# Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Southern Health NHS Foundation Trust Hospitals, Mental Health and Learning Disability Units

**Version:** 3

## Summary:
The purpose of this procedure is to direct staff in the management of Slips, Trips and Falls in patients / service users in Southern Health NHS Foundation Trust Hospitals, Mental Health and Learning Disability Units.

## Keywords (minimum of 5):
(To assist policy search engine)
- Slip
- Trip
- Fall
- Bedrail
- Head Injury

## Target Audience:
Applies to all staff who work with patients / service users at risk of falls in Trust hospitals, mental health and learning disability units. It applies specifically to clinical staff, who care for patients who are at risk of falling or who have fallen, prior to or subsequent to admission.

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Change Record

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1. Introduction

1.1 The purpose of this procedure is to raise awareness of slips, trips and fall risks to staff that work with patients / service users in Southern Health NHS Foundation Trust (hereafter referred to as The Trust) Hospitals, Mental Health and Learning Disability Units. The aim is to reduce the risks of falling and subsequent harm in patients / service users by providing adequate falls risk identification, multi-factorial assessment, and implementing appropriate interventions for prevention and mitigation of injury when a likelihood of falling is present.

1.2 This Slips, Trips and Falls procedure is underpinned by the Trust’s Slips, Trips and Falls policy (SH CP 24) and staff should refer to both documents.

1.3 Falls are the highest reported cause of incidents for older people in hospitals and healthcare premises. Falling is often seen as an inevitable part of ageing. However, the National Patient Safety Agency’s report ‘Slips, Trips and Falls in Hospitals’ (2010) has shown that much can be done to reduce, prevent and manage falling, particularly in hospital environments.


1.5 It is recognised that people with a learning disability may experience falls at an earlier age for a variety of reasons including:

- Long term neurological conditions e.g. cerebral palsy, epilepsy
- Premature ageing e.g. early onset of dementia in Down’s Syndrome
- Impaired or poorly developed gait pattern, balance and saving reactions
- Sensory impairment and sensory processing problems
- Inability to recognise or assess risk to themselves.

Trust staff working with service users with learning disabilities will need to adapt their assessments and interventions to reduce falls risks in this client group.

1.6 The risks for falling are multi-factorial and, therefore, the requirement to impact on reducing the number of falls or improved management of falls, needs a multi-factorial and multi-disciplinary approach to assessment and appropriate targeted interventions. It is therefore essential that all staff involved in patient / service user care and their managers are familiar with the details of this procedure.

2. Scope

2.1 This procedure applies to staff who work with patients / service users who are at risk of falls in Trust Hospitals, Mental Health and Learning Disability Units. It applies specifically to clinical staff, who care for patients / service users who are at risk of falling or who have fallen, prior to or subsequent to admission.
2.2 The procedure applies to Trust clinical staff working in Hampshire and to clinical staff who provide specialist services for people with learning disabilities and other long term complex care needs in Oxfordshire.

2.3 All inpatients cared for within Trust Hospitals and Older Persons Mental Health (OPMH) and Learning Disability (LD) units will have a ‘Falls Risk Inpatient Assessment for OPMH and Community Hospitals’ (Appendix 1) completed within six hours of admission, with the exception of Medical Admissions Unit (MAU) at Lymington Hospital, where the standard will be within 24 hours of admission. On MAU, patients identified as being at risk of falls will wear a coloured band to highlight their falls risk until the falls care plan is completed.

2.4 In OPMH wards, all service users will be treated as being at high risk of falls on admission until such time as the falls assessment identifies otherwise.

2.5 In Adult Mental Health (AMH) the front page of the ‘Falls: Inpatient Screen and Assessment: AMH’ (Appendix 2) needs to be completed within 6 hours of admission and the subsequent pages will need to be completed within 24 hours of admission if falls risks identified.

3. Duties / Responsibilities

3.1 Matrons or Lead Nurses have a responsibility to:

- Ensure that staff are aware of and comply with this procedure
- Work directly with Ward Managers to address issues identified regarding slips, trips and falls hazards reported according to the Trust's Incident Reporting System
- Ensure that action plans are developed with Ward Managers for falls risks highlighted in any root cause analysis undertaken on the wards; also for inpatient falls audits and investigations into Serious Incidents (SIs), and ensure that learning is shared across the Divisions and that improvements are implemented.

3.2 Ward Managers have a responsibility to:

- Be aware of and comply with this procedure
- Ensure that all adult inpatients / service users in Trust Hospitals, Mental Health (MH) and LD units are assessed for the risk of falling within 6 hours of admission in accordance with the documentation in this procedure
- Ensure that if a patient / service user is identified as being at risk of falls, their risks are reviewed weekly, as prompted by the falls assessment documentation, after each inpatient fall and when their condition alters
- Identify and support Falls Links (Community Hospitals and OPMH wards), release them to attend falls meetings, training and allow them dedicated time to undertake quarterly Critical Analysis of falls incident data (if appropriate to the setting)
- Work directly with Falls Links to develop action plans and implement improvements resulting from root cause analysis of falls incident data / weekly 'Falls Quality Indicator' form (Appendix 15) and from inpatient audits
- Ensure that the above action plans are shared with ward staff at staff meetings
- Ensure that staff within their responsibility, in the event of a slip, trip or fall incident, complete an Incident form on the Trust Incident Reporting System
- All incidents should be appropriately investigated according to the Trust’s Incident Reporting System. RIDDOR reportable incidents must be brought to the attention of the Head of Health, Safety and Security and the HSE RIDDOR form completed (or the RIDDOR information sent to Health and Safety for completion, depending on local protocol).
3.3 **Falls Prevention Co-ordinators** have a responsibility to:

- Maintain the content of the Falls Prevention folders on the wards, by sending electronic updates to Falls Links
- Maintain the content of the Falls Grab Bag folder, by sending electronic updates to the Falls Links
- Report bi-annually to Health and Safety Committee on falls prevention Quality Indicators and any falls audits that are carried out within SHFT hospitals
- Report quarterly on thematic review of falls SI incidents.

3.4 **Falls Links** have a responsibility to:

- Understand and implement the role as described (Appendix 7), under the supervision of the Falls Prevention Co-ordinator and the Ward Manager
- Undertake quarterly critical analysis of falls incident data, if appropriate to their setting and develop a local action plan (Appendix 10) with the Ward Manager to address issues raised.

3.5 **Clinical nursing and therapy staff in Trust Hospitals, OPMH, AMH and LD inpatient settings (according to the Trust Training Needs Analysis) involved in the care of people who are at risk of falls** have a responsibility to:

- Complete the falls risk assessment documents included in this policy (if relevant to their area of practice) within 6 hours of admission to demonstrate that they have undertaken falls assessments, except on MAU at Lymington Hospital, where the standard will be within 24 hours of admission. On MAU, patients identified as being at risk of falls will wear a coloured band to highlight their risk of falls until the falls care plan is completed
- Complete the ‘Falls Risk Inpatient Assessment for OPMH and Community Hospitals’ (Appendix 1) or ‘Falls: Inpatient Screen and Assessment: AMH’ (Appendix 2) to demonstrate that they have undertaken the appropriate multi-faceted interventions for each patient
- Complete the ‘Post Fall Checklist’ (Appendix 1) after each inpatient fall adhering to the ‘Post Fall Protocol’ (Appendix 5)
- Extra care must be taken to assess patients for injury after a fall, especially if a fall from height is suspected
- Complete an incident form for all falls and near misses according to the Trust’s ‘Procedure for Reporting and Managing Incidents’ (SH NCP 17)
- Review the patient’s / service user’s falls risks weekly as prompted by falls assessment documentation, after each inpatient fall and when their condition alters
- Record details of the falls incident in the patient / service user’s notes. Any member of Trust staff who cannot complete the online incident form (for whatever reason) must inform their line manager of the incident.

4 **Main Procedure Content**

4.1 **Falls Risk Assessment and Care Planning**

4.1.1 Risk factors that are most significant in hospital patients / service users are: unsteady gait, confused and agitated, incontinence or frequency, previous falls, postural hypotension and taking sedatives and psychotropic medications.

4.1.2 Patients with dementia are more likely than those without memory problems to require hospital admission and are at least twice as vulnerable to falls. See Trust Guidelines ‘Managing Behaviour Problems in Patients with Dementia’ SH CP 02 (December 2015).
4.1.3 Multi-factorial interventions may reduce the number of falls in hospital by 18% - 20%. It is less clear whether they are as effective for people with dementia.

4.1.4 It is recognised that people with a learning disability may experience falls at an earlier age for a variety of reasons including:

- Long term neurological conditions e.g. cerebral palsy, epilepsy
- Premature ageing e.g. early onset of dementia in Down’s Syndrome
- Impaired or poorly developed gait pattern, balance and saving reactions
- Sensory impairment and sensory processing problems
- Inability to recognise or assess risk to themselves.

Some of these people will have experienced falls throughout their lives and the risk and frequency of falls will increase as they get older. It is not uncommon for some people with a learning disability and challenging behaviour to put themselves or collapse onto the floor. It is important to distinguish between these behaviours and a true fall. Additionally people with a learning disability may need a much longer course of treatment in order to consolidate skills learned.

4.1.5 Falls can often be a symptom of underlying illness and therefore warrant a full medical review. NICE Quality Standard QS86 (March 2015) ‘Statement 3: Older people who fall during a hospital stay have a medical examination.’

4.1.6 It is vital to assess each patient / service user to identify their modifiable risk factors and review these after each fall. Staff in Community Hospitals and OPMH wards, AMH and LD wards should follow the appropriate Inpatient Falls Pathway (Appendices 3 and 3a).

4.1.7 The falls risk assessment should be shared with patients / service users whenever possible (and family / carers where consent is obtained) whenever the risk changes following a review.

4.1.8 The outcome of the falls risk assessment will indicate the level of care planning required by the multi-professional team and a record made of those involved and the decisions made.

4.1.9 Intentional Rounding on Trust wards will ensure that patients are offered the opportunity to use the toilet, prompt to use / have their call bell and walking aid to hand. Consideration needs to be given to those patients / service users who have fluctuating capacity or the inability to use the call bell.

4.1.10 Staff should ensure that patients, relatives and carers in Community Hospitals are provided with the Trust information leaflet ‘Preventing falls in hospital’.

4.1.11 Undertaking a lying and standing blood pressure to identify postural hypotension (by staff who have received training to do so) is a core element of a falls risk assessment and must be recorded for all patients / service users who are able to stand. If a patient / service user is unable to stand this must be documented and a lying and sitting blood pressure should be undertaken.

4.1.12 The ward team should consider the following for each patient / service user:

- Detecting and highlighting causes of delirium / cardiovascular illness
- Reviewing medication. A patient on medication which is not clinically indicated is at greater risk of falling – see ‘Commonly prescribed medicines that may cause an increase in the risk of falls in older people’ (Appendix 11)
- Ensuring adequate nutrition and hydration
- Recommending suitable footwear (shoes / slippers with good support and grip)
• Undertaking a lying and standing blood pressure (Appendix 9) to identify postural hypotension and requesting treatment if symptomatic
• Providing 24 hour access to suitable walking aids
• Physiotherapy assessment and encouraging mobility
• Referral to falls prevention exercise programme
• Drug and alcohol misuse problems must be identified and appropriate actions planned
• Identifying and managing incontinence or urgency
• Assessing for and requesting treatment for Osteoporosis
• Hip protectors (in OPMH long stay settings only – Appendix 8)
• Patient eyesight (wearing correct glasses) and hearing
• Ensuring adequate lighting in all areas
• Checking accessibility of call bells
• Appropriate use of Ultra Low beds - see ‘Guideline for the Safe Use of Ultra Low Beds’ (Appendix 12)
• Appropriate use of bedrails (Appendix 4)
• Appropriate use of bed or chair monitors / alarms (‘Factsheet: Falls Prevention Alarms’ Appendix 13)
• Ensuring areas near beds are uncluttered and devoid of items which may lead to tripping.

