NHS
University Hospitals of
Derby and Burton
NHS Foundation Trust

TRUST POLICY AND PROCEDURES FOR THE PREVENTION AND MANAGEMENT OF PATIENT FALLS

<table>
<tr><td>Reference Number:</td><td>Version: 1.0</td><td>Status: FINAL</td><td colspan="2">Author:
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<tr><td rowspan="4">Version/Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1.0</td><td>March 2023</td><td>Natalie Keightley</td><td>Fully revised document. This policy is a revised version of Falls Policy UHDB: Inpatient Falls including prevention and the use of bed safety equipment in adults and replaces this policy.</td></tr>
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<tr><td colspan="5">Intended Recipients: All medical and clinical staff involved in the care and management of patients including agency staff and students</td></tr>
<tr><td colspan="5">Training and Dissemination: Dissemination via the Trust Intranet. Mandatory trust induction training and two-yearly falls training update.</td></tr>
<tr><td colspan="5">To be read in conjunction with: Adult Policy for the Safe Use of Bed Rails, Management of Head Injury after a fall as an inpatient – clinical guideline, Escalation Planning, Including Head Injury after a Fall as an Inpatient – NMU only – clinical guideline, Head Injury - Paediatric Guidelines, Drugs Contributing to Falls in Elderly – clinical guideline, Trust Policy for Incident Reporting, Management and Learning, Delirium – Prevention, Diagnosis and Management Clinical Guideline, Safety Management Standard Moving and Handling, Enhanced Nursing Care UHDB Policy and Procedure, Consent - Including the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust</td></tr>
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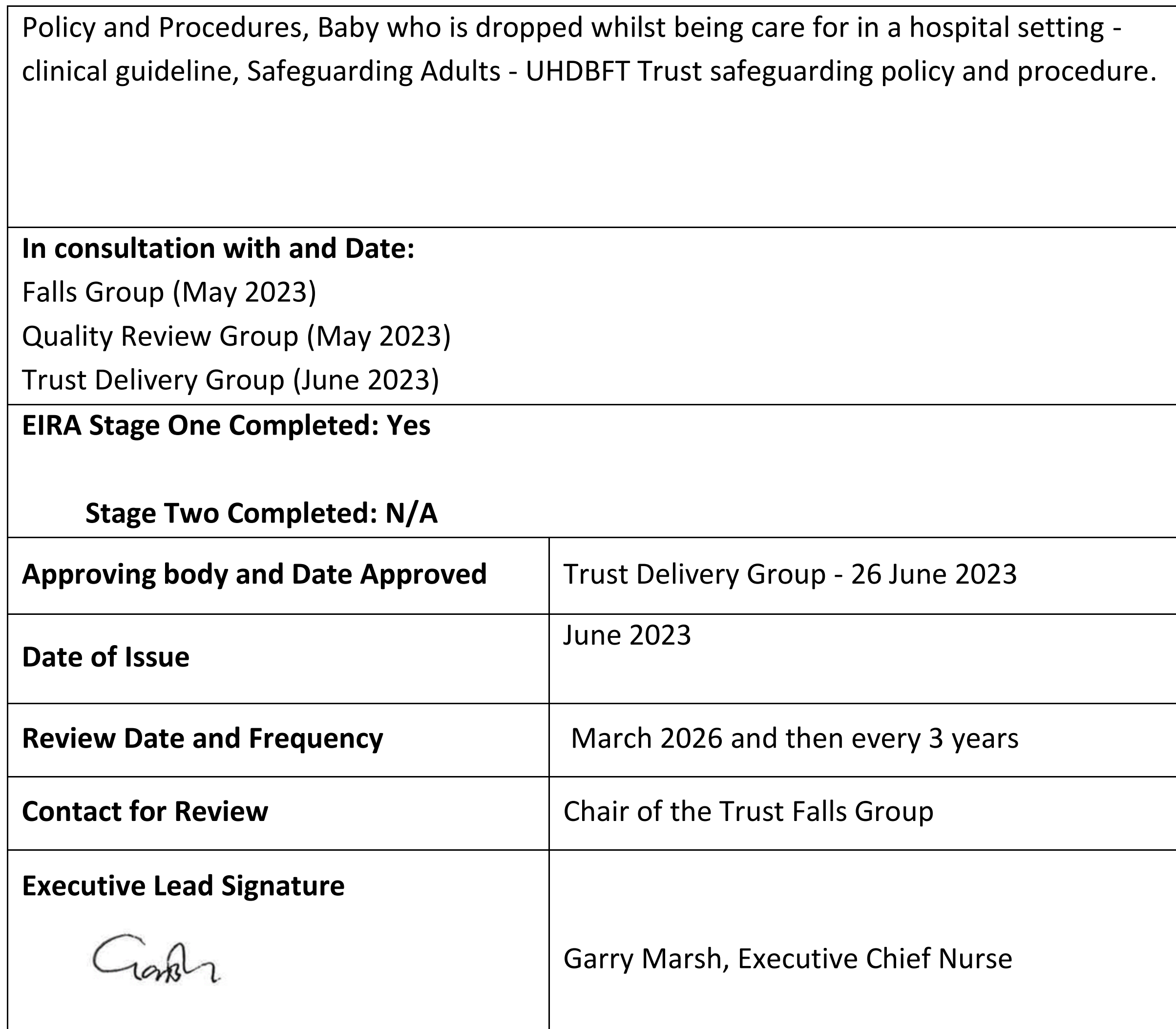

Policy and Procedures, Baby who is dropped whilst being care for in a hospital setting - clinical guideline, Safeguarding Adults - UHDBFT Trust safeguarding policy and procedure.	
In consultation with and Date: Falls Group (May 2023) Quality Review Group (May 2023) Trust Delivery Group (June 2023)	
EIRA Stage One Completed: Yes **Stage Two Completed: N/A**	
Approving body and Date Approved	Trust Delivery Group - 26 June 2023
Date of Issue	June 2023
Review Date and Frequency	March 2026 and then every 3 years
Contact for Review	Chair of the Trust Falls Group
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1 INTRODUCTION

University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) recognises that falls are a common and potentially life-changing event for individuals. Falls and falls related injuries are a major cause of disability and the second leading cause of mortality in older people globally (WHO 2021). They cost the NHS more than £2.3 billion pounds a year and falls in hospitals are the most commonly reported patient safety incident with more than 240,000 reported in acute hospitals and mental health trusts in England and Wales annually (PHE 2022).

