC 2015)[5] is applied and consideration is to be given to declaring a Serious Incident Requiring Investigation (SIRI) for all falls where severe harm is sustained. (NHS England 2015)[6].
- In the event of an inpatient fall resulting in a fractured neck of femur, information will be uploaded to the National Audit of Inpatient Falls database
- All patient slips, trips and falls resulting in harm will be discussed at care group governance forums.
- A monthly report will be circulated to provider areas concerning falls numbers and levels of harm; with periodic reports to Quality Committee
- Any new lessons learned will be publicised through the Learning to Improve bulletin

4.6 Falls in the Community / Non In-patient Setting

- The management of the risk of falling in the community setting is as complex as inpatient settings with the added risk of the clinician not being able to control the environment and/or observe the patient as within our inpatient settings. The key priorities (8.1) are applicable in community settings, only moving the patient once they have been assessed for the level of harm, the recording of observations where possible, establishing a level of consciousness and requesting a medical review/999 dependent of the suspected level of harm. Following the fall incident reporting and clear documentation within the patient record are essential.
- All older people (aged over 65 years) in contact with a health care professional should routinely be asked whether they have fallen in the last 12 months; and if so should be asked about the frequency, context and characteristics of the fall
- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year should be offered a multi-factorial falls assessment.
- Community Teams use a multi factorial and osteoporosis risk assessment. Ensuring that when a falls risk assessment is required every adult patient where in contact with Nurse, OT or Physiotherapist receives a standard initial falls assessment.

5. ATTACHMENTS	
Number	**Title**
1	Measurement of Lying and Standing Blood Pressure
2	Guidance for Suspected Spinal Injury and Head Injury
3	Post Falls Checklist
4	Use of Hoverjack
5	Post falls procedure in the patients home setting
6	Harm Descriptors
7	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/SOP/011	Using bedrails safely and effectively (hospital inpatients) http://uhmb/cs/tpdl/Documents/CORP-SOP-011.docx
Corp/Proc/022	Reporting and Investigation of Incidents including Serious Incidents http://uhmb/cs/tpdl/Documents/CORP-PROC-022.docx
Corp/Proc/029	Techniques for the manual handling of patients http://uhmb/cs/tpdl/Documents/CORP-PROC-029.docx
Corp/SOP/074	Comfort Rounding (Intentional Rounding) http://uhmb/cs/tpdl/Documents/CORP-SOP-074.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS **References in full**	
Number	**References**
1	NICE Clinical Guideline [CG161] (2013). Falls in older people: assessing risk and prevention. Available at: https://www.nice.org.uk/guidance/cg161 (accessed 19.8.19)
2	NICE (2015, updated 2017) Falls in older people [QS86]. Available at: https://www.nice.org.uk/guidance/qs86 (accessed 19.8.19)
3	NICE (2010, updated 2019). Delirium: prevention, diagnosis and management [CG103]. Available at: https://www.nice.org.uk/guidance/CG103 (accessed 19.8.19)
4	NICE (2014, updated 2017). Head injury: assessment and early management [CG176]. Available at: https://www.nice.org.uk/Guidance/CG176 (accessed19.8.19)
5	CQC (2015) Duty of candour. Available from: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour (accessed 19.8.19)
6	NHS England (2015). Serious Incident framework. Available from: https://improvement.nhs.uk/resources/serious-incident-framework/ (accessed 19.8.19)
7	Royal College of Physicians (2017) Measurement of lying and standing blood pressure: A brief guide for clinical staff. Available from: https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff (accessed 19.8.19)
Bibliography	

8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	**Definition**
Fall	an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level. A fall is **not** a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack, a faint or vertigo.
Bed Rails	rails on the sides of beds, sometimes referred to as cot sides, side rails or safety rails
Falls risk assessment	documentation to support the risk assessment and management process.
FRAMP	the risk screening and falls prevention and management tool to be used in all community inpatient areas. The FRAMP contains all the identified predictors of falls risk as defined by the National Inpatient Falls Audit (NAIP 2015) and is tailored to meet the needs of each individual patient. It also facilitates a shift by shift check of interventions in place to minimise the risk of falling.
Ultra-low bed	Lowers to less than 30cm from the top of the mattress to the ground
TABS mat	early warning system that alerts staff when the patient attempts to stand unsafely or leave the bed without assistance, can be a permanent fixture, a bed sensor or a chair sensor
Root cause Analysis	framework for reviewing and analysing patient safety incidents to identify and recommend areas for change
Enhanced supervision	Cohorting groups of patients prone to falls into falls bays with a CSW or RN overseeing the bay. This involves staff awareness of the expectations of their role using distraction techniques when necessary, and regularly rotating staff throughout the shift and for comfort breaks