4.1.13 During the rehabilitation process, patients’ / service users’ mobility and abilities fluctuate. Ward staff should review patients’ / service users’ falls risks weekly, after a fall and whenever their condition changes to ensure that their falls risks have not increased.

4.1.14 Falls prevention monitors / sensors should be used as an early warning system. The bed and chair monitors are most effective when the patient / service user has been carefully selected and they are used as part of an active falls prevention plan. (Appendix 13)

4.1.15 Patients who have an infection e.g. UTI / chest infection are potentially at greater risk of falls and are likely to sustain a serious injury as a result of a fall. This is because they may have less insight into risk and are more unlikely to use the call bell for assistance. They should be on

• 4 hourly observations
• Fluid charts
• Nursed in an observation bed / cohort bay as appropriate

4.1.16 If isolation / single room is required / advised as part of patient management for infection reasons, this must be balanced against any falls risk identified. The safety of the patient must always take priority, however if after discussion with IPC team, isolation is considered essential for certain resistant organisms, the overall management of the patient must be planned to address both of these risks as safely as possible e.g. this may require 1:1 nursing of a patient in a single room.

4.2 Essential Care after an Inpatient Fall

4.2.1 The National Patient Safety Agency’s Rapid Response Report (2011) requires that NHS Trusts have a Post Fall Guidance document in place to ensure that when a patient / service user falls in hospital, appropriate assessments will take place to identify fractures and spinal injuries before the person is moved; and that patients / service users will be immobilised, if appropriate, whilst awaiting attendance of ambulance services. It also states that Trusts will agree with their local ambulance trust appropriate thresholds for accessing their services after an inpatient fall. This has been underlined by NICE Quality Standard QS86 (March 2015) Statements 1 and 2, which require documentation of assessment and method of moving the patient off the floor. Extra care should be taken when assessing injuries following a fall from height.
4.2.2 The Trust has developed a Post Fall Protocol (Appendix 5) to comply with the above report. All clinical staff in Trust Hospitals must comply with the Post Fall Protocol which should be laminated and displayed on all wards. A copy of the Post Fall Protocol must be stored in the falls prevention folder (in Community Hospitals) on the ward and highlighted to all staff in falls training.

4.2.3 After each inpatient fall the ‘Post Fall Checklist’ (Appendix 1), which reflects the Post Fall Protocol, must be completed to ensure that all the correct actions have been undertaken. If a patient / service user has fallen from height, appropriately trained staff should undertake an assessment to exclude fractures and spinal injury before they are moved.

4.2.4 After any patient / service user fall an incident form should be completed according to the Trust’s Incident Reporting System within 24 hours and the incident should be recorded in their notes.

4.2.5 When considering the most appropriate manoeuvre for moving a patient from the floor after a fall, staff must ensure compliance with The Trust’s Moving and Handling Policy SH HS 05 (July 2014).

4.2.6 After an inpatient / service user fall the patient should be reviewed by medical staff, the Trust has developed a post fall sticker which can be used in the medical notes as a prompt for medical staff. (Appendix 16)

4.3 Falls and Osteoporosis in Fracture Prevention

4.3.1 As the presence of Osteoporosis increases the risk of an older person sustaining a fracture resulting from a fall, Osteoporosis must be targeted in a joint approach with falls prevention (Ref: NICE TAG 160 and 161: The primary and secondary prevention of fragility fractures).

4.3.2 When undertaking a falls risk assessment, Trust staff should also consider the following Osteoporosis risks:

- Early menopause under 45years or untreated hysterectomy
- Family history of Osteoporosis or hip fracture
- Fragility fracture after age 50
- Oral steroid use for over 3 months
- Anti-epileptic and / or anti-psychotic medications
- Low body weight
- Other conditions: Crohn’s disease, Coeliac disease, hyperthyroidism, liver disease
- Immobility
- Rheumatoid Arthritis
- Smoking
- Excessive alcohol intake.

4.3.3 The falls risk assessment prompts the assessment of the above Osteoporosis risks. If a clinician identifies that a patient may be at risk of Osteoporosis, this should be highlighted to the medical team on the ward, requesting that treatment with bone-sparing agents are considered (with or without DXA scan, depending on the patient / service user’s age).

The Osteoporosis Guidelines (Appendix 14) highlight to the medical team on the ward the requirement for Osteoporosis risk assessment using the FRAX tool (www.shef.ac.uk/FRAX).

4.4 Using Bedrails Safely and Effectively

4.4.1 This part of the Slips, Trips and Falls procedure is based on:
- MHRA (December 2013) Safe use of bed rails
- MHRA Device Bulletin 2006(06): Safe use of bed rails
- NPSA safer practice notice: Using bedrails safely and effectively
- NPSA bedrails literature review
- Department of Health Mental Capacity Act and Deprivation of Liberty Safeguards (2005)

For the purpose of this document the term ‘bedrails’ will be adopted, although other names are often used such as: cot sides, bedside rails.

4.4.2 All clinical staff using bedrails as part of patient / service user care must comply with and adhere to this procedure when making the decision to use bedrails. Staff should use their professional judgement to consider the risks and benefits for individual patients / service users.

The purpose of this section of the procedure is to improve the safety of patients / service users in Trust Hospitals by informing staff about the relative risks of falls and injury with and without bedrails, and what steps they can take to reduce the risks to their patients / service users. It aims to ensure that bed rails are not used inappropriately as a form of restraint. (Ref: DH Deprivation of Liberty Safeguards, Mental Capacity Act, 2005).

4.4.3 Bedrails should only be used to reduce the risk of a patient / service user accidentally slipping, sliding, falling or rolling out of bed. Bedrails used for this purpose are not a form of restraint. Restraint is defined as ‘the intentional restriction of a person’s voluntary movement or behaviour’ (Queensland Health 2003).

The Mental Capacity Act and Deprivation of Liberty Safeguards provide legal protection for vulnerable people who may lack capacity to consent to the arrangements made for their care or treatment in order to protect them from harm and ensure their best interests. To comply with the above, staff must ensure that the use of bedrails will not increase the risk of harm to the patient / service user and that they are in their best interests.

4.4.4 When staff are assessing for suitability of bedrails:

- Consider alternatives including the use of Ultra Low beds (see ‘Guidance for the Safe Use of Ultra Low Beds’, Appendix 12)
- All beds should always be maintained at the lowest possible height
- Nursing and / or therapy staff must assess those at risk of falling out of bed by referring to the ‘Bedrails Risk Matrix Tool and Flowchart’ (Appendix 4)
- Consider the use of bedrail bumpers to prevent entrapment between the bedrail and the mattress and to prevent injuries
- Verbal consent of the patient / service user and the co-operation of the relative will be sought for the use of bedrails and documented in their records
- Bedrails are only to be used for people at risk of rolling out of bed
- Bedrails should not be used for people who are mobile and confused enough to climb over or round them
- If using mattresses for pressure relief with bedrails, consider:
  o reduction in the effective height of the bedrail relative to the top of the mattress may allow the patient / service user to roll over it
  o hazard of entrapment between the side of the mattress and the bedrail.
- If a patient / service user is found in a position which could lead to bedrail entrapment e.g. feet or arms through rails, halfway off the side of their mattress or with legs through gaps between split rails, this should be taken as a clear indication that they are at risk of serious injury from entrapment. Urgent changes must be made to the plan of care. These could include changing to a different type of bedrail, using bedrail...
bumpers or deciding that the risks of using bedrails now outweigh the benefits and considering an Ultra Low bed

- If a patient / service user is found attempting to climb over their bedrail, or does climb over their bedrail, this should be taken as a clear indication that they are at risk of serious injury of falling from a greater height. The risks of using bedrails are likely to outweigh the benefits and an Ultra Low bed / increased levels of supervision e.g. 1:1, cohort nursing and specialing should be considered.

4.4.5 People in hospital may be at risk of falling from bed for many reasons:

- Disorientation
- Delirium
- Dementia
- Lowered consciousness level
- Impaired mobility
- Sensory loss – visual impairment
- Medications (Appendix 11)
- Postural hypotension
- Poor balance.

4.4.6 Decisions about bedrails need to be made in the same way as decisions about other aspects of treatment and care as outlined in the Trust's Consent Policy and patient / service user choice should be considered, wherever appropriate. This means that:

- The patient / service user should decide whether or not to have bedrails if they have capacity and are able to weigh up the risks and benefits of bedrails once these have been explained to them (Ref: Department of Health Deprivation of Liberty Safeguards & Mental Capacity Act 2005)
- Staff should discuss the benefits and risks of using bedrails with relatives; however the relatives cannot make decisions for the patient / service user (unless they hold a Lasting Power of Attorney extending to healthcare decisions). The Trust does not require written consent for bedrail use but discussions and decisions must be documented by staff. Patients / service users / relatives should be provided with The Trust's information for patients leaflet ‘About Bedrails’.
- If a staff member believes that the person lacks capacity (Ref: Department of Health Deprivation of Liberty Safeguards & Mental Capacity Act 2005) they must decide if bedrails are in their best interests and document this, using the mental capacity assessment tool.

4.4.7 Most decisions about bedrails are a balance between competing risks. The risks for individual patients / service users can be complex and relate to their physical and mental health needs, the environment, their treatment, their personality and their lifestyle. Staff should use their professional judgement to consider the risks and benefits for individual patients / service users (Appendix 4).

If bedrails are not used, how likely is it that the person will come to harm?
Ask the following questions:

- How likely is it that the person will fall out of bed?
- How likely is it that the person would be injured in a fall from bed?
- Will the patient feel anxious if the bedrails are not in place?

If bedrails are used, how likely is it that the person will come to harm?
Ask the following questions:

- Will bedrails stop the person from being independent?
- Could the person climb over the bedrails?
- Could the person injure themselves on the bedrails?
- Could using bedrails cause the person distress?
Use bedrails if the benefits outweigh the risks.

4.4.8 Other considerations for Nursing and Therapy Staff:

- All patients / service users in Community Hospitals and OPMH settings should have a falls risk assessment (including a Bedrails Risk Assessment) completed within six hours of admission. If, prior to the full falls risk assessment being completed, bedrails are deemed appropriate, the bedrails assessment section should be completed.
- Where the assessment indicates that the patient / service user is at risk of falling from bed, clinical reasoning should be clearly documented to support any decision to use bedrails.
- Any decision for the use of bedrails should be discussed with the multi-disciplinary team, as appropriate, and clearly documented.
- The use of bedrails should be reviewed if there are significant changes to the patient's / service user's physical condition and / or capacity.
- Any refusal by the person / relative for the use of bedrails or any insistence on their use should be clearly documented in their notes.
- Any accidents or incidents that involve bedrails may require a further accident investigation. In these circumstances, the Health and Safety Team can be contacted to support any competent persons in the investigation process.

4.4.9 Maintenance of bedrails:

When bedrails are in place, it is the responsibility of the staff member raising them to ensure they are:

- checked for signs of damage, faults or cracks
- clean and functioning correctly
- all fittings are in place and the rail feels secure
- correct size for the patient
- that there is no gaps present that could present an entrapment risk to any part of the patient's body
  - Gap between the bars of the bed rails is 120 mm max
  - Gap between the bed rail and side of mattress is 120mm max
  - Gap between the lower bed rail and the mattress allowing for compression is a 120mm max
  - Gap from headboard to bed rail end is less than 60mm.