The potential physical harm of falling includes minor injuries such as skin tears and bruising but can also result in more serious injuries such as fractures and intracranial bleeding from head injuries. These injuries can have a significant impact on an individual's quality of life and in a minority of cases these injuries can lead to death. Although the majority of falls occur with no or low harm this can still cause significant psychological distress and fear leading to a loss of an individual's independence. Falling not only affects the individual involved but can also cause distress to families and carers (NICE Guideline CG161, 2013)

Inpatient falls are one of the most commonly reported patient safety incidents within UHDB. Although the risk of falling can never be eliminated, due to the clinical condition of the individual and the environment in which the care is given, there are strategies that can be used to minimise this risk. It is necessary to balance reducing the risk of falls alongside the individual's right to privacy, dignity, choice, independence and rehabilitation. This will support an individual's recovery and provide a positive as possible experience whilst under the care of UHDB.

UHDB takes patient safety seriously and is committed to reducing the number of inpatient falls, particularly those which cause harm. Our aspiration is to eliminate all avoidable harm caused by falls.

2 PURPOSE AND OUTCOMES

The purpose of this policy is to:

- Ensure that all key professionals are clear of their responsibilities towards patients in relation to reducing their risk of falls
- Promote early identification of patients at risk of falling
- Reduce the risk of patient falls by using robust assessment, interventions, documentation and information
- Ensure effective and appropriate protocols are in place to prevent and manage patient falls before, during and post incident
- Ensure reporting of patient falls is carried out appropriately

The principles contained within the policy reflect best practice and should be adopted by all colleagues in all clinical areas of the trust including agency staff, staff with honorary contracts and students on placement. This policy applies to all patients within UHDB departments encompassing inpatients and outpatients.

Adherence to the policy will minimise the risk of an individual falling and suffering harm within the organisation.

3 KEY RESPONSIBILITIES/DUTIES

3.1 Trust Board

The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

3.2 Patient Safety Group (PSG)

Patient Safety Group meets regularly in accordance with the terms of reference. The Trust Falls Group reports to Patient Safety Group. Patient Safety Group provides advice, support and escalation of information or concerns as necessary in relation to these reports.

3.3 Trust Falls Group

The Falls Group is a formal group accountable to the Patient Safety Group established to strengthen the delivery of the Trusts PRIDE ambition “Putting our patients and communities first” and “Right First Time”. The purpose of the Falls Group is:

- To lead and co-ordinate the sustained improvement in falls management for the Trust in line with the Trust’s Quality Strategy and Strategic Objectives.
- To lead on the development of effective falls reduction, prevention and management methods for all patients within the trust.
- To review policies and procedures in relation to falls incidents and latest national guidance to ensure ongoing updates and improvement.
- Members of the group will collate and disseminate Trust wide learning from falls incidents, ensuring cascaded within Business units and Divisions.
- The group will develop and support quality improvement work across the Trust around falls assessment, prevention and management and share the learning trust wide.
- To seek assurance from Business Units and Divisions that best practice guidance is effectively implemented across the Trust.
- The group will ensure that falls education is in line with national guidance and monitor compliance.

3.4 Divisional Directors, Divisional Nurses and Divisional Medical Directors

In consultation with staff, Divisional Directors, Divisional Nurses and Divisional Medical Directors will ensure implementation of the policy by:

- Monitoring the attendance of staff at mandatory training

- Ensuring staff are aware of the policy
- Promoting all falls incidents are reported via Datix (this includes near miss incidents)
- Ensuring a safe clinical environment in which care is delivered
- Provide oversight regarding the incidence of falls and feedback of relevant learning/information to staff

3.5 Divisional Governance Teams – Clinical Governance Facilitators and Clinical Governance Advisors

In consultation with Line managers, Team leads and clinical staff the divisional governance teams support the implementation of the policy by:

- Promoting all falls incidents are reported via Datix (this includes near miss incidents)
- Having oversight of all falls incidents including ensuring where a fall has resulted in moderate harm or above that duty of candour has been undertaken
- To promote accurate reporting of falls incidents in line with the Trust Policy for Incident Reporting, Management and Learning, providing feedback if required
- Supporting staff with post falls investigations as required
- Identifying themes from falls incidents and steering QI work alongside team leads and the patient safety team to address these themes

3.6 Line Managers and Team Leads

Line Managers and Team Leads will ensure the implementation of the policy by:

- Ensuring, by delegation, that all environmental hazards that may contribute to slips, trips and falls are acted upon
- Ensuring staff are trained, educated and updated in the prevention and management of falls
- Promote the reporting of all falls incidents and ensure staff understand how and when to report
- That all moderate/severe harm or death related to falls incidents have an investigation/learning completed and actions implemented in line with the Trust Policy for Incident Reporting, Management and Learning
- Ensuring that staff participate in clinical audits and actions are taken following these audits
- Provide quarterly reports to Falls Group to discuss number of falls, outcomes, learning, ongoing quality improvement work and escalate any concerns

3.7 Senior Falls Practitioner – Prevention and Management

- Contribute to and support the Trust's falls group

- To drive evidence-based developments in falls prevention and management practice to improve patient care, outcomes and experiences
- Take a lead role in the development of appropriate evidence-based assessment and screening tools related to patient falls
- Provide specialist education, training and advice to Trust staff
- Review reported incidents of patient falls in hospital and work with matrons, governance team and ward managers to identify any themes and assist in steering local action plans, especially where there are a higher numbers of falls
- Contribute to national audits of clinical practice related to patient falls
- Undertake audits within the Trust to ensure compliance with falls prevention strategies and identify areas for improvement
- Provide key visible leadership to provide support and expert advice in relation to falls prevention and management across the clinical workforce