9. CONSULTATION WITH STAFF AND PATIENTS

Enter the names and job titles of staff and stakeholders that have contributed to the document

Name	Job Title	Date Consulted
Sue Smith	Executive Chief Nurse	05/2019
Lynne Wyre	Director of Nursing	05/2019
Joann Morse	Director of Nursing	05/2019
Gill Speight	Associate Director of Nursing Community	05/2019
Mel Woolfall	Associate Director of Nursing Medicine	05/2019
Jane Kenny	Associate Director of Nursing Surgery	05/2019
Jane Dickinson	Governance Lead Community Care Group	05/2019
Emily Henry	Governance Lead Medicine Care Group	05/2019
Sarah Rigby	Governance Lead Surgery Care Group	05/2019
Dianne Smith	Matron Dementia	05/2019
Claire Rawes	Matron Surgery	05/2019
Nicole Dixon	Matron Medicine	05/2019
Hayley Reading	Matron Medicine	05/2019
Michaela Shepherd	Matron Quality, Safety, Patient	05/2019

	Experience	
Sue Clark	Clinical Services Manager	06/2019
Jo-Anne Halliwell	Clinical Improvement Lead	07/2019
Simon Lindsay	Manual Handling Trainer	13/09/2019

10. DISTRIBUTION PLAN	
Dissemination lead:	Kim Wilson
Previous document already being used?	No
If yes, in what format and where?	n/a
Proposed action to retrieve out-of-date copies of the document:	n/a
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Include in the UHMB Friday Corporate Communications Roundup or Weekly News. New documents uploaded to the Document Library.

11. TRAINING

Is training required to be given due to the introduction of this procedural document? Yes

Action by	**Action required**	**Implementation Date**
Care Group associate directors of nursing and matrons	To inform clinical staff of the new guideline, disseminate it and provide clarity when required	09/2019

12. AMENDMENT HISTORY

Version No.	**Date of Issue**	**Section/Page Changed**	**Description of Change**	**Review Date**

Appendix 1: Measurement of Lying and Standing Blood Pressure

Identify if you are going to need assistance to stand the patient and simultaneously record a BP.

Use a manual sphygmomanometer

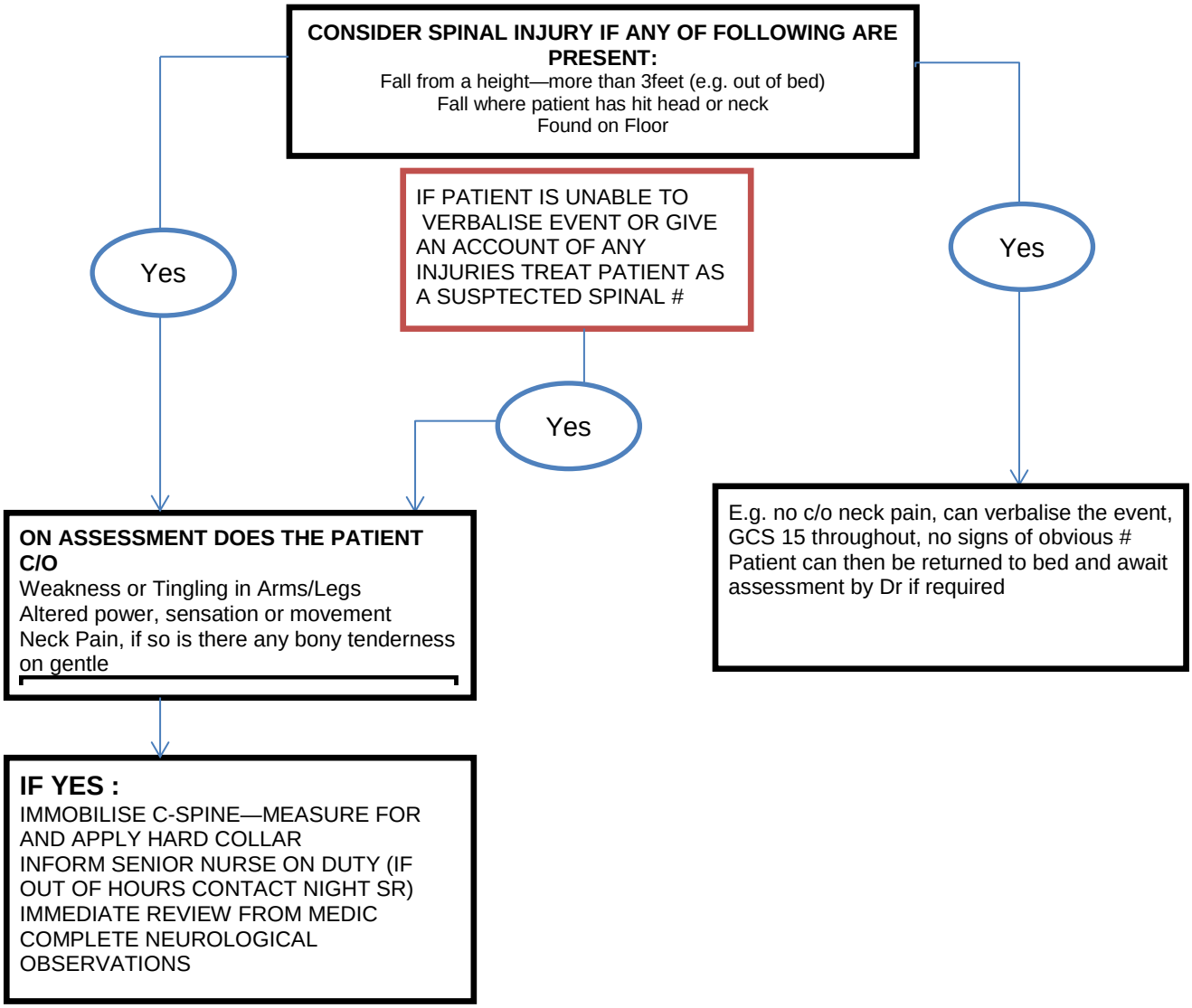
1. Explain procedure to the patient.
2. The first BP should be taken after lying for at least five minutes.
3. The second BP should be taken after standing in the first minute
4. A third BP should be taken after standing for three minutes
5. This recording can be repeated if the BP is still falling
6. Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.
7. A positive result is:
   a. a drop in systolic BP of 20mmHg or more (with or without symptoms)
   b. a drop to below 90mmHg on standing even if the drop is less than 20mmHg. (with or without symptoms)
   c. a drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)
8. Advise patient of results and if the result is positive,
   a. inform the medical and nursing team
   b. take immediate actions to prevent falls and or unsteadiness.
9. In the instance of positive results, repeat regularly until resolved.