If bedrails are identified as not working correctly, they must be removed, clearly labelled and reported to Estates for repair.

4.5 Management of Minor Head Injuries in Trust Hospitals or Mental Health Settings

4.5.1 The situation regarding head injury management of patients / service users in Community Hospitals, Mental Health or Learning Disability Units is not fully covered by the NICE Clinical Guideline 56. Many patients / service users in Trust Hospitals suffer a fall because of their frailty and the nature of the rehabilitation services that the Trust provides. Some of these people will be likely to suffer a head injury.

4.5.2 This procedure is supplementary to NICE Clinical Guideline 56, which should already be familiar to all qualified clinical staff who work with patients / service users at risk of falls in Trust Hospitals or Inpatient Units.

4.5.3 Any patient / service user in a Trust Hospital who suffers a head injury or has an unwitnessed fall will be fully assessed to ensure that the following can be ascertained:
• a change to their baseline neurological observations from those at admission assessment
• sustained a loss of consciousness, or a lack of full consciousness (for example, problems keeping eyes open), as a result of the fall
• Glasgow Coma Scale (GCS) of less than 15 or alteration in their GCS since the fall
• focal neurology present i.e. new difficulty in speaking, seeing or limb movement
• skull fracture e.g. clear fluid running from the ears or nose, black eye with no associated damage around the eye, bleeding from one or both ears, new deafness in one or both ears, bruising behind one or both ears, obvious depression of a bony part of the skull or scalp which is of concern to the health care professional, severe local tenderness and bruising
• persistent headache since the fall
• vomiting episodes since the fall
• seizure (‘convulsion’ or ‘fit’) since the fall
• fall or injury resulted from a high energy collision i.e. a fall from a height of greater than 1 metre, or a fall down more than 5 stairs
• anti-coagulant medication, e.g. Warfarin, Gabigtran, Apixaban, Edoxaban, Rivaroxaban, Clopidogral, or have a bleeding / clotting disorder. NICE Clinical Guidance 176 (January 2014) highlights the need for a patient taking Warfarin and sustaining a head injury to have a CT scan within 8 hours (this procedure to be followed for all listed anti-coagulants above).

4.5.4 If any of the above features are not immediately and obviously present, the patient / service user should be observed according to The Trust’s Neurological Observation Chart (Appendix 6).

4.5.5 If any of the above are present, patients / service users in Trust Hospitals, Mental Health or Learning Disability Units should be sent to the local Emergency Department in an ambulance. The Emergency Department should be called in advance to advise of the referral and to outline the reasons for concern and the patient’s / service user’s background.

4.5.6 If a patient / service user sustains a head injury in a Trust outpatient setting or elsewhere on Trust premises i.e. they are not occupying a Trust bed, they should be transferred to the nearest Emergency Department.

4.5.7 The duty medical cover will be informed about all patients / service users who have sustained a head injury as a result of a fall.

4.5.8 Neurological Observations: The minimum acceptable documented neurological observations are:

- Glasgow Coma Scale
- pupil size and reactivity
- limb movements
- respiratory rate
- heart rate, blood pressure and temperature
- blood oxygen saturation.

4.5.9 Unwitnessed fall in Trust Hospitals, Mental Health or Learning Disability Units should have neurological observations undertaken, as outlined in this procedure, in exactly the same way as those who have hit their head and the neurological observations must be continued for a minimum of 24 hours. The duty medical cover must be informed if the member of staff has any concerns about the patient’s / service user’s condition.
Frequency of observations: The minimum frequency of observations for patients with Glasgow Coma Scale equal to 15 should be as follows after the initial assessment:

- every 15 minutes for 1 hour - then reassess patient / service user and decide whether to continue every 15 minutes for a further hour or to change to half-hourly. Document rationale for decision to change frequency
- then half-hourly for 2 hours. Document rationale for decision to change frequency
- then hourly for 4 hours
- then 2 hourly thereafter until 24 hours from the incident
- patient should be reviewed by a doctor, which should be within 24 hours of the incident
- if the GCS is equal to 15 and there has been no sign of deterioration after 24 hours, the observations can be discontinued without consent from a doctor
- if the GCS was below 15 at the start of the observations, this score should be communicated to all staff and the person monitored against this lower score
- should a person with GCS equal to 15 show any signs of deterioration (see examples below) after the initial 2 hour period, observations should revert to every 15 minutes and follow the original frequency schedule. This should also prompt referral to the duty medical cover
- if there have been variations or concerns within the first 24 hours the observations should be continued 4 hourly for a further 24 hours.

4.5.10 As medical cover is always available at Lymington Hospital, patients are often seen by a doctor more quickly. **Even if the patient has been seen by a doctor and their GCS is 15, the neurological observations must be continued for 24 hours.**

4.5.11 Any change in observations, such as those outlined below should result in a call to the duty medical cover for an immediate review. Should a medical review not be possible, and if the circumstances are of concern to the nurse in charge of the unit, the patient / service user should be sent via ambulance to the local Emergency Department.

4.5.12 Where transfer to an acute Trust is being considered, staff should refer to the care pathway for the deteriorating patient / service user for each site.

**Any of the following examples of neurological deterioration should prompt urgent referral to the duty medical cover or Emergency Department:**

- development of agitation or abnormal behaviour
- a sustained (for at least 30 minutes) drop of one point in GCS level (greater weight should be given to a drop of one point in the motor response score of the GCS)
- any drop of three or more points in the eye-opening or verbal response scores of the GCS
- a drop of two or more points in the motor response score
- development of severe or increasing headache or persistent vomiting
- new or evolving neurological symptoms or signs such as pupil inequality or asymmetry of limb or facial movement.

4.5.13 To reduce inter-observer variability and unnecessary referrals, a second member of staff competent to perform observation should confirm deterioration before involving the doctor, wherever possible. This confirmation should be carried out immediately. Where such confirmation cannot be performed immediately (for example, no staff member available to perform the second observation) the doctor or ambulance should be contacted without the confirmation being performed.
4.5.14 The Glasgow Coma Scale for adults

The Glasgow Coma Scale is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters:

Best Eye Response,
Best Verbal Response,
Best Motor Response.

The definition of these parameters is given below:

**Best Eye Response (4)**
1. No eye opening
2. Eye opening to pain
3. Eye opening to verbal command
4. Eyes open spontaneously

**Best Verbal Response (5)**
1. No verbal response
2. Incomprehensible sounds
3. Inappropriate words
4. Confused
5. Orientated

**Best Motor Response (6)**
1. No motor response
2. Extension to pain
3. Flexion to pain
4. Withdrawal from pain
5. Localising pain
6. Obey commands.

4.6 Recurrent Inpatient Fallers – unwitnessed falls in patients on prescribed anticoagulants

- All unwitnessed falls should raise suspicion of and be treated as if there has been a head injury and therefore the patients will require scanning if on anti-coagulants
- In some patients (for example those who are terminally ill) it might not be appropriate to refer for brain scanning, in which case a senior clinician (Associate Specialist, Consultant, Consultant Practitioner) could make a contemporaneous decision not to do so. In this case the clinical reasoning leading to that decision must be recorded in the patient’s health record
- In patients who fall repeatedly it might not be in their best interest to be referred for repeated scans. In patients who do not have capacity to make this choice themselves, it is expected that an advance discussion between relevant members of the responsible team and the patient’s family or advocate is held. This discussion should consider the relative risks of not repeating the scan versus the risk / disruption of doing so and should draw conclusions based on the patient’s best interest. This decision must be formally documented in the patient’s health record
- Even in patients for whom an advance decision is made not to routinely refer for scanning, the usual guidance for neurological observations should be followed and, if there is any cause for concern, the senior clinician on call should be contacted to consider changing the plan.
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<th>Title</th>
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<td>Inpatient Falls Pathway for Community Hospitals and Older Persons Mental Health Wards</td>
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<td>Inpatient Falls Pathway for Adult Mental Health Wards</td>
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<td>Bedrails Risk Matrix Tool and Flowchart</td>
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<td>Neurological Observation Chart</td>
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<td>Guidelines for use of Hip Protectors on Inpatient OPMH wards</td>
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<td>How to Undertake a Lying and Standing Blood Pressure</td>
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<td>Quarterly Critical Analysis Action Plan for Falls Incident Forms (Community Hospitals &amp; OPMH wards only)</td>
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<td>Commonly prescribed medicines that may cause an increase in the risk of falls in older people</td>
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<td>Guideline for the Safe Use of Ultra Low Beds</td>
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<td>Osteoporosis Guidelines</td>
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<td>Falls Quality Indicator</td>
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</table>
Appendix 1: Falls Risk Inpatient Assessment for OPMH and Community Hospitals / Post Fall Checklist

Falls Risk Inpatient Assessment for OPMH and Community Hospitals
The assessment and care plan should be completed within 6 hours of admission

Rationale: All people aged 65 or older who are admitted to hospital should receive a multifactorial assessment for their risk of falling during their hospital stay. NICE Guidelines 161 (2013)

<table>
<thead>
<tr>
<th>Assessing Clinician Name (print)</th>
<th>Admitting WARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for patient’s admission:</td>
<td>Admission Date/Time</td>
</tr>
</tbody>
</table>

Falls History – Falls in the last year

<table>
<thead>
<tr>
<th>Date/time (if known)</th>
<th>Details (number of falls/times/place/activity/injuries/able to get up/call for help)</th>
</tr>
</thead>
</table>

Bed Rails Assessment – refer to bedrails flowchart (page 7) and document on it decision, date/time and initial

<table>
<thead>
<tr>
<th>Date</th>
<th>Bedrails in place</th>
<th>Discussed with patient/relative/carers</th>
<th>Verbal consent</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Assessment of Fall Risk Factors- Consider any difference in day and night needs

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Yes = care plan required</th>
<th>Yes/No</th>
<th>Actions for consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Capacity</td>
<td>Does the patient have signs of Delirium?</td>
<td>Y</td>
<td>Observation bed (in line of sight from nurse desk)</td>
</tr>
<tr>
<td></td>
<td>Is the patient confused, agitated or disorientated?</td>
<td>N</td>
<td>Consider increase in supervision</td>
</tr>
<tr>
<td></td>
<td>Diagnosed Dementia/Depression? (check medical notes)</td>
<td>Y</td>
<td>Consider bed and chair sensors/alarms</td>
</tr>
<tr>
<td></td>
<td>Is there fluctuating mental capacity?</td>
<td>N</td>
<td>Undertake mental test score – MOCA/AMTS</td>
</tr>
<tr>
<td></td>
<td><strong>2. Fear of Falling</strong></td>
<td>Y</td>
<td>Consider mental capacity in relation to fall risk</td>
</tr>
<tr>
<td></td>
<td>Does patient have a fear of falling?</td>
<td>N</td>
<td><strong>Check if falls prior to admission and how many</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Refer to Physio/OT</strong></td>
</tr>
</tbody>
</table>
### Appendix 1: Falls Risk Inpatient Assessment for OPMH and Community Hospitals / Post Fall Checklist