3.8 Ward Sister/Charge Nurse/Department Lead/Team Lead

- To ensure that the falls policy is adhered to in the clinical setting and that there is a clear process for dissemination
- To ensure that all falls incidents including near misses or where no harm has resulted are reported via the Incident Reporting System (Datix) in line with the Trust Policy for Incident Reporting, Management and Learning.
- To ensure that where a fall has resulted in moderate harm or above that Duty of candour is undertaken
- That patient falls are reviewed and actions are taken to manage/reduce the risk of further falls
- To lead/contribute to investigation/learning where a patient has fallen including the completion of quality improvement work identified through investigation
- To ensure wards undertake monthly ward assurance audits across the Trust
- That staff undertake 2-yearly mandatory training and records of attendance are kept
- That all patient documentation is completed accurately and contemporaneously
- To monitor the clinical environment for factors that may contribute to slips, trips and falls

3.9 All Clinical Staff Working with Patients

- Will undertake mandatory 2-yearly training to maintain their awareness and skill concerning the prevention and management of falls.
- Will report all falls incidents including near misses, no harm and low harm via the Incident Reporting System (Datix) in line with the Trust Policy for Incident Reporting, Management and Learning

- Will ensure that all patient documentation is completed accurately and contemporaneously
- Undertake mandatory training in patient handling and mobilise the patient in accordance with DIAG (Derbyshire Inter-Agency Group) guidance. Following or completing the patient handling plan as appropriate and providing a patient with their usual mobility aid if required
- Will adhere to the falls policy in the clinical setting including completing the falls multi-factorial risk assessment, actioning the subsequent falls multi-factorial intervention care plan as appropriate and following actions as outlined post fall to ensure effective management of patients across all areas of the Trust.

4 DEFINITIONS USED

4.1 Definitions/Abbreviations:

Fall	An event which results in a person coming to rest on the ground or floor or lower level (WHO 2012)
The Trust	University Hospitals of Derby and Burton NHS Foundation Trust
Hazard	Something that has the potential to cause harm or loss
Risk	The likelihood of harm or loss occurring in defined circumstances
Low-Low bed	A bed designed to provide near floor level care with a height adjustable function
Patient Safety Group (PSG)	Clinical governance group used to review and escalate learning, issues and or concerns from trends and themes identified from Patient Safety, Reporting and Learning, Patient Experience. Reviews and escalates as required
PSIRF	Patient Safety Incident Response Framework
Datix	The Trust's system used to report and manage incidents and complaints
WHO	World Health Organisation
Egress Test	A screening tool used to determine the ability to transfer or mobilise
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
CQC	Care Quality Commission
MRFA	Multi-factorial risk assessment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

4.2 Definitions of degrees of harm

NPSA has set out definitions for degrees of harm following a fall as below. The Trust has given examples to support with application of these terms.

Level of harm	Definition	Examples
0. No Harm (impact prevented) also known as a "Near Miss"	Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm	Water spill in a public place, cleaned up before adverse event occurred
1. No Harm (impact not prevented)	Any patient safety incident that ran to completion but no harm occurred	Water spill in public place, individual falls, but does not injure themselves
2. Low Harm	Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm	Patient shaken and upset Patient has small cut to arm
3. Moderate Harm	Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons	Patient fractured wrist Patient required suturing of wound Patient transferred to ED
4. Severe Harm	Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons	A patient who fractures their neck of femur is unlikely to regain levels of function they had prior to a fall A patient that sustains a subdural haematoma is unlikely to regain levels of function they had prior to a fall

5. Death	Any unexpected or unintended incident that directly resulted in the death of one or more persons	Patient lost signs of life after fall Patient transferred to another area for additional care related to the fall but died the same day

5 PREVENTION AND MANAGEMENT OF FALLS IN ADULT INPATIENT SETTINGS

5.1 Falls Risk Assessment

All patients over the age of 65 or patients over the age of 50, who are judged by a clinician to be at risk of falls due to an underlying condition, should be identified as being at risk of falling whilst in hospital. Examples of conditions that could be included in this are: Parkinson's disease, dementia or being registered blind.

These individuals should have a falls multi-factorial risk assessment (MRFA) completed to identify the individual factors that affect the risk of falling. According to NICE guidance the MFRA should encompass nine areas: cognitive impairment, continence problems, falls history (including causes and consequences), footwear that is unsuitable or missing, health problems that may increase their risk of falling, medication, postural instability, mobility problems or balance problems, syncope syndrome and visual impairment.

Patients should have a falls risk assessment completed or reviewed by a registered professional at the following points during their inpatient stay:

- Within 2 hours of their admission to hospital
- Within 2 hours of transfer between clinical areas
- Weekly
- Following a significant change in the patient's condition
- After experiencing an inpatient fall

The MFRA is included in patient's admission booklet or electronically as "Inpatient Falls Assessment". If a falls risk assessment is not completed for a patient the reasoning for this should be clearly documented in the patient's clinical notes.

5.2 Falls Care Plan

The MFRA will form the basis for individualised multi-factorial interventions and should be reviewed each time the MFRA is completed.

Patients should consent to and be encouraged to participate in their individualised falls prevention plan as appropriate which should be facilitated by open discussion, collaboration and information sharing. If this is not possible due to cognitive impairment the care plan should be completed in a patient's best interests following the guidance outlined in 'Consent - Including the Mental Capacity Act (Lawful Authority for Providing Examination, Care or Treatment) - Trust Policy and Procedures'.

Interventions to reduce the risk of falls should be completed using an MDT approach and is not the responsibility of any one profession. All professionals involved in a patient's care have the responsibility to contribute to the falls prevention care plan if required, including: medical staff, nursing staff, physiotherapists, pharmacists, occupational therapists, psychologists and dietitians.

Areas of importance to note concerning Falls Care Plans:

5.2.1 Cognitive impairment

A patient who is assessed to have cognitive impairment that is significantly increasing their risk of falling should have the Enhanced Care Bundle completed which will provide guidance around behavioural triggers and management as well as the appropriate level of supervision required to reduce this risk.
Patient safety may be compromised if staffing resources do not allow for the appropriate level of care recommended by the Enhanced Care Bundle. If this situation arises, the nurse in charge must escalate their concern and the requirement for additional staff in line with the Enhanced Nursing Care Policy and an incident form should be completed on Datix.