If symptoms change, repeat the test.

https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing- bloodpressure-brief-guide-clinical-staff

Appendix 2: Guidance for Suspected Spinal Injury and Head Injury

GUIDANCE FOR SUSPECTED SPINAL INJURY



GUIDANCE FOR SUSPECTED HEAD INJURY

SUSPECT A HEAD INJURY IN THE FOLLOWING CIRCUMSTANCES:
Patient cannot verbalise how they fell and / or no witness to the fall
Fall from a height (e.g. out of bed)
Fall where patient or witness states has hit head and or obvious head injury
If any of the above are present undertake GCS and request immediate review from medical staff. Neurological observations to be repeated every 30 mins until reviewed by Doctor. Once reviewed continue observations as per Drs instructions or as detailed below. This assumes patient had a GCS of 15 prior to the fall and is not subject of a head injury

IF GCS IS NOT 15 NEUROLOGICAL OBSERVATIONS TO BE RECORDED ON A HALF-HOURLY BASIS UNTIL GCS 15 REACHED. THEN AS FOLLOWS:
HALF HOURLY FOR 2 HOURS
THEN 1 HOURLY FOR 4 HOURS
THEN 2-HOURLY FOR 4 HRS OR UNTIL GCS 15 REACHED
IF GCS 15 IS NOT REACHED WITHIN 24HRS THEN FURTHER CT SCAN TO BE CONSIDERED

WHILE UNDERTAKING GCS IF ANY OF THE FOLLOWING OCCUR PATIENT FOR IMMEDIATE MEDICAL REVIEW:
Development of agitation or abnormal behaviour
Sustained drop of 1 point in GCS over 30 mins
Drop of 3 or more points in eye opening or verbal response scores or 2 or more in motor scores
Development of severe or increasing headache or persistent vomiting
New evolving neurological symptoms

Appendix 3: Post Fall / Found on Floor Checklist

For printable version see: http://uhmb/cs/tpdl/Attachments/CORP-POL-025/Post-fall%20or%20found%20on%20floor%20checklist.docx