<table>
<thead>
<tr>
<th>Patient ID Label</th>
<th>3. Mobility</th>
<th>4. Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Is the patient unsteady?</td>
<td>Does the patient have difficulty getting in and out of bed?</td>
</tr>
<tr>
<td></td>
<td>Does their mobility vary at different times?</td>
<td>Does the patient have difficulty using the call bell for help; either due to poor memory or poor compliance?</td>
</tr>
<tr>
<td></td>
<td>Are walking aids used/required?</td>
<td>Are there any slip/trip hazards around the bed space?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>5. Feet &amp; Footwear</th>
<th>6. Continence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are there any issues with footwear?</td>
<td>Urinalysis test positive – send MSU</td>
</tr>
<tr>
<td></td>
<td>Any problems with foot health?</td>
<td>Urinary incontinence or constipation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>7. Medications</th>
<th>8. Vision &amp; Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Taking 4+ prescribed medications per day or on falls risk medications?</td>
<td>Does patient have difficulty using the call bell for help; either due to poor memory or poor compliance?</td>
</tr>
<tr>
<td></td>
<td>Is the patient on anti-coagulant therapy?</td>
<td>Is there sufficient lighting?</td>
</tr>
<tr>
<td></td>
<td>Is the patient taking night sedation?</td>
<td>Does the patient need help with toileting?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>9. Lying &amp; Standing BP</th>
<th>10. Osteoporosis risk factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the patient have postural hypotension? (drop of 20mmHg systolic or 10mmHg diastolic)</td>
<td>History of fragility fracture &gt; 50</td>
</tr>
<tr>
<td></td>
<td>Are they adequately hydrated?</td>
<td>Menopause/hysterectomy &lt; 45</td>
</tr>
</tbody>
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<tr>
<th></th>
<th>11. Medical Conditions</th>
<th>12. Communication/Information</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Delirium due to infection?</td>
<td>Provide leaflets, as appropriate:</td>
</tr>
<tr>
<td></td>
<td>Stroke/TIA/Parkinson’s/Diabetes</td>
<td>'Introduction to Osteoporosis' (NOS)</td>
</tr>
</tbody>
</table>

- **Document relevant actions and review dates in Care Plan/RiO**
- **Review weekly and after every fall**
- **Ensure that medical, therapy and ward staff are aware of patient’s falls risks**
- **Highlight falls risks at handover, at ward rounds and in ward documentation**

**Staff Signature:**

**Assessment completed date/time:**

- **Ensure moving and handling risk assessment completed**
- **Communicate mobility status on handover**
- **Refer to Physio for mobility assessment**
- **Provide walking aid**
- **Ensure walking aid has patient’s name on, and is within reach at all times. Check ferrules**
- **Confirm bed at correct height**
- **Consider:**
  - a. Ultra Low Bed
  - b. Bed at safe height setting
  - c. Crash mat - consider trip risk and storage
- **Explain call bell system and ensure within reach**
- **Ensure all personal items and drink are within reach**
- **De-clutter bed space & consider lighting**
- **Refer to Dr for review of medications that could increase the risk of falls – use falls medication list**
- **Ensure glasses are clean and within reach**
- **Can patient see objects at end of bed? Has hearing aids in?**
- **Refer to Dr if recent deterioration**
- **Consider lighting near patient’s bed**
- **Undertake lying & standing BP using manual sphygmomanometer on admission**
- **Take manual pulse**
- **Refer to Dr for review if postural drop identified and record for next for 3 days**
- **Review osteoporosis risk factors**
- **Check if taking bone protection medication e.g. Alendronic Acid/Risedronate plus Calcium and Vitamin D**
- **Check compliance with taking bone protection at home**
- **If osteoporosis risk factors are identified, this should be highlighted to the medical team on the ward, requesting that treatment with bone-sparing agents are considered. Highlight to the medical team the requirement for osteoporosis risk assessment using the FRAX tool (www.shef.ac.uk/FRAX).**
- **Check MUST score**
- **Assess and treat cause of sepsis**
- **Consider medication timing for Parkinson’s**
- **Consider hemianopia, attention deficit, neglect for Stroke**
- **SHFT ‘Falls Prevention in Hospital’**
- **Getting up from the floor – on discharge**

**Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Trust Hospitals, Mental Health and Learning Disability Units**

**Version:** 3

**April 2017**
Falls Inpatient Care Plan

Problems should be numbered using the numbers on the falls assessment and reviewed on pages 5 and 6

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Problem Number</th>
<th>Problem</th>
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**Goal**

To reduce or minimise the risk of falls and the potential for subsequent injury during admission to hospital

**Plan of Action**

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Falls Inpatient Care Plan (continued)

Problems should be numbered using the numbers on the falls assessment and reviewed on pages 5 and 6

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**Goal**

To reduce or minimise the risk of falls and the potential for subsequent injury during admission to hospital

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</tbody>
</table>
Falls Inpatient Review of Risk Factors – use this continuation sheet for weekly reviews and after a fall

<table>
<thead>
<tr>
<th>Item for review - Insert comments below:</th>
<th>Change? Yes/No</th>
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</thead>
<tbody>
<tr>
<td>1. Mental Capacity</td>
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<tr>
<td>2. Fear of Falling</td>
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<tr>
<td>3. Mobility</td>
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<td>4. Environment</td>
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<td>4. Environment</td>
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<tr>
<td>5. Feet &amp; Footwear</td>
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<tr>
<td>7. Medications</td>
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<td>7. Medications</td>
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<tr>
<td>8. Vision &amp; Hearing</td>
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<tr>
<td>10. Osteoporosis</td>
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<tr>
<td>11. Medical Conditions</td>
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<tr>
<td>12. Information</td>
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<td>12. Information</td>
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<tr>
<td>Communication – handover, medical notes</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Staff Name: ____________________________  Ward: ____________________________  Date: ____________

Staff Name: ____________________________  Ward: ____________________________  Date: ____________
# Falls Inpatient Review of Risk Factors – use this continuation sheet for weekly reviews and after a fall (continued)

<table>
<thead>
<tr>
<th>Item for review - Insert comments below:</th>
<th>Change? Yes/No</th>
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<td></td>
<td>Communication – handover, medical notes</td>
<td></td>
</tr>
</tbody>
</table>

Staff Name: Ward

Date

Staff Name: Ward

Date
Appendix 1: Falls Risk Inpatient Assessment for OPMH and Community Hospitals / Post Fall Checklist

**Patient ID Label**

Complete this checklist to ensure appropriate assessment after every inpatient fall

Use in conjunction with physiological observation chart and SBAR(d) communication tool

<table>
<thead>
<tr>
<th>Assessment Required</th>
<th>Document Actions Undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perform Initial assessment</strong> on patient – ABCDE (airway, breathing, circulation, disability, exposure)</td>
<td></td>
</tr>
<tr>
<td>Is there a change in the patient’s condition?</td>
<td></td>
</tr>
<tr>
<td><strong>Assess for injury</strong></td>
<td></td>
</tr>
<tr>
<td>Is there any new pain, limb deformity, loss of sensation that could indicate an injury – e.g. head injury, spinal or hip fracture or medical condition (e.g. stroke, seizure, diabetic emergency)?</td>
<td></td>
</tr>
<tr>
<td>Document your assessment</td>
<td></td>
</tr>
<tr>
<td>Can the patient tell you why they fell? Consider the physiological cause of the fall</td>
<td></td>
</tr>
<tr>
<td>If any of the above is suspected, do not unnecessarily move the patient (other than to make them more comfortable). Do you need to call (9)999 for an emergency ambulance?</td>
<td></td>
</tr>
<tr>
<td>If not, and you intend to move the patient, document how the patient was moved and what equipment was used?</td>
<td></td>
</tr>
<tr>
<td>Document <strong>time of call</strong> to ambulance or doctor ..........</td>
<td></td>
</tr>
<tr>
<td>Document <strong>time of arrival</strong> of ambulance or doctor ..........</td>
<td></td>
</tr>
<tr>
<td>Perform physiological observations on the patient as per track and trigger physiological observation chart</td>
<td></td>
</tr>
<tr>
<td>Was the fall witnessed or un-witnessed?</td>
<td></td>
</tr>
<tr>
<td>Has the patient hit their head?</td>
<td></td>
</tr>
<tr>
<td><strong>If they have hit their head or had an un-witnessed fall:</strong></td>
<td></td>
</tr>
<tr>
<td>Start recording physiological observations as per track and trigger tool and record neurological observations, which will be required as follows:</td>
<td></td>
</tr>
<tr>
<td>- <strong>Every 15 minutes for 1 hour</strong> – then reassess patient and decide whether to continue every 15 minutes for a further hour, or to change to half-hourly. Document rationale for decision to change frequency</td>
<td></td>
</tr>
<tr>
<td>- Then <strong>every 30 minutes for 2 hours</strong>. Document rationale for decision to change frequency</td>
<td></td>
</tr>
<tr>
<td>- Then <strong>every 60 minutes for 4 hours</strong>.</td>
<td></td>
</tr>
<tr>
<td>- Then <strong>2 hourly for 24 hours</strong>. The patient should be reviewed by a doctor within 24 hours of the incident</td>
<td></td>
</tr>
<tr>
<td>Is the patient on anti-coagulant therapy? If they are on WARFARIN, they will require a CT scan within 8 hours</td>
<td></td>
</tr>
<tr>
<td>Consider pressure relief, pain relief and fluid balance</td>
<td></td>
</tr>
<tr>
<td>Explain to patient what is happening and why</td>
<td></td>
</tr>
<tr>
<td>Has the next of kin been informed?</td>
<td></td>
</tr>
<tr>
<td>If not, document why not</td>
<td></td>
</tr>
<tr>
<td>Complete adverse event form on Ulysses</td>
<td></td>
</tr>
<tr>
<td>Record incident number in patient’s care plan</td>
<td></td>
</tr>
<tr>
<td>Review risk factors for falls and fragility fractures</td>
<td></td>
</tr>
<tr>
<td>Review the Falls Care Plan – document when completed</td>
<td></td>
</tr>
<tr>
<td>Ensure this is still in the notes and is current</td>
<td></td>
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<tr>
<td>Sign:</td>
<td>Print name:</td>
</tr>
</tbody>
</table>
Appendix 2: Falls: Inpatient Screen and Assessment: AMH

**NAME:**

DOB: Affix label if available

**NHS NUMBER:**

The screening questions, assessment & care plan should be completed within 6 hours of admission

<table>
<thead>
<tr>
<th>Ask</th>
<th>Date &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient 65 years of age or older or 50 years of age with a Learning Disability as well?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is there a history of falls in the 12 months before admission?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does the patient appear over-sedated from taking psychotropic medication?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does the patient complain of dizziness?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does the patient have an unsteady gait or use a walking aid?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is the patient anxious about falls?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is the patient registered blind or partially sighted?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does the patient have any other long term conditions (e.g. Epilepsy, Pseudo-seizures, Diabetes, Stroke) that predispose to falls?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**If yes to any question above, complete falls assessment overleaf**

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Clinician signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician Name (print)</td>
<td></td>
</tr>
</tbody>
</table>

**Falls History**

<table>
<thead>
<tr>
<th>Date/time (if known)</th>
<th>Details (number of falls/times/place/activity/injuries/able to get up/call for help)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Clinician name (print):</th>
<th>Sign:</th>
</tr>
</thead>
</table>

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Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Trust Hospitals, Mental Health and Learning Disability Units
Version: 3
April 2017

24
## Appendix 2: Falls: Inpatient Screen and Assessment: AMH

### NAME:

### DOB:

### NHS NUMBER:

**Inpatient Falls Assessment: AMH**

Complete within 6 hours of admission if Yes to any screening question overleaf and review every week, or if the patient’s condition changes and after each fall.