5.2.2 Footwear or foot condition

Patients who attend the hospital with no appropriate footwear need a safe replacement immediately. If appropriate footwear cannot be provided by a carer/relative, anti-slip socks should be provided to the patient.

Any patient who is identified to have feet in poor condition should have this addressed as part of their essential care and falls prevention interventions. Toenails can be cut by registered nursing staff or non-registered staff who have attended the appropriate training. Nail care training can be accessed via My Learning Passport. Patients who have more complicated footcare needs can be referred to inpatient podiatry services via the consultant to consultant referral system or a referral to outpatient podiatry can be completed via the podiatry referral form located on Net-i.

5.2.3 Syncope

All patients at risk of falling should have a lying and standing blood pressure reading taken at least once throughout their inpatient stay. The need to continue monitoring of lying and standing blood pressure will be determined by medical staff. Staff who complete lying and standing blood pressure readings within their role should be familiar with guidance for the accurate completion of a lying and standing blood pressure. This can be found at Measurement of lying and standing blood pressure: A brief guide for clinical staff | RCP London (See Appendix 2).
If a lying and standing blood pressure reading is not able to be completed for a patient the reasoning for this should be clearly documented in the patient's clinical notes.

5.2.5 Medication Review

Patients deemed at risk of falling should have a review of their prescribed medications as some are commonly implicated in falls. Particular consideration should be given with the prescribing of psychotropic medications and any psychotropic medications should be reduced where possible.
Guidance around medications that should be considered when reviewing medication in relation to falls risk is provided in the 'Drugs contributing to Falls in Elderly Patients - Full Clinical Guideline' or Derbyshire Joint Area Prescribing Committee guidance can be found via PrescQIPP as 'Deprescribing: Medication and falls'.

5.2.6 Mobility

Patient's mobility should be reviewed as part of the falls MRFA and care plans. The egress test can be used by staff to assess the patient's ability to safely stand, step and mobilise (see appendix 3). The resulting mobility decision needs to be recorded in the individual's personal handling plan. Training on the egress test can be provided via patient handling training and updates. Where additional training or updates are required, this can be obtained via manual handling key trainers. A training video is available on Net-i to support use of the egress test.

Patients who regularly use mobility aids at home should have access to the same or most similar aid during their admission to hospital. Patients' usual mobility aids should be encouraged to be brought into hospital by carer/relative where possible, particularly if this aid is not standard hospital stock i.e. bespoke wheelchairs. If it is not possible to bring in the aid from home a suitable equivalent aid should be issued. This can be issued by any staff member who has completed patient handling training. Mobility aids should be issued as soon as a need is identified and recorded in the falls risk assessment and the personal handling risk assessment. Where it is

not possible to complete a mobility assessment or provide a mobility aid the reasoning should be clearly documented within the patient's clinical record.

Mobility aids should be checked prior to use to see they are in good condition ensuring any brakes are working, no joints or buttons are loose, there are no signs of significant wear and tear and ferrules are intact. Consideration of the patient's height and weight should be made alongside the equipment design and safe working load. Aids should be measured and adjusted as per patient handling training. Mobility aids should be left within reach of the patient, at all times, to encourage safer mobility.

If a patient has a change in mobility status due to a presenting condition, is assessed as unsafe to transfer/mobilise or previously used equipment that is no longer suitable a referral to a physiotherapist should be made as early as possible for further assessment.

5.3 Use of Bed Rails and Bed Height

Bed rails should be always used in line with the Adult Policy for Safe Use of Bed Rails.

Patients identified as being at risk of falling must have the position of their bed and bed height considered as part of ensuring a safe environment. Bed height should be individual to each patient and should allow patients to complete bed transfers safely whilst considering that any additional bed height could lead to increased severity of injury if the patient fell from the bed. Beds kept at an inappropriate height could be deemed as restraint if this affects the opportunity for the patient to complete bed transfers (too high or too low).

Patients who are bedbound should have their bed in the lowest position, except when receiving care in bed and the bed is being used to support moving and handling to reduce the likelihood of injury to staff.

5.3.1 Use of Low-Low Beds

A low-low bed can be used to reduce the risk of injury for patients who are at risk of falling out of bed. Risk factors that may indicate the consideration of a low-low bed include agitation or challenging behaviour. The decision to provide a low-low bed should consider the patient's mobility and ability to transfer as if provided inappropriately could be deemed as restraint.
Patients must be assessed individually to ensure that this is the most appropriate method of preventing potential falls from bed and low-low beds should not be used as a standalone falls prevention intervention. The decision to use a low-low bed

must be recorded in the nursing notes. The patient's family/carers should also be informed of the decision as appropriate.
Guidance on issuing and accessing low-low beds can be found on Medical Devices Net-i page under clinical equipment.

5.4 Environment

The clinical environment is considered to have an important role in falls prevention. Review and actions taken to make the environment safer can have a significant impact on falls risks. A safe clinical environment should be maintained across clinical areas by:

- Maintaining adequate lighting in a room, low level lighting at night
- Ensuring floors are clear of clutter that could be a potential trip hazard
- Orientating patients to their environment. This includes advising of the nearest toilet/washing facility and orientation to their bed space
- Ensuring the nursing call bell is always within reach and is in working order. Ensure the patient understands how to use this and is encouraged to ask for support when needed
- Placing necessary/frequently used items within easy reach i.e. drinks, phones
- Ensuring spillages are cleared up promptly
- Ensuring appropriate equipment is available, well maintained and serviced appropriately
- Ensuring the bed is at the most appropriate height for the patient and the brakes are locked

5.5 Management of inpatients post fall

In the event of a patient fall the protocol for assessing the patient and retrieving them from the floor is outlined in Appendix 1 (Immediate Management of a patient's retrieval from the floor). This guidance is for the safety of patients and staff. The management varies between acute and community sites so the appropriate protocol for the area should be followed.