Post Fall / Found on Floor Checklist			
CIR number …….. Relatives informed …….. (Date and time)			
The patient has had a fall / found on floor on …….. (Date) …….. (Time) **Doctor /Nurse Practitioner informed Name…….. (Date)…….. (Time)……..** **Reviewed by Doctor/ Nurse Practitioner. Name …….. (Date) …….. (Time)……..** (If not reviewed straight after please document reason in nursing notes)			
Nursing actions	**Sign**	**Date & time**	**Comments**
Patient has been checked by nursing staff for signs or symptoms of fracture or potential for spinal injury before the patient is moved			
Ensure safe moving handling methods for patients with signs or symptoms of fracture or potential for spinal injury are adhered to. E.g. use of hoverjack			
IF head injury suspected* undertake GCS and inform medical staff for immediate review. Repeat observations every 30 minutes until medical review			
Follow protocol overleaf for neurological observations (NICE Head injury CG56)[4]			
At the next routine intentional care round re assess for undetected injury, and escalate to doctor/nurse practitioner as needed			
Following the inpatient fall, complete (if not already in place) or update falls care bundle for **more vulnerable patients** (safety care bundle) within 4 hours			
Inform (where appropriate): **Family (within first hour where fall is moderate to severe harm)** □ OT □ Physio □ Ward pharmacist □			
Patient Safety Incident completed giving following information : Time of fall Type of injury and severity Type and frequency of observations completed post fall Location of fall on ward Staffing levels at the time of fall Footwear of patient Lighting in area Any cognitive impairment			**Guidance on levels of harm;** 1.No Harm- no injury 2. Low Harm-minor injury 3.Moderate Harm- Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm e.g. fractured wrist 4 Severe Harm-Any patient safety incident that appears to have resulted in permanent harm e.g. fractured neck of femur/sub arachnoid haemorrhage. 5. Death- as a direct result of the fall
Consideration for prevention of further falls (if applicable): Appropriate level of observation for the patient Are bed rails being used appropriately? – see risk assessment in safety care bundle Appropriate use of restrictive practice to ensure patient safety with supporting documentation			

Appendix 4: Hoverjack

Short Guide to Raising the Fallen Patient

- Connect air supply to mains using extension lead if needed.
- Lay out Hovermatt and Hoverjack making sure the chamber with Valve #4 is on the top and the chamber with Valve #1 is against the floor; ensure the 4 red caps are fastened.
- If hip fracture is suspected unravel slide sheet under patient without rolling patient and slide on to Hovermatt. Remove slide sheet. If no suspected fracture the patient can be rolled and Hovermatt placed under them.
- The feet can extend over the matt but the head must not.
- Loosely fasten straps over patient
- Connect the air supply to the Matt and inflate, leave pump connected and running.
- Move the Matt with patient onto Hoverjack, foot end is marked and is the end with valves. Ensure central position.
- Turn pump off and disconnect from Matt.
- Hold pump over valve #1 on Hoverjack turn on and **fully inflate**, a change in tone of the pump can be heard when fully inflated. Continue to inflate in sequence, #2, #3, and #4 turn off pump.
- Use handles on Hoverjack to slide patient next to transfer surface.
- Reconnect pump to Matt, switch on and slide patient on to bed/trolley. Switch off and disconnect.
- To deflate Hoverjack red caps are unscrewed, to avoid a sudden rush of air from the valve some air can be removed by placing a finger into the inlet valve prior to removing the red cap.
- Please report any damage of the Hoverjack immediately to Medical Engineering.

Please ensure that you have received training in the use of the Hoverjack

and are familiar with the manufacturer's directions for use

Appendix 5: Post Falls Guidance (in patient's own home / clinic setting)

This SOP provides guidance for community staff for a patient has fallen in their own home/clinic setting

Procedure: If the patient is still on the floor:

Check the environment is safe for self, patient and others and take appropriate steps to make safe if possible. If it is not safe to approach the person (e.g. electricity), provide reassurance if the patient is conscious and call the appropriate emergency services for assistance.

If the environment is safe scan the patient for injuries, check for pain, bleeding, swelling, lacerations, abnormalities or deformities.

Take the appropriate first aid action if required in line with role and competence. If there are concerns that the patient may be seriously injured (for example shortening or rotation of a limb) do not move the person and call an ambulance. If an ambulance is requested, make the patient as comfortable as possible and give reassurance. (if clinic setting within a hospital – contact the ward staff for advice on use of equipment/hoisting)

If the person is able, encourage them to turn on to their hands and knees and place a chair or other sturdy object close to them so that he/she can lever him/herself up. If the patient reports pain at any time **stop** and reassess the need for emergency services assistance.

If the person is unable to get him/herself up with minimal assistance do not attempt to lift them.