### Checklist

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>Inpatient Care Plan interventions prompt Document relevant interventions in Falls Care Plan</th>
<th>Assessed Date/Time/Signature</th>
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</thead>
<tbody>
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</tbody>
</table>

### 1. Mental capacity
- Does the patient have:
  - signs of Delirium?
  - a diagnosis of Dementia?
- Is the patient confused, agitated or disoriented?
- **Y** Consider increase in supervision
- **Y** Undertake mental test score – MOCA /AMTS
- **Y** Consider mental capacity in relation to fall risk

### 2. History:
- Has the patient fallen in past year, or do they fear falling?
- **Y** Check if falls prior to admission and how many
- **Y** Refer to OT

### 3. Mobility
- Is the patient unsteady on transfer (with or without aid)?
- **Y** Ensure moving and handling risk assessment completed
- **Y** Refer to OT for mobility assessment

### 4. Environment:
- Does the bed space need assessing for any environmental risks?
- **Y** If patient appropriate for disabled room, consider:
  - a. Ultra Low Bed
  - b. Bed at lowest height setting
  - c. Crash mat - consider trip risk and storage
- **Y** Explain call bell system, and within reach
- **Y** Ensure all personal items are within reach
- **Y** De-clutter bed space

### 5. Current Clinical Condition
- Urinalysis test positive? (send MSU)
- Urinary incontinence? Constipation?
- **Y** Refer to Dr for review
- **Y** Need for regular toileting? Commode at night?
- **Y** Monitor fluid intake and encourage fluids

### 6. Osteoporosis risk factors:
- History of fragility fracture > 50?
- Menopause/hysterectomy < 45?
- Long term history of steroids, anti-epileptic or anti-psychotic medication?
- Parental history of hip fracture or osteoporosis?
- Crohn’s or Coeliac Disease, Hyperthyroidism, Rheumatoid Arthritis or Liver Disease?
- Low BMI <22?
- Smoking and excessive alcohol?
- **Y** Review osteoporosis risk factors
- **Y** Check if taking bone protection medication e.g. Alendronic Acid / Risedronate plus Calcium and Vitamin D
- **Y** Check compliance with taking bone protection at home
- **Y** Discuss with Dr any risk factors identified and whether treatment is appropriate

### 7. Communication / Information
- Would information leaflets be helpful to the patient/carer?
- **Y** SHFT 'Falls Prevention in Hospital
- **Y** 'Introduction to Osteoporosis' (NOS)
- **Y** Highlight falls risks at handover, at ward rounds and in ward documentation
NAME:  
DOB:  
NHS NUMBER:  
Affix label if available

**Post Fall Checklist**

**Date and Time of Fall:** ……………………………

**Complete this checklist to ensure appropriate assessment after each inpatient fall**

*(within 24 hours of fall)*

<table>
<thead>
<tr>
<th>Assessment required</th>
<th>Actions undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check ABC (airway, breathing &amp; circulation).</td>
<td></td>
</tr>
<tr>
<td>Is there a significant change to the patient’s condition?</td>
<td></td>
</tr>
<tr>
<td>Assess for injury. Is there any pain, limb deformity or loss of sensation that could indicate a head injury, limb, hip fracture or spinal fracture?</td>
<td></td>
</tr>
<tr>
<td>If so, consider how to move patient from floor to avoid further injury. If spinal injury or hip fracture suspected, leave patient on the floor and call an ambulance.</td>
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<tr>
<td>Document how patient was moved (or if immobilised)</td>
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<tr>
<td>Decide whether to inform doctor / ambulance service / neither</td>
<td></td>
</tr>
<tr>
<td>Time of call to Dr: ……………… or Ambulance: ………………</td>
<td></td>
</tr>
<tr>
<td>Time of visit by Dr: …………….. or Ambulance: ………………</td>
<td></td>
</tr>
<tr>
<td>Baseline observations to include AVPU (Alert, Voice, Pain Unresponsive), temperature, pulse, blood pressure, respiratory rate, blood oxygen saturations &amp; blood sugar.</td>
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<tr>
<td>Is the patient on anti-coagulant therapy?</td>
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</tr>
<tr>
<td>Was the fall unwitnessed? Has the patient hit their head?</td>
<td></td>
</tr>
<tr>
<td>If so, start neurological observations every 15 minutes for 1 or 2 hours (document rationale for decision regarding frequency) then half-hourly for 2 hours, then hourly for 4 hours, then 2 hourly until reviewed by a doctor (which should be within 24 hours of the injury).</td>
<td></td>
</tr>
<tr>
<td>Consider pressure relief, pain relief and fluid balance.</td>
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<tr>
<td>Explain to patient what is happening and why.</td>
<td></td>
</tr>
<tr>
<td>Has next of kin been informed? Yes / No</td>
<td></td>
</tr>
<tr>
<td>If not, why was this?</td>
<td></td>
</tr>
<tr>
<td>Complete adverse event form on Ulysses.</td>
<td></td>
</tr>
<tr>
<td>Incident number:</td>
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</tr>
<tr>
<td>Review risk factors for falls and fragility fractures.</td>
<td></td>
</tr>
<tr>
<td>Review the falls care plan. Initial when completed.</td>
<td></td>
</tr>
<tr>
<td><strong>Sign……………………………. Print name……………………………. Date: ……………… Time ……………….</strong></td>
<td></td>
</tr>
</tbody>
</table>
Inpatient Falls Pathway for Community Hospitals and Older Persons Mental Health Wards

Patient aged >65 years admitted to hospital

Falls Risk Inpatient Assessment within 6 hours of admission

Consider the following risk factors:
Cardiac causes, neurological disorders, medication, bone health, dizziness, orthostatic hypotension, gait and balance, feet and footwear, environment, vision and hearing, infection, cognition

Investigate and modify any risk factors identified and provide Trust Inpatient Falls Leaflet

Medical and Bone Health Review

Is the patient confused to a level that puts them at risk in the ward area? Consider mental capacity, falls sensor alarms, bed rail assessment, 1-1 or cohort nursing

Physiotherapy and Occupational Therapy Falls Assessment

Individual treatment and/or Ward-based exercise group e.g. Steady and Strong, Zumba

If all risk factors have been modified and all actions are complete, or if risk factors fully investigated and non-modifiable, then instigate relevant injury prevention or health promotion interventions and inform GP on discharge

Review Falls Care Plan weekly, after a fall, or when patient’s condition alters, paying particular attention to the deteriorating patient

Home visit prior to discharge

Refer to Social Services / third sector agencies if care needs are identified

Refer to Community Balance classes

Consider:
- Medical Outpatient follow-up
- onward referral to Syncope Clinic
- onward referral for DXA scan

Refer to Community Balance classes
Appendix 3a: Inpatient Falls Pathway for Adult Mental Health Wards

INPATIENT FALLS PATHWAY FOR ADULT MENTAL HEALTH WARDS

Patient admitted to hospital

Ask the 8 screening questions on the front page of the Falls: Inpatient Screen and Assessment: AMH within 6 hours of admission.

Any ‘yes’ answers?

Professional identifying falls risk completes ‘Falls: Inpatient Assessment and Care Plan’ within 24 hours of admission

Consider the following risk factors:
Cardiac causes, neurological disorders, medication, bone health, dizziness, orthostatic hypotension, gait and balance, feet and footwear, environment, vision and hearing, infection, cognition

Investigate and modify any risk factors identified and provide Trust Inpatient Falls Leaflet. Review falls care plan weekly, after a fall, or when patient’s condition alters

Cause of falls unexplained

Refer to Specialist Falls Service

Assessments, investigations or required actions incomplete

Consider:
*medical outpatient follow-up
*onward referral to Falls Clinic
*onward referral to community team

answered ‘No’ to all questions

Is the patient confused to a level that puts them at risk in the ward area? Consider mental capacity and take appropriate actions

Not confused / has capacity

No further action

If all risk factors have been modified and all actions are complete, or if risk factors fully investigated and non-modifiable, then instigate relevant injury prevention or health promotion interventions & inform GP on discharge

Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Trust Hospitals, Mental Health and Learning Disability Units
Version: 3
April 2017
### Bedrails Risk Matrix Tool

Risk matrices provide a familiar format that is easy to understand but may over-simplify some decisions. For example, in the matrix below there are more relevant elements than the matrix suggests, including vulnerability to injury and visual and spatial awareness.

This tool is to be used in conjunction with the Bedrails Flow Chart on next page.

<table>
<thead>
<tr>
<th>Mental State</th>
<th>Patient is delirious and disorientated</th>
<th>Patient is drowsy</th>
<th>Patient is orientated and alert</th>
<th>Patient is unconscious</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use bedrails with care</td>
<td>Bedrails recommended</td>
<td>Use bedrails with care</td>
<td>Bedrails NOT recommended</td>
</tr>
<tr>
<td></td>
<td>Bedrails recommended</td>
<td></td>
<td>Bedrails recommended</td>
<td>Bedrails NOT recommended</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bedrails recommended</td>
<td>Bedrails NOT recommended</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOBILITY</th>
<th>Patient is immobile (never leaves bed or is hoist-dependant)</th>
<th>Patient is neither independent nor immobile</th>
<th>Patient can mobilise without help from staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Trust Hospitals, Mental Health and Learning Disability Units
Version: 3
April 2017
Appendix 4: Bedrails Risk Matrix Tool and Flowchart

Flowchart - When to use bedrails

Is the patient/service user at risk of falling out of bed? Consider the following….
- Has the patient/service user or family asked for bedrails? OR
- Is the patient unconscious / has a reduced level of consciousness? OR
- Does the patient/service user have a diagnosis of dementia or delirium and is likely to fall out of bed?

Yes

Complete ‘Falls: Inpatient Care Plan’

Does the patient understand the purpose of bedrails?

Yes

Bedrails may be used with caution and only the patient’s informed consent. Bumpers should be used if assessed appropriate. Call bell must be within easy reach. Discuss alternatives

No

Is the patient being transferred to another department for treatment where their conscious level may be altered? (e.g. theatres)

Yes

Is patient/service user delirious enough to attempt to climb over or round bedrails? Consider Deprivation of Liberty Safeguards

No

Bedrails must not be used due to increased risk of injury/ falls / frustration or agitation

Document in notes

No bedrails needed

No

Document in notes

Does this patient/service user need to be on the Falls Pathway? If yes, please instigate
Appendix 5: Post Fall Protocol

Post Fall Protocol

All staff must be aware of how to call for emergency assistance in their place of work if they find someone who has fallen either in an inpatient or community setting.

Local procedures must comply with the following minimum requirements:

- First person on scene to check for danger to self and injured parties
- Check responsiveness of the injured person
- Summon for additional help and support by shouting for other staff and / or activating alarm
- If you are alone, leave the casualty and get appropriate help, ambulance / emergency team, then return to the patient and begin appropriate first aid procedures
- If there are two or more staff members present, one will phone (9)999/222 * as appropriate and one will assess the casualty for further interventions
  * Lymington New Forest Hospital: use code blue call button for emergencies
    Petersfield Hospital: dial 555 if downstairs or 222 upstairs
  A “999” ambulance may still be required at these locations
- Check for signs or symptoms of fracture eg limb deformity, pain, altered behaviour
- Check for signs or symptoms of spinal injury / fracture eg loss of sensation, tingling, pain
- Check for signs or symptoms of head injury; if the fall was unwitnessed, assume a head injury and start neurological observations (trained staff)
- Is the person taking WARFARIN? If so, they require a brain scan within 8 hours, transfer to ED

Stop Think Consider

- Is it safe to move the person / patient?
- What is the best method of moving this person / patient?
- What lifting aid(s) are available at this location – are you trained to use it? Document what you did
- If no injury is identified, assist the patient from the floor (if possible)
- Have you done a set of physical observations?
- Have you done a set of neurological observations?
- Keep the patient warm and consider their pressure areas
- Inform patient’s next of kin

Clinically review, reassure and inform the patient / person of your plan at all times

If bony injury or head injury suspected, do not move the patient / person unnecessarily

FOR ALL FALLS INCIDENTS FOLLOW THE GUIDANCE BELOW

<table>
<thead>
<tr>
<th>Community Setting</th>
<th>Inpatient Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call 999 and ask for an ambulance, if appropriate Call team and re-allocate any patients you cannot visit</td>
<td>Consider medical help and assessment Use neurological observation chart in conjunction with physiological observation chart Refer to hospital falls pathway Review risk factors for falls and fragility fractures Complete Post Falls Checklist Document in patient notes Complete incident form</td>
</tr>
<tr>
<td><strong>On returning to base:</strong> Inform line manager or senior member of staff in team Review risk factors for falls and fragility fractures Complete incident form (as soon as possible)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: Neurological Observation Chart

### Neurological Observations – this MUST be completed in conjunction with the physiological observation chart “track and trigger”.