For all unwitnessed falls or witnessed falls where the patient has sustained a suspected head injury, neurological observations should be completed in line with NICE: Head injury: assessment and early management (2019) and Management of Head Injury after a fall as an inpatient clinical guideline, except in case of the fall occurring within the Nightingale Macmillan Unit or ward 2 at Florence Nightingale Community Hospital who have their own guideline for this due to the differing needs of the patients within this unit.

In line with the Trust policy for incident, reporting, management and learning, an incident form should be completed on Datix as soon as reasonably practicable but within 24 hours. A

verbal duty of candour must be completed and documented in patient's notes after an incident has occurred involving the next of kin if required.
Some incidents involving patients should be reported in line with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Please refer to the RIDDOR definition link within Datix for further guidance. Examples of RIDDOR reportable patient falls include patients tripping over objects on the floor or patients not being provided with recommended support, such as mobility aids, resulting in a fall that leads to moderate/severe harm or death.

The Trust post falls documentation must be completed for all falls by nursing and medical staff. This document is designed to provide guidance on actions to take immediately post fall to ensure the patient is fully assessed and minimise harm that may occur. It also prompts actions to be considered to reduce the risk of further falls or injury as much as possible.

5.5.1 Safeguarding referral

Some falls may occur because of neglect and acts of omission. A safeguarding adult referral should be made when there is a concern that omissions of care has resulted in the fall. Please refer to appendix 4 for the falls and safeguarding assessment tool to support with decision making.

5.6 Handover, transfer and discharge

Patients identified as being at risk of falling must be clearly identified as part of the handover process between shifts, teams or when transferred between clinical areas. This includes patients being transferred to clinical areas internally for reasons such diagnostic testing. Any inpatient falls should be included in the SBAR handover and on Extramed using the falls icon.
Patients who have fallen whilst in the care of the Trust must have that information clearly recorded in their discharge letter. If indicated a referral should be made to the appropriate clinical pathway for further falls prevention interventions beyond discharge.

6 PREVENTION AND MANAGEMENT OF FALLS IN INPATIENT PAEDIATRIC SETTINGS

It is acknowledged that children are at risk of falls. Children fall as they grow, develop coordination and new skills and are often unaware of their limitations. Data suggest those at the highest risk of falls are those in the toddler age group (1-2 years) and the adolescent group (10-17 years).

6.1 Reducing falls risk within inpatient paediatric settings

All children and young people are considered at risk of falling and simple prevention strategies should be put in place to ensure the risk of injury is minimised. A safe environment should be maintained for all children and young people within the trust.

Standard safety measures should be put in place for all children and young people regardless of identified risk, these include:

- Orientate all patients, parents/carers to room and ward
- The choice of nursing a patient in a bed or cot is a clinical decision based on what is appropriate for the patient's age and development and based on their fall or entrapment risk. Usually, children under 18 months should be nursed in a cot although each child needs to be individually assessed
- The use of bed rails and cot sides is also an individual assessment and should be assessed
- Keep beds in low position with brakes on and bed ends in place
- Appropriate nonslip footwear for ambulatory children and young people
- Nurse call within reach, educate children and young people and parents/carers on its functionality
- Maintain adequate lighting in room, low level lighting at night
- Keep floors clear of clutter including equipment and toys
- Secure and supervise all children and young people with a safety belt or harness in wheelchairs, highchairs, strollers, infant seats, and any specialist seating (e.g., Tumbleforms)
- Children on trolleys are always under the immediate and direct supervision of a staff member or a health care support worker
- Infants in an incubator have portholes securely fastened and door closed unless directly attended
- Assist unsteady child/young person with ambulation; refer to physiotherapy notes where available
- Place necessary items a child/young person may need within reach (drinking water, phone, etc)
- Patients who have received sedation or general anaesthetic may be unsteady and require supervision
- Ensure appropriate equipment is available, well maintained and serviced appropriately (such as wheelchairs and commodes)

6.2 Educating families and carers

Most parents/carers are aware of maintaining a safe environment for their children in the home environment; any are unaware of the environmental risks when in hospital due to being in an unfamiliar environment accompanied with increased levels of anxiety related to hospital admission.

The hospitalisation of children and young people provides an opportunity to reinforce parent/carer information and education concerning normal psychological and motor development of small children, which is related to falls risks and other hazards both inside and outside hospital.

Parents/carers should be encouraged to:

- Reinforce hospital orientation with their child and or young person
- Provide non-slip footwear for their child whilst in hospital - no mobilising in socks
- Maintain physical contact with infant when cot sides are down, when bathing or weighing their infant
- Assist their child to the toilet when appropriate
- Use bed rails or cot sides where appropriate when leaving child's bedside, even for short periods
- Inform nursing staff when their child/young person is unattended
- Assist child/young person with mobilising as needed when out of bed/cot

6.3 Management of a child or young person post fall including the management of dropped babies

In the event of a child or young person falling the protocol for assessing and retrieving them from the floor is outlined in Appendix 1 (Immediate Management of a patient's retrieval from the floor). This guidance is for the safety of patients and staff.
The child or young person should be reviewed initially by a nurse who should escalate to a medic if any symptoms of significant injury are noted. If a child or young person has a suspected head injury from a fall guidance outlined in 'Head Injury in Children- Full Clinical Paediatric Guideline – Joint Derby & Burton' should be followed.

In line with the Trust policy for incident, reporting, management and learning, an incident form should be completed on Datix as soon as reasonably practicable but within 24 hours. A verbal duty of candour must be completed and documented in patient's notes after an incident has occurred involving the parents/carer. Some incidents involving children and young people should be reported in line with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Please refer to the RIDDOR definition link within Datix for further guidance. Examples of RIDDOR reportable falls within a paediatrics setting include children tripping over an object on the floor resulting in moderate/severe harm or death

6.3.1 Management of a baby who is dropped.

The risks of accidentally dropping a baby are well known, particularly when a parent falls asleep while holding a baby; or when a parent or healthcare worker holding the baby slips, trips or falls. A National Patient Safety Alert was issued in May 2019 after a consultant neonatologist raised concerns about an increase in the number of accidentally dropped babies in his organisation.

Accidental dropping of a baby should be reported as a patient fall via the trust incident reporting system (Datix). A dropped baby should be immediately escalated to the midwife or nurse who should follow the direction outlined in the Trust 'Baby who is dropped while being cared for in a hospital setting clinical guideline'.