- Stay with the patient and provide reassurance.
- Call emergency services if indicated.
- Make the person as comfortable as possible using pillows, cushions, blankets or other supportive objects and provide reassurance.
- Contact as many colleagues as may be necessary to attend and assist.
- Agree on the actions to be taken.
- One staff member to take the lead.
- Using recognised moving and handling techniques move the patient in small stages allowing time between each movement to reassess the patient's condition and plan the next movement until they are in a position to be transferred to a chair or bed.
- If the patient reports pain at any time **stop** and reassess the need for emergency services assistance or contact the patients GP or Out of Hours GP service for instruction regarding administration of pain relieving medication

THEN:

- Reassess the patient and take appropriate first aid actions if necessary.
- Record BP lying/sitting/standing if possible.
- Contact the patients GP or out of hours' service to establish if U&Es and FBC blood tests are required and the time frame for the blood to be taken.
- Arrange for a urinalysis to be undertaken at the earliest convenience.
- With the patient's consent contact their family or carers to inform them of the event.
- Refer to appropriate service for a falls assessment

Document the outcome of the incident and complete an incident form

Appendix 6: Harm Descriptors: a guide

The descriptors in the table below describe the level of harm to be reported against the injury type.

Level of harm	Descriptor of harm	Examples of injury per harm
No harm	Fall occurred but with no lasting harm to the patient	Bruises, soreness, redness, abrasions, grazes. Cuts/skin tears/lacerations requiring only pressure or a simple dressing.
Low/minor harm	Harm requiring minor/first-aid level of treatment only, no lasting injury or disability	Cuts/skin tears/lacerations may need more complex dressings, glue or steri strips
Moderate harm – Duty of Candour applies.	Harm is likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital, but a full recovery is expected	Fractured of small bones such as finger, toes, clavicle, pubic rami, wrist. At UHMB fractured long bone (NOF) where there were no lapses in care is also moderate
Severe/Major harm – SIRI to be considered, STEIS reportable.	Harm causing permanent disability; the patient is unlikely to regain their previous level of independence	Head injury with an intracranial bleed, fractured neck or skull, and hip fractures where lapses in care were identified (opportunities to improve)
Death – SIRI / STEIS reportable.	Death was the **direct** result of the fall	

Appendix 7: Equality & Diversity Impact Assessment Tool

University Hospitals of Morecambe Bay NHS Foundation Trust

Equality Impact Assessment Form

Department/Function	Corporate Nursing		
Lead Assessor	Kim Wilson		
What is being assessed?	Prevention and Management of Patient Slips, Trips and Falls		
Date of assessment	16/08/2019		
What groups have you consulted with? Include details of involvement in the Equality Impact Assessment process.	Equality of Access to Health Network	○ Yes	◉ No
	Staff Side Colleague	○ Yes	◉ No
	Service Users	○ Yes	◉ No
	Staff Inclusion Network(s)	○ Yes	◉ No
	Personal Fair Diverse Champions	○ Yes	◉ No
	Other (including external organisations) Please give details:	○ Yes	◉ No

1) What is the impact on the following equality groups?

Positive:	**Negative:**	**Neutral:**
➢ Advance Equality of opportunity ➢ Foster good relations between different groups ➢ Address explicit needs of Equality target groups	➢ Unlawful discrimination / harassment / victimisation ➢ Failure to address explicit needs of Equality target groups	➢ It is quite acceptable for the assessment to come out as Neutral Impact. ➢ Be sure you can justify this decision with clear reasons and evidence if you are challenged

Equality Groups	**Impact** (Positive / Negative / Neutral)	**Comments** ➢ Provide brief description of the positive / negative impact identified benefits to the equality group. ➢ Is any impact identified intended or legal?
Race (All ethnic groups)	Neutral	
Disability (Including physical and mental impairments)	Positive	Improved preventative measures in place
Sex	Neutral	
Gender reassignment	Neutral	
Religion or Belief	Neutral	
Sexual orientation	Neutral	
Age	Positive	Supplementary assessments in place for those aged over 65 years
Marriage and Civil Partnership	Neutral	
Pregnancy and maternity	Neutral	
Other (e.g. caring, human rights)	Neutral	

2) In what ways does any impact identified contribute to or hinder promoting equality and diversity across the organisation?	

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3) If your assessment identifies a negative impact on Equality Groups you must develop an action plan **to avoid discrimination and ensure opportunities for promoting equality diversity and inclusion are maximised.**

- This should include where it has been identified that further work will be undertaken to further explore the impact on equality groups
- This should be reviewed annually.

Action Plan Summary

Action	**Lead**	**Timescale**

This form will be automatically submitted for review for Policies and Procedures once approved by Policy Group. For all other assessments, please return an electronic copy to EIA.forms@mbht.nhs.uk once completed.