For action on the colours use the definitions on the front page of the physiological observation chart.

<table>
<thead>
<tr>
<th>Best Eye Opening</th>
<th>Best Verbal Response</th>
<th>Best Motor Response</th>
<th>Best Sensory Response</th>
<th>15 point Glasgow Coma Scale (GCS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Spontaneously</td>
<td>Spontaneous activity – no verbal or touch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 To speech</td>
<td>Eye opens in response to speech, initially in a normal voice, resting level if no response</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 To pain</td>
<td>Eye opens in response to application of noxious or painful stimuli only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 None</td>
<td>No response to any stimuli</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Orientated</td>
<td>Oriented to time, place and person spontaneously or on questioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Confused</td>
<td>Confused and unable to make meaningful response, although may be responsive to verbal or physical stimuli</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Inappropriate words / stereotyped response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Incoherent sounds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 None</td>
<td>No response to any stimuli</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Obvious Withdrawal / normal Reaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Withdrawal / normal Reaction</td>
<td>Withdrawal of limb is observed in response to painful stimuli. Limbs flex towards the body, but does not reach the stimulus.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Abnormal Flexion (extensor)</td>
<td>Abnormal flexion is observed in response to painful stimuli. Arm – arm is flexed at the elbow, wrist and fingers, hands extended into the body.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Extensor (extensor)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 None</td>
<td>No response to any stimuli</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

The Face, Arm, Speech Test (FAST) can help you recognise the symptoms of FAST

**FAST**

- **Facial weakness**: Does the person smile on one side?
- **Arm Weakness**: Can the person raise both arms?
- **Speech problems**: Does the person speak clearly and understand what you say?

**Why act FAST?**

Stroke is a medical emergency. By calling 999 you can help to save lives, and can prevent further damage to the brain and keep scavengers (boris from infarct) away from the head. By acting quickly and providing the right treatment from the start, patients can achieve the best possible outcome. If you think someone is having a stroke, call 999 and ask for an ambulance.

**If you suspect a stroke, act FAST and call 999**

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Procedure for Managing Slips, Trips and Falls in Patients / Service Users in Trust Hospitals, Mental Health and Learning Disability Units

Version: 3

April 2017

32
Appendix 7: The Role of the Falls Link

The Role of the Falls Link

- Take a lead in raising awareness about Fall and Fracture Prevention at ward or department level, liaising with the Falls Prevention Co-ordinator / Falls Lead.

- Encourage all interdisciplinary team members to attend Slips, Trips and Falls training, including those members who may be on rotational placement.

- Attend all Falls Links meetings or arrange for a suitable deputy.

- Ensure that the minutes / actions from each meeting are cascaded to all interdisciplinary team members in a timely and appropriate manner.

- Ensure that all falls–related training they receive is recorded in their own Professional Development Portfolio and relevant training record at ward level.

- Act as a source of clinical expertise for the assessment, intervention and management of patients who have fallen or who are at risk of fall / fracture.

- Liaise with ward manager to ensure that inpatient falls audit / Key Performance Indicators (KPIs) are undertaken and work together to develop a local action plan after each audit / KPI review.

- Take a lead in working with the ward manager to critically analyse quarterly falls incident data and produce an action plan, as identified within this procedure.
Appendix 8: Guidelines for use of Hip Protectors on Inpatient OPMH wards

Guidelines for use of Hip Protectors on Inpatient Older Persons Mental Health Wards

Background
The incidence of osteoporotic hip fractures in older people is rising exponentially with an annual cost to the NHS of approximately £2 billion. The prevention of hip fractures in older people requires multi-disciplinary identification and assessment of both fall and fracture risk factors. There is some evidence for the effectiveness of hip protectors in reducing hip fractures in Care Homes; there is no evidence for the use of hip protectors in inpatient settings. Compliance is a major limitation to the efficacy with adherence rates in trials of between 60-19%. Key reasons identified in trials have been - not comfortable/too tight/poor fit, extra effort needed to wear them, urinary incontinence, physical difficulties/illnesses, causing increased agitation, and cost.

In certain circumstances where the patient’s falls history is known to be high and management of the risk is primarily around damage limitation then Hip protectors along with other items such as helmets and elbow/knee protectors can continue to be used for those patients who are compliant with their use and who do not increase the level of incontinence / agitation.

There is a danger that staff may reduce their vigilance, thinking that the patient is safe while wearing hip protectors, (see caution note below); all measures to reduce falls incidents must continue.

Indications for the provision of hip protectors:
- Age 80+
- History of recent falls/fractures with non-modifiable risk factors
- Diagnosis of Osteoporosis
- Impaired cognition
- Mobile with or without aid
- Low BMI
- Hospital patients with planned discharge to Care or Nursing Home
- Patient gives consent.

Contra-indications
- No intact hips ie both hips replaced
- Pressure sores on hip or sacral areas
- Patient declines to wear hip protectors
- Where the wearing of hip protectors causes increased agitation and increases the risk of injury through falling while trying to take the hip protectors off.

Cautions
Hip protectors will not prevent all fractures, eg if patient falls onto their buttocks, pelvic fractures may be sustained while wearing hip protectors. Bruises may be sustained from falling onto the protectors and skin irritation may occur.

Hip protectors should not be sent to the hospital laundry.

Assessment
Hip protectors may be provided for appropriate patients if:
1. The patient has had a falls risk assessment, including:
   - measurement of postural blood pressure
   - medication review and withdrawal of culprit drugs as appropriate
   - identification of possible causes of systemic infection
   - assessment of feet and footwear
Appendix 8: Guidelines for use of Hip Protectors on Inpatient OPMH wards

1. Assessment and intervention will include the following assessments:
   - assessment of vision/glasses
   - assessment of mobility and walking aid
   - environmental assessment and provision of equipment
   - nutritional assessment.

2. The patient’s fall events are recorded and monitored with regular critical analysis and documented action to reduce further falls.

3. The patient is prescribed and compliant with high strength Calcium and Vitamin D3 with or without Bisphosphonate as appropriate.

Compliance
Since compliance is a major limitation to the efficacy of hip protectors, comfort and good fit are essential. Adherence has been shown to be higher with soft shell hip protectors and different styles are now available to allow for continence and physical difficulties. Two pairs will be required for each patient.

Ward staff should receive training in the measurement, fitting and correct positioning of hip protectors provided for individual patients, including regular inspection of tissue viability.

Staff should encourage and support the wearing of hip protectors by patients 24/7 in order to improve efficacy of the garments.

 Manufacture & Cost
Recommended manufacturers:-
- BSN Medical
  Safehip Soft shell
  www.bsnmedical.co.uk
  01482 670100
- Winhealth
  HipSaver Soft shell
  www.win-health.com/hipsaver
  01835 864866

See websites for current prices.

References
How to undertake a lying and standing blood pressure

- **Do not** use automated equipment – use a manual sphygmomanometer

- Ensure the cuff size is appropriate for the patient

- Ensure the patient/service user is lying down for at least 15 minutes & record blood pressure in lying

- Leaving the cuff in place, stand the patient/service user (with assistance if necessary)

- **Immediately**, retake the blood pressure

- Repeat readings at 1 minute and 3 minutes (if the patient/service user cannot stand, they can sit for this)

- Document the result and how you did it.
# Quarterly Critical Analysis Action Plan for Falls Incident Forms

## Ward | Quarter Dates | Number of reports
--- | --- | ---
Common features

## Critical analysis

## Action plan update from last report

## Revised action plan

<table>
<thead>
<tr>
<th>Action Plan shared with Ward Manager</th>
<th>Action Plan shared with Ward team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review of Action Plan</th>
<th>Analysis carried out by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Sign:</td>
</tr>
<tr>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td></td>
<td>Date:</td>
</tr>
</tbody>
</table>

The Falls Link should review the previous 3 months Incident Forms involving patient falls for the following dates:

- 01.04 - 30.06 (Quarter 1);
- 01.07 - 30.09 (Quarter 2);
- 01.10 - 31.12 (Quarter 3);
- 01.01 - 31.03 (Quarter 4).

Original document to be retained on the ward and an electronic copy emailed to:

[hp-tr.SpecialistFallsTeam@nhs.net](mailto:hp-tr.SpecialistFallsTeam@nhs.net)
Appendix 11: Commonly prescribed medicines that may cause an increase in the risk of falls in older people

Commonly prescribed medicines that may cause an increase in the risk of falls in older people

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Benzodiazepines and non-benzodiazepine hypnotics (sometimes referred to as Z-drugs)</th>
<th>e.g. diazepam, clonazepam, lorazepam, nitrazepam, temazepam, zopiclone, zolpidem, zaleplon</th>
<th>Sleeping tablets (hypnotics) can cause ataxia, memory problems and confusion leading to falls and injury. Avoid long-acting benzodiazepine such as nitrazepam as it produces a hangover effect the next morning, excessive sedation and slower reaction times. Newer hypnotics e.g. Zopiclone are associated with less hangover effects, but there is no clear difference in the risk of falls between long- and short-acting hypnotics. All are licensed for short-term use only. Complete withdrawal of the drug may not be achievable, but benefit will still be gained by reducing the dose to minimum effective and often involves gradually reducing the dose over a period of time (to prevent withdrawal syndrome) according to national guidance. Always prescribe for short-term use only and review regularly.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-psychotics</td>
<td>e.g. chlorpromazine, trifluoperazine, haloperidol, benperidol, flupentixol, prochlorperazine, zuclopentixol, risperidone*, amisulpiride*, clozapine*, olanzapine*, quetiapine*,</td>
<td>May cause drowsiness and postural hypotension. Hypotension is dose-related and can be reduced by starting with a low dose and titrating slowly. All anti-psychotics can cause extra-pyramidal (movement) disorders although the incidence is less with atypicals*. Prochlorperazine is frequently inappropriately prescribed for dizziness and vertigo in the elderly and is the most frequently implicated drug causing drug induced Parkinsonian symptoms.</td>
<td></td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>Tricyclics - amitriptyline, imipramine, lofepramine, dosulepin, nortriptyline, clomipramine</td>
<td>SSRIs - citalopram, fluoxetine, escitalopram, paroxetine, sertraline</td>
<td>All tricyclic anti-depressants can cause drowsiness, (imipramine and lofepramine are less sedating) and hypotension can lead to dizziness or fainting. Tricyclics with high anti-muscarinic activity resulting in blurred vision, constipation and retention of urine (e.g. amitriptyline) should be avoided. SSRIs are less sedating but they can cause hyponatraemia resulting in falls.1</td>
</tr>
</tbody>
</table>
### Anti-depressants (cont’d)

<table>
<thead>
<tr>
<th>Others -</th>
<th>Anti-depressants</th>
</tr>
</thead>
<tbody>
<tr>
<td>trazodone, mirtazapine, venlafaxine, duloxetine</td>
<td>Mirtazapine and trazodone are potent sedative anti-depressants which may increase the risk of falls by causing next-day sedation.</td>
</tr>
</tbody>
</table>