7 PREVENTION AND MANAGEMENT OF FALLS IN INPATIENT MATERNITY SETTINGS

Typically, individuals who use maternity services are at low risk of falls, however, it is recognised that the health needs of individual maternity users can be complex which may increase this risk.

7.1 Reducing falls risk within inpatient maternity settings

There is no requirement to complete a multi-factorial risk assessment for maternity patients, however, staff should take reasonable measures to ensure the risk of falls for all individuals within a maternity setting is reduced as much as possible including:

- Maintaining adequate lighting in a room, low level lighting at night
- Ensuring floors are clear of clutter that could be a potential trip hazard
- Orientating patients to their environment. This includes advising of the nearest toilet/washing facility and orientation to their bed space
- Ensuring the nursing call bell is always within reach and is in working order. Ensure the patient understands how to use this and is encouraged to ask for support when needed
- Supervision should be provided to maternity users when mobilising post delivery due to an increased risk of syncope
- Placing necessary/frequently used items within easy reach i.e. drinks, phones
- Ensuring spillages are cleared up promptly
- Ensuring appropriate equipment is available, well maintained and serviced appropriately
- Ensuring the bed is at the most appropriate height for the patient and the brakes are locked

7.2 Management of maternity patients post fall

In the event of a maternity service user fall the protocol for assessing the patient and retrieving them from the floor is outlined in Appendix 1 (Immediate Management of a patient's retrieval from the floor). This guidance is for the safety of patients and staff. The management varies between acute and community sites so the appropriate protocol for the area should be followed.

Any suspected injuries from a fall should be reviewed by a midwife and escalated to a medic if required.

In line with the Trust policy for incident, reporting, management and learning, an incident form should be completed on Datix as soon as reasonably practicable but within 24 hours. A verbal duty of candour must be completed and documented in patient's notes after an incident has occurred involving the next of kin if required. Some incidents involving patients that result in moderate/severe harm or death should be reported in line with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). Please refer to the RIDDOR definition link within Datix for further guidance.

8 PREVENTION AND MANAGEMENT OF FALLS IN OUTPATIENT SETTINGS

8.1 Prevention of falls in outpatient settings

Due to the relatively low level of risk, there is no requirement to complete a Falls Risk Assessment for outpatients. An assessment of risk should be made according to each patient's clinical need, action taken to minimise any immediate risk and the patient referred on to the appropriate clinical pathway if this is indicated.
A safe clinical environment should be maintained across outpatient areas by:

- Maintaining adequate lighting in a room
- Ensuring floors are clear of clutter that could be a potential trip hazard
- Ensuring spillages are cleared up promptly
- Ensuring appropriate equipment is available, well maintained and serviced appropriately

8.2 Management of patients post fall in an outpatient setting

In the event of a patient fall the protocol for assessing the patient and retrieving them from the floor is outlined in Appendix 1 (immediate management of a patient's retrieval from the floor). This guidance is for the safety of patients and staff. The management varies between acute and community sites so the appropriate protocol for the area should be followed.

In line with the Trust policy for incident, reporting, management and learning, an incident form should be completed on Datix as soon as reasonably practicable but within 24 hours. A verbal duty of candour must be completed and documented in patient's notes after an incident has occurred involving the next of kin if required.

If the patient has any suspected head injury, fracture or other injury requiring intervention the patient should be advised and assisted to attend the emergency department via the most appropriate clinical pathway for further assessment and treatment.
If the patient is returning to an inpatient ward the ward staff should be informed of the fall so they can continue with appropriate management when the patient returns.

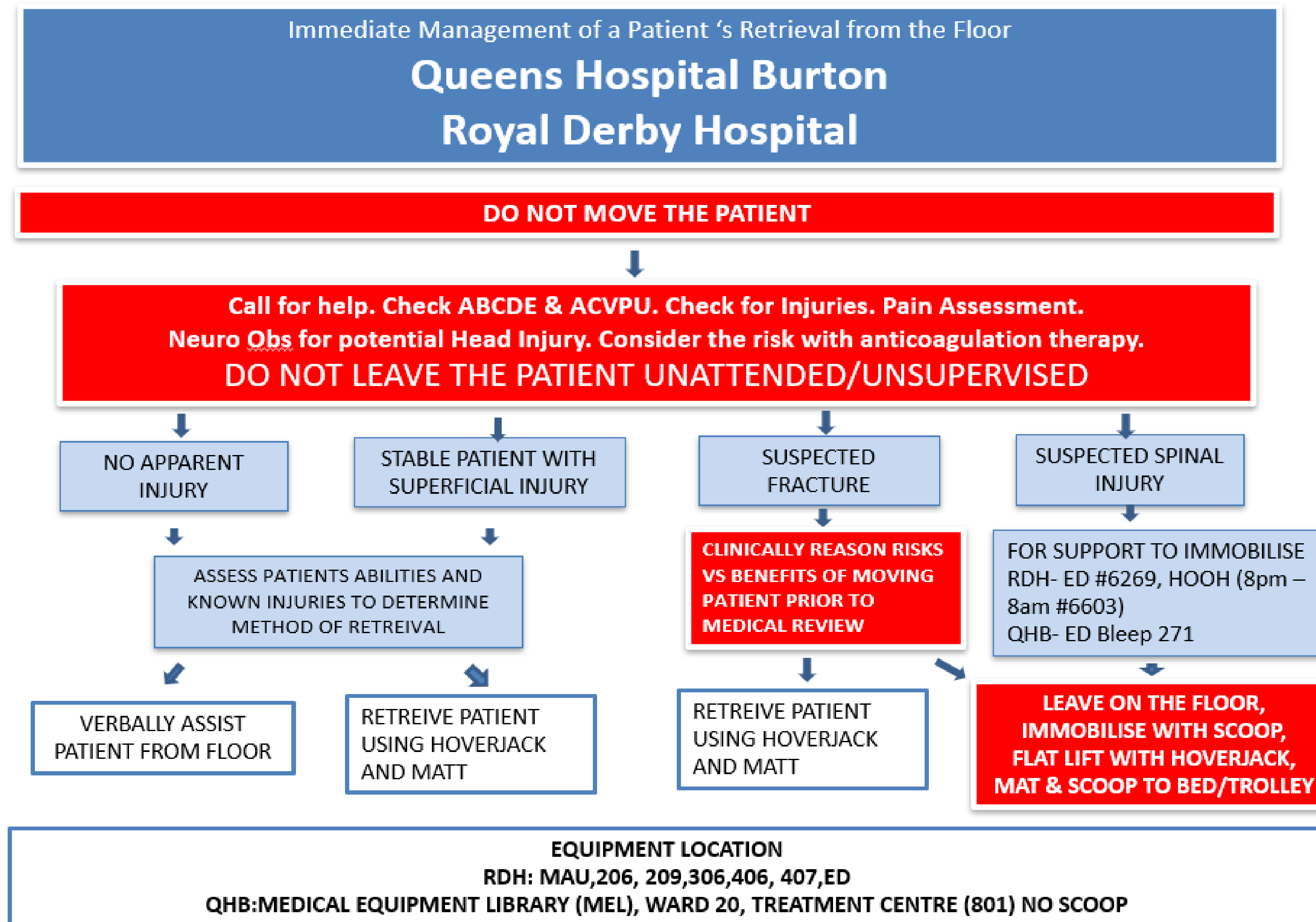
9 MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring Requirement:	Compliance with policy
Monitoring Method:	Falls training compliance Audit and thematic analysis of falls incident data Business unit reports presented to falls group Audit of falls assessments and care plans via ward assurance
Report prepared by:	Senior Falls Practitioner
Monitoring report presented to:	Patient Safety Group Learning from Deaths Group
Frequency of report:	Patient Safety Group – monthly Learning from Deaths Group – as required

10 REFERENCES

- World Health Organisation (WHO), *Falls Fact Sheet* (April 2021)
- Public Health England (PHE), *Falls: applying All Our Health* (Feb 2022)
- National Institute for Clinical Excellence (NICE) *Head injury: assessment and early management* (2019)
- National Institute for Clinical Excellence (NICE), *CG 161 The Assessment & Prevention of Falls in Older People* (June 2013)
- National Reporting and Learning System, *Degree of harm FAQ* (2019)
- Equality Act (2010)
- Department Of Health, *National Service Framework For Older People* (2001)
- *Age UK, Falls prevention Exercise – following the evidence* (2013)
- Health and Safety Executive, *Managing for health and safety* (2013)
- Health and Safety Executive, *Safer Use of Bed Rails Guidance* (2013)
- Royal College of Physicians*, How to measure a lying and standing blood pressure* (2017)
- Derbyshire InterAgency Group, A Parker, G Nicholls and T Doherty, *A Code at Practice: Care and Handling for People in Hospital, Community and Educational Settings* (2011)
- NHS Improvement, *Patient Safety Alert: assessment and management of babies who are accidentally dropped in hospital* (2019)

APPENDIX 1 – Immediate Management of a Patient's Retrieval from the Floor



Immediate Management of a Patient 's Retrieval from the Floor

COMMUNITY HOSPITALS

DO NOT MOVE THE PATIENT

Call for help. Check ABCDE & ACVPU. Check for Injuries. Pain Assessment.
Neuro Obs for potential head injury. Consider the risk with anticoagulation therapy.
DO NOT LEAVE THE PATIENT UNATTENDED/UNSUPERVISED

NO APPARENT INJURY

STABLE PATIENT WITH SUPERFICIAL INJURY

SUSPECTED FRACTURE

SUSPECTED SPINAL INJURY

Assess patients ability and known injuries to determine Method of retrieval

CLINICALLY REASON RISKS VS BENEFITS OF MOVING PATIENT PRIOR TO MEDICAL REVIEW

Verbally assist patient from floor

Retrieve patient using hoverjack and matt

Retrieve patient using hoverjack and matt

LEAVE ON THE FLOOR, IMMOBILISE, CALL DOCTOR/ADVANCED PRACTITIONER/9-999

ARRANGE DOCTOR/ADVANCED PRAC/9-999

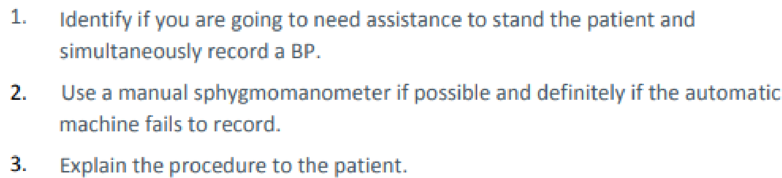
CALL 9-999 FOR AMBULANCE AT NIGHT/OUT OF HOURS IF NO DR AVAILABLE, TO TRANSFER PATIENT, TO IMMOBILISE WITH SCOOP SPINAL BOARD (999 Crew)