### Anti-epileptics

| Phenytoin, carbamazepine, phenobarbitone, gabapentin, sodium valproate | Long-term phenytoin use can cause brain changes leading to unsteadiness. Phenytoin side effects such as dizziness, blurred vision, etc., may be signs of drug-related toxicity. Incidence of dizziness, drowsiness, ataxia and blurred vision are dose-related side effects observed with carbamazepine but may be reduced by altering timing or choice of formulation. Carbamazepine can also cause hyponatraemia. Long-term treatment with carbamazepine, phenytoin, primidone, sodium valproate and levetiracetam may lead to osteomalacia, osteopenia and osteoporosis increasing the risk of fracture following a fall. |

### Drugs used in Parkinson’s Disease

| e.g. co-beneldopa, co-careldopa, pramipexole, ropinirole, selegiline | Sudden excessive daytime sleepiness can occur with levodopa and other dopamine receptor agonists. Careful dose titration is particularly important when initiating treatment because of the additional risk of inducing confusion. As the patient ages, maintenance doses may need to be reduced. Other relevant side effects include postural hypotension, dizziness, insomnia, confusion and shaking. |

### Anti-muscarinic drugs (Anti-cholinergics)

| E.g. oxybutinin, tolterodine | Oxybutinin and tolterodine are used in treatment of urinary incontinence. Procyclidine and orphenadrine are used to treat Parkinsonian side effects from therapy with anti-psychotics. Common side effects of anti-muscarinic drugs include dizziness, blurred vision, retention of urine and confusion. Oxybutynin may cause acute confusional states in the elderly especially those with pre-existing cognitive impairment. This can be lessened by switching to another drug such as tolterodine, trospium or solifenacin. The side effects of tolterodine are comparable to those of modified release oxybutin. |

### Cardiovascular

| a) Ramipril, perindopril, enalapril, lisinopril, quinapril, candesartan, losartan, valsartan | a) The risk of hypotension is potentiated by concomitant diuretic use. Dizziness and fatigue can also occur. |
### Appendix 11: Commonly prescribed medicines that may cause an increase in the risk of falls in older people

<table>
<thead>
<tr>
<th>b) Alpha-blockers</th>
<th>b) doxazosin, prazosin, tamsulosin</th>
<th>b) Alpha-blockers can cause drowsiness, postural hypotension, dizziness, tiredness, blurred vision and syncope.</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) Beta-blockers</td>
<td>c) atenolol, bisoprolol, propranolol, sotalol, labetalol</td>
<td>c) Reports of dizziness may be due to postural hypotension and can affect up to 10% of patients. Beta-blockers are also associated with fatigue and sleep disturbances and may cause falls if a patient becomes bradycardic. Topical application of beta-blocker eye drops may also produce a systemic effect.</td>
</tr>
<tr>
<td>d) Vasodilator anti-hypertensive drugs</td>
<td>macitentan, riociguat</td>
<td>d) Risk of hypotension</td>
</tr>
<tr>
<td>Nitrates</td>
<td>e.g. glyceryl trinitrate, isosorbide mononitrate nicorandil, ivabradine</td>
<td>Dizziness may be due to postural hypotension. Advise patient to sit when using GTN spray.</td>
</tr>
<tr>
<td>Anti-anginals</td>
<td>e.g. furosemide, bendroflumethiazide, bumetanide, amiloride, metolazone, spironolactone, co-amilofruse</td>
<td>Postural hypotension, dizziness and nocturia are the most frequent problems seen in the elderly. They can also cause hyponatraemia and hypokalaemia. Diuretics should <strong>not</strong> be prescribed for long-term use in the treatment of gravitational oedema. For patients prescribed anti-hypertensive therapy, the falls risk can be reduced by slowly titrating therapy up to the lowest therapeutic dose and by monitoring blood pressure on a regular basis. Postural hypotensive side effects usually wear off after 7-14 days and patients should be counselled to move more cautiously into an upright position during this period to reduce the chance of a fall.</td>
</tr>
<tr>
<td>Diuretics</td>
<td>e.g. morphine, codeine, dihydrocodeine, tramadol, oxycodone, fentanyl, buprenorphine</td>
<td>Sedation, slower reaction time, balance impairment and delirium can occur especially in older people, debilitated individuals and in those who have renal impairment. A dose reduction is recommended. Other side effects include bradycardia, vertigo, postural hypotension, hallucination and confusion</td>
</tr>
<tr>
<td>Opioid Analgesics</td>
<td>(Opiates refer to alkaloids from opium poppy, whereas opioid act on opioid receptors)</td>
<td>Moderate Risk</td>
</tr>
<tr>
<td>Cardiovascular a) Anti-arrhythmics</td>
<td>a) digoxin, amiodarone, flecainide</td>
<td>a) Dizziness and drowsiness are possible signs of digoxin toxicity – risks of toxicity are greater in renal impairment or in the presence of hypokalaemia. Amiodarone can cause bradycardia and sleep disorders, and flecainide has a high risk for drug interactions and can also cause dizziness</td>
</tr>
</tbody>
</table>
### Appendix 11: Commonly prescribed medicines that may cause an increase in the risk of falls in older people

<table>
<thead>
<tr>
<th>b) calcium channel blockers</th>
<th>b) amlodipine, nifedipine, felodipine, lercanidipine, diltiazem and verapamil</th>
<th>b) These can cause hypotension and diltiazem and verapamil may also cause bradycardia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sedating Anti-histamine</strong></td>
<td>e.g. chlorphenamine, promethazine, hydroxyzine</td>
<td>Sleepiness may affect up to 40% of patients prescribed older anti-histamines e.g. chlorphenamine</td>
</tr>
</tbody>
</table>

#### Low Risk

<table>
<thead>
<tr>
<th>Dementia</th>
<th>e.g. donepezil, galantamine, memantine, rivastigmine</th>
<th>All these medicines can cause dizziness. In addition, other side effects with donepezil, galantamine and rivastigmine include syncope and bradycardia. Avoid concomitant administration with anti-muscarinic drugs where possible as they oppose the effect of some anti-dementia drugs and increase confusion, delirium and disorientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid regulating drugs</td>
<td>e.g. lomitapide</td>
<td>May cause dizziness</td>
</tr>
<tr>
<td>HIV infection</td>
<td>e.g. dolutegravir</td>
<td>Can cause dizziness</td>
</tr>
<tr>
<td>Anti-diabetic drugs</td>
<td>e.g. canaglifozin</td>
<td>Can cause postural hypotension (less common)</td>
</tr>
</tbody>
</table>

- **Polypharmacy is a risk factor for falls** – patients on four or more medicines are at greater risk of having a fall. Regular medication reviews are important.

- **Psychotropic drugs are most often implicated in falls especially benzodiazepines, anti-psychotics and tricyclic anti-depressants** – they should be used for specific indications for the minimum time necessary.

- **Benzodiazepines and hypnotics increase in falls risk can be reduced by reducing the dose even if they can't be withdrawn altogether** – withdrawal should be gradual and may be aided by changing to an equivalent dose of diazepam and then reduced in a stepwise manner as suggested in the BNF.

- **Hypotension is recognised as a key contributor to falls** – Postural hypotension caused by drugs is not uncommon in older people. To screen for this perform **lying** and **standing** blood pressures with a manual sphygmomanometer (defined as a drop in systolic BP >20mmHg or diastolic BP >10mmHg).
Appendix 11: Commonly prescribed medicines that may cause an increase in the risk of falls in older people

- The risk of falling increases with the number of associated intrinsic factors, ie:
  
  Previous fall  
  Poor mobility or gait  
  Balance disorders  
  Cognitive impairment  
  More than 4 drugs  
  Psychotropic drugs  
  Visual Impairment  
  Renal impairment (through reduced drug clearance and increased cerebral sensitivity).  
  Alcohol > 1 unit / day  
  Postural hypotension  
  Hearing impairment  

- One of the key priorities for the implementation of NICE Clinical Guideline 161 (June 2013) ‘Falls in Older People: Assessing Risk and Prevention’ is to offer multifactorial falls risk assessments and multifactorial interventions including medication review with modification / withdrawal.

Reference:
   Available at: [http://www.bmj.com/content/343/bmj.d4551](http://www.bmj.com/content/343/bmj.d4551) <accessed 30/10/13>


Bibliography


(INFO: Citalopram commonly causes somnolence (manufacturer), clinical experience / use demonstrated postural hypotension. SSRI implicated in equal if not more risk of causing falls than tricyclic anti-depressants – this may reflect volume of prescribing of SSRI v TCAs).

(Updated May 2015)
Guideline for the Safe Use of Ultra Low Beds

This Guideline should be used when using or considering use of an Ultra Low bed

1. **Introduction**

Some patients are at risk of falling from bed. Risk factors include dementia, delirium, agitation, disorientation, limited mobility and acute illness. These patients may, in the past, have been nursed on mattresses on the floor.

Where the use of bedrails is inappropriate, consideration should be given to the use of an Ultra Low bed. However, they should not be seen as a universal falls prevention solution and provided inappropriately for mobile patients, as this could be deemed as restraint.²

Ultra Low beds can reduce the risk of a fall from height, whilst allowing staff to attend to the patient, with consideration to back care.

It is important to note that even when Ultra Low beds are used correctly in the lowest position, some patients may still sustain serious injuries such as a fractured hip or intracranial injury. As a result, it is important that even falls from Ultra Low beds are taken seriously.³

2. **Before an Ultra Low bed is used:**

Patients should be assessed individually by a registered nurse or therapist to establish the most appropriate method of preventing falls from bed.

This should include: a) Completion of the Falls Care Plan b) Completion of the Bedrails risk assessment.

3. **Consider:**

a. Physical illness – Some medical or nursing interventions may be difficult or impractical when using an Ultra Low bed.

b. Psychological illness or distress – the unusual position of the bed may trigger distress, agitation or increased confusion for the patient.

c. Previous accidents and injuries resulting from falls - the time, place and cause of a previous fall may or may not indicate that an Ultra Low bed would reduce the patient’s risk.

d. Tissue viability – recent concerns have been highlighted about the compatibility of certain Ultra Low beds with some air flow mattresses.

If the patient has a Braden or Waterlow score that indicates that their skin integrity is at risk, the assessing nurse should consider if the Ultra Low bed available has a full profiling capability. Some Ultra Low beds do not have a ‘knee break’ i.e. they raise the patient’s legs so that their lower legs are horizontal. This results in the patient’s sacral area sitting in a ‘V’ with undue pressure on the sacrum. If the patient’s skin integrity is at risk, a fully profiling bed should be used, allowing the patient to sit in a naturally contoured position. (NB Spirit and Pegasus Ultra Low beds profile fully. Montcalm Carroll beds do not).

e. If the Ultra Low bed may cause a problem when used with certain mattresses e.g. it has been noted that when a patient sits on the side of the Richmond bed and compresses the standard
Appendix 12: Guideline for the Safe Use of Ultra Low Beds

mattress, this can result in pressure on the back of their legs. If this is the case, staff should ensure that the patient does not sit on the side of the bed for protracted periods or they should identify a more suitable mattress.

f. If the bed will be compatible with a bed table as they may not fit under some Ultra Low beds.

g. Mental capacity. When patients are assessed individually by a registered nurse or therapist for an Ultra Low bed, it would be deemed good practice to document in the patient’s notes / falls care plan that the patient has been consulted with regarding the use of the Ultra Low bed. Documentation should include that the patient is aware of the restrictions the Ultra Low bed may impose on them, but have given their consent to its use to reduce the risk of further falls.