EQUIPMENT LOCATION: FNCH: WARD 3 SAMUEL JOHNSON : ANNA WARD SIR ROBERT PEEL : ANDREW WARD

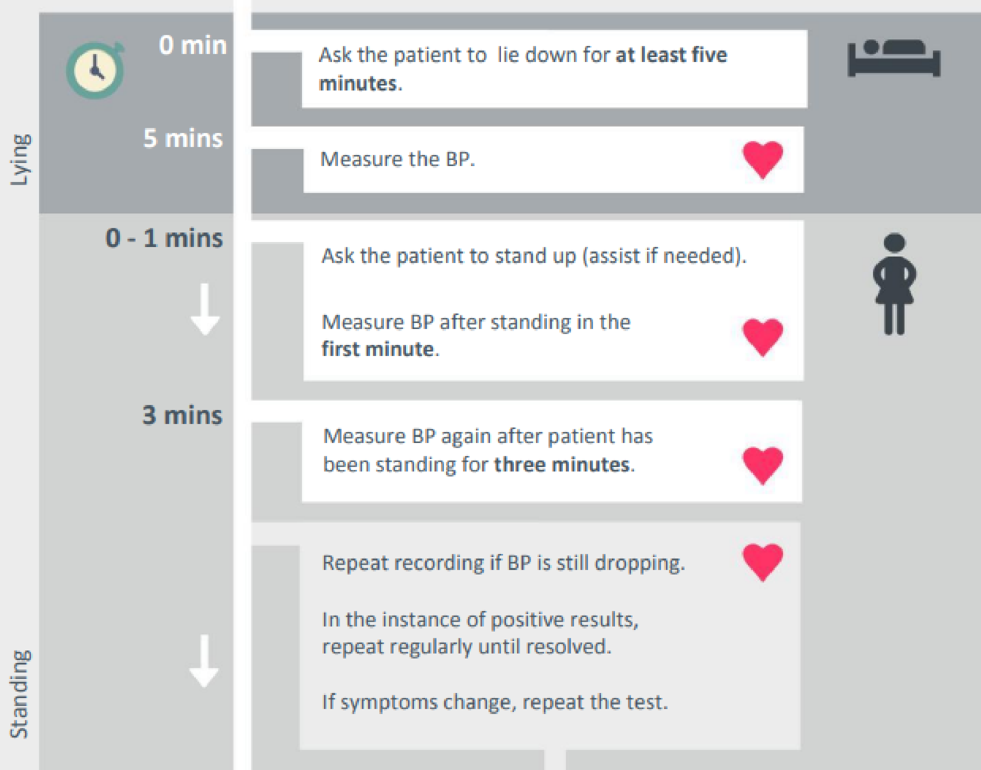
APPENDIX 2 – Measurement of Lying and Standing Blood Pressure

Falls and Fragility Fracture Audit Programme

How to measure a lying and standing blood pressure (BP) as part of a falls assessment



1. Identify if you are going to need assistance to stand the patient and simultaneously record a BP.
2. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
3. Explain the procedure to the patient.



Notice and document **symptoms** of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.

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.

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 less significant than a drop in systolic BP).

<u>APPENDIX 3 – Egress Test</u>

The Egress Test

Purpose:

To ensure a patient's ability to stand, transfer weight and step prior to mobilising.

Test 1: Sit-to-stand.

Sit-to-stand demonstrates knee extension ability and is critical to assess the ability to rise from a surface.

If the patient requires assistance beyond cues, then a rotunda or hoist should be used until he is able to safely complete this sit to stand task.

Test 2: Marching on the spot.

There are situations in which a patient may have sufficient strength to raise a leg from the floor and step forward, but that same leg may lack the strength to support the patient's entire bodyweight. So it is critical to test both the strength required to lift each leg, and the ability of each leg to support the patient's total bodyweight during a single leg stance.

Marching on the spot allows carers to test consistency and to redirect the patient back to a sitting position should the patient become unable to complete the task. Too many patients fall or become stranded mid-transfer because endurance had not properly been tested prior to leaving the starting surface.

If the patient requires assistance beyond cues, then a rotunda or hoist should be used until he is able to safely complete this sit to stand task.

Test 3: Advance step and return each foot

Before the patient is allowed to step away from the starting surface, a last test of endurance and function must be performed.

While the carer maintains a guarding position at the bed edge, the patient is asked to advance one leg forward and then return it to the starting position. The task is repeated in the other leg.

Should a patient be unable to bring the leg back, the carer encourages the patient to sit back down. Note that the patient always has one leg touching the starting surface.

If, during any part of the Egress Test, the patient demonstrates difficulty or need for physical assistance beyond cues, then a rotunda / hoist must be used.

K. Webster & C.Noble July 2017

APPENDIX 4 - Safeguarding assessment tool

Circumstances	Yes	No	Rag rating	Possible category of abuse
Is there historical evidence that the patient was at risk of falls, but a) there was no falls risk assessment and/or b) no risk-reduction plan in place				Neglect/acts of omission
Is there evidence of assessment that the person required continuous supervision/1:1 care and the person fell while unattended?				Neglect / acts of omission
Did the fall likely result from failure to complete tests/observations/give appropriate medications e.g. because they have diabetes and their blood sugars hadn't been checked, they were post-operative or medication had been given incorrectly?				Neglect / acts of omission
Did the patient have a fall and staff failed or delayed seeking medical advice?				Neglect / acts of omission
Did the fall happened as the result of poor moving and handling activity?				Neglect / acts of omission
Were they known / assessed to be a falls risk and objects e.g. bell / drinks / glasses not in easy reach? Did they fall trying to reach to reach them ?				Neglect / acts of omission
Was the patient identified as confused or disorientated but bed rails were in use?				Neglect / acts of omission
Was the fall caused by the height of the bed being too high/too low?				Neglect / acts of omission
Was the patient assessed as requiring a mobility aid but was not issued this or this was left out of reach of the patient?				Neglect / acts of omission
Did the person have a fall because there was a loose carpet or an equipment maintenance issue?				Neglect / acts of omission
Was there an assault by a 3rd party involved e.g. patient or visitor?				Physical abuse / assault

If the answer is yes to any of the above a social care referral should be made and CQC informed. The Trust must notify CQC of all incidents that affect the health, safety and welfare of people who use services, as specified under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.In cases where a care provider has failed to take specific actions to identify, assess, address, and reduce risks, this could lead to enforcement action due to failure to have safe systems of work in place.

The Health and Safety Executive RIDDOR guidance is clear that accidents to members of the public (this is anyone not at work in the care setting) must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury.

- Examinations and diagnostic tests do not constitute 'treatment' in such circumstances.
- Incidents do not need to be reported where people are taken to hospital purely as a precaution when no injury is apparent.

- If the accident occurs in a hospital care setting, then it only needs to be reported to RIDDOR if the injury is a ‘specified injury’ as set out in the HSE guidance.

In both cases of safeguarding and incidents/accidents, report records should show:

- What happened?
- How it happened?
- Who has been spoken to (including the resident and/or their family/advocate, witnesses, management, any health professionals, key social care worker, police etc.) and what have they said?
- What action has been taken (both immediate emergency action and longer term action such as management investigation or disciplinary etc.)?
- What has been put in place to stop/reduce it happening again (such as action plans, training, briefings, lessons learnt being shared across all services etc.)?

How this will be monitored and review the actions?