If however, there are concerns that the patient may not have capacity to consent to its use, then an assessment of capacity should be made in line with the 5 principles of The Mental Capacity Act 2005.

If the assessment of capacity demonstrates that the patient lacks capacity to make this decision themselves, then the multi-disciplinary team should make a best interest decision also involving the patient’s next of kin.

The outcome of the capacity assessment should also be clearly documented in the patient’s notes / falls care plan.

h. Variation in cognitive status over a 24 hour period e.g. nocturnal confusion

i. Disability / capability – the use of an Ultra Low bed may improve / impede the patient’s ability to transfer.

j. Patient’s weight – check the weight limit for the Ultra Low bed available, as it may not be suitable for patients over a certain weight.

4. When using an Ultra Low bed:

a. Document the decision to use or not use an Ultra Low bed in the nursing notes and falls care plan. This should include the rationale and whether or not bedrails are required.

b. Ensure the decision is communicated to all members of the multi-disciplinary team.

c. The use of Ultra Low beds should be reviewed daily (on wards where alternative bed options available) and recorded.

d. Ensure the Ultra Low bed is kept away from floor level furniture, doors, lockers, pipes, wheelchairs, commodes, radiators and other low level hazards to reduce the risk of patient injury or burns.¹

e. Ensure the Ultra Low bed is either placed flush to a wall or with a large enough gap either side, to prevent asphyxial entrapment if the patient slipped between the side of the mattress and the wall.¹

f. When the patient is on the Ultra Low bed, the bed must be returned to the lowest level to prevent a fall from height after being attended to by staff. All staff must ensure that the bed is at a low level if the patient is left unattended.¹

h. In the majority of cases, if a patient is at risk of falls from bed and an Ultra Low bed is deemed appropriate, it should be carefully considered whether bedrails should be used, as these might negate the purpose of the bed.¹ Some Ultra Low beds have integral bedrails which cannot be removed.
Appendix 12: Guideline for the Safe Use of Ultra Low Beds

Staff who are unfamiliar with the patient’s current fall status should check the Inpatient Falls Care Plan and Bedrail Risk Assessment before contemplating use of the bedrails if they are attached to the bed.

h. Crash mats at the side of an Ultra Low bed should be used with caution. These can cause a trip hazard for both patient and staff.¹ When the patient is not using the Ultra Low bed e.g. sitting in an armchair, any crash mat in use should be removed from the bed area and stored safely.

i. Choice of mattress to be used on the bed should be determined by assessing the patients weight, skin integrity and any risks of injury or entrapment. The assessing nurse should ensure that any air flow mattress being considered is suitable for use with the Ultra Low bed available.

j. Take care when positioning the legs of a hoist under the Ultra Low bed, as limitations imposed by the low height of the bed could cause a manual handling concern.

k. Prior to completing any manual handling manoeuvre, ensure that the bed is at the correct height for the patient and staff.

5. Obtaining an Ultra Low Bed

If there are any difficulties with obtaining an Ultra Low bed for a patient assessed as needing one, Ward Managers should contact the Modern Matron to discuss availability of beds from other areas / wards or rental options.

6. Related Policies and Guidelines:

SHFT Slips, trips and falls policy (2011)

National Patient Safety Agency, Signal Report: The safe use of ultra low beds (Feb 2011)¹


MHRA: Safe Use of Bed Rails DB2006 (Dec 2006)

RCN Let’s talk About Restraint (2008)²


With thanks to Alison Aylen, Clinical Falls Lead, Buckinghamshire Healthcare NHS Trust for ‘Guideline for the Safe Use of Low Level Beds’.
Factsheet: Falls Prevention Alarms

Falls alarms are an early warning system – they will not, on their own, prevent a person from falling. They work best when the patient has been carefully selected, and when the alarms are part of an active falls prevention plan.

Patients likely to benefit:

- Impaired mobility / unsafe transfers but is forgetful or unwilling to ask for help or use the call bell.
- History of incontinence, infection, retention, nocturia.
- A newly admitted patient with cognitive impairment and disorientated.
- History of multiple falls.
- Patients who are suddenly feeling better and stronger and want to try and be independent.
- Patients whose cognitive function is suddenly declining but whose functional mobility is the same.
- Patients with fluctuating levels of consciousness including hyper / hypomania associated with delirium.

Patients unlikely to benefit:

- Extremely confused, cannot settle, constantly wandering or trying to get up out of the bed or chair. The alarm will be going off continually and may cause distress to the person and others around.
- A confused person with some insight, who declines to use the alarm, kicks it under the chair, etc.
- Patients who are extremely confused and liable to interfere with the alarm i.e. pick it up, walk off with it.

They work best when:

- All staff respond to the alarms.
- There is thought and assessment by staff around the patient’s falls risk behaviours that indicate an alarm may be helpful.
- There is good communication between shifts as to which patients have the alarms.
- They are used in conjunction with other falls reduction interventions (bed heights / footwear / glasses / medication review, etc).
They are not a form of restraint as the person is not prevented from moving as a result of using it; however some patients (and relatives) may be unwilling to use the alarms and their wishes should be respected and documented.

How to use the alarms:

The alarms can be used with a sensor mat for bed or chair, with or without cord or cord only (for commodes and toilets). The behaviours of the person will determine the equipment used.

Review and discontinuation of use:

After 12 hours, review appropriateness of the alarm and record in the Inpatient Falls Care Plan. Thereafter re-assess daily and certainly within 72 hours.

It is generally better to use the alarms for short periods (hours and days) rather than days and weeks as continued long term use may encourage staff to “get used to the noise” and not respond in a timely manner. Additionally patients may become used to how the equipment works and attempt to remove it.

Alarms should not be used with patients who decline (refuse) or who may be at risk of using the equipment inappropriately (the cord could potentially be a neck / limb /digit ligature)

Use of the voice recording function:

Make sure the staff or family member making the recording uses a clear pleasant tone when speaking.

Record a short positive message using the person’s name affirming what you would like them to do, such as:

“Please sit down Mr Smith, a nurse will be with you shortly”

Some confused patients may find this function worrying (a disembodied voice that sounds like a family member who is not there). It might well encourage them to go looking for them, thereby increasing the falls risk.

With thanks to Julie Windsor, Clinical Nurse Specialist, Portsmouth Hospitals Trust.
Medical Management of men and women over 45yrs who have or are at risk of Osteoporosis

**CLINICAL RISK FACTORS FOR OSTEOPOROSIS**

- Previous fragility fracture
- Current glucocorticoid use ≥ 3 months
- Parental history of hip fracture
- Female hypogonadism
  - post-menopause
  - untreated premature menopause
  - drug or surgically induced menopause
  - premenopausal amenorrhoea ≥6 months, (excl. pregnancy)
- Body Mass Index (<19kg/m²)
- Caucasian/Asian origin
- Current smoking
- > 3 units alcohol daily
- Male hypogonadism *
- Drugs associated with osteoporosis:
  - long-term heparin
  - anticonvulsants
  - antipsychotics
  - Depo-Provera, >2yrs treatment
  - Aromatase inhibitors**, GnRH analogues*

**FRAX® – Fracture Assessment Tool**

The FRAX® tool is an algorithm which calculates fracture risk. (Available at www.shef.ac.uk/FRAX & it links to guidance published by the National Osteoporosis Guideline Group (NOGG) for the management of osteoporosis).

### TABLE A

**Antifracture Efficacy Of Pharmacological Interventions For Osteoporosis (when given with calcium and colecalciferol)**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Vertebral</th>
<th>Non-vertebral</th>
<th>Hip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alendronate</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Risedronate</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Zoledronic acid</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Etidronate</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ibandronate*</td>
<td>+</td>
<td>+*</td>
<td>-</td>
</tr>
<tr>
<td>Raloxifene</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PTH (1-84)</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Teriparatide</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Strontium ranelate</td>
<td>+</td>
<td>+</td>
<td>+*</td>
</tr>
</tbody>
</table>

* post-hoc analysis in high risk group
* Injection only available on Formulary

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1. Guideline for the diagnosis and management of osteoporosis in postmenopausal women and men from the age of 50yrs in the UK. Produced by J Compston, A Cooper, C. Cooper, R Francis, JA Kanis, D Marsh, EV McCloskey, DM Reid, P Selby, and M Wilkins, on behalf of the National Osteoporosis Guideline Group (NOGG) Oct 2008 (www.shef.ac.uk/NOGG/)

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* Further information available in full text guidelines.
** For guidance and algorithms on Management of Bone Loss in Early Breast Cancer…..please see full text guidelines, or refer to Reid DM et al, Cancer Treatment Rev 2008; 34: S1-18
Measure BMD (DXA scan, hip + spine) then recalculate fracture risk to determine if intervention is appropriate.

- No appropriate
- Advise or refer to Falls Service as appropriate
- Assess falls risk daily
- Consider treatment depending on age and fracture probability.

**Basingstoke, Southampton and Winchester District Prescribing Committee**

**OSTEOPOROSIS MEDICAL MANAGEMENT GUIDELINES 2009 – Abbreviated version**

For full details & additional text please refer to the complete guidelines on SUHTranet, SCPCT & NHS Hampshire intranets, & as emailed to GPs.

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**Medical Management of Men and Women over 45yrs who have or are at risk of Osteoporosis**

- **Risk Factors**
  - Is bone density assessment clinically indicated?
  - Yes
  - No

- **Previous fragility fracture**

- **Assess fracture risk using Frax**

- **Measure BMD (DXA scan, hip + spine) then recalculate fracture risk to clinical context or refer to NOGG guidance**

- **Consider treatment**

- **Measure BMD**

- **Normal**
  - T score above -1

- **Osteopenia**
  - T score -1 to -2.5

- **Osteoporosis**
  - T score below -2.5

**Advises Treatment**

- **Advise three/six monthly review of adherence to therapy. Seek specialist opinion if patient sustains a fracture on therapy**

- **1st Line**
  - ALENDRONATE 70mg WEEKLY
  - Or
  - ALTERNATIVE BISPHOSPHONATE (if intolerant to alendronate - refer to Table A on Page 3)

- **Strontium Ranelate 2.5 gram AT NIGHT**

- **49-60 mg/day Risedronate**

- **General Measures**

- **Recommended for all patients who have osteoporosis**

- **Recommended dietary intake**

- **Reduced risk of falls, fractures & hip risk in men & women over 60**

- **No previous fragility fracture**

- **Measure BMD (DXA scan, hip + spine) then recalculate fracture risk to clinical context or refer to NOGG guidance**

- **Consider treatment**

- **Measure BMD**

- **Normal**
  - T score above 0

- **T score between 0 and -1.5**

- **T score -1.5 or lower**

**52-70 mg Calcium 1-2 gram + colecalciferol 20 micrograms (800 IU) daily**

- **General Measures**

- **Consider treatment depending on age and fracture probability**

---

**Glucocorticoid therapy expected to be 2-3 months OR cumulative dose equivalent to 1.5 gram per year (for patients prescribed repeated short courses)**

- **Age >65yrs**

- **Previous fragility fracture**

- **Measure BMD (DXA scan, hip + spine) then recalculate fracture risk to clinical context or refer to NOGG guidance**

- **Consider treatment**

- **Measure BMD**

- **Normal**
  - T score above 0

- **T score between 0 and -1.5**

- **T score -1.5 or lower**

---

All patients must also be prescribed:

- Calcium 1-2 gram + colecalciferol 20 micrograms (800 IU) daily

- Unless clinician is confident patient has adequate calcium intake and is vitamin D replete

- Initiate osteoporosis management when glucocorticoid is started and stop treatment six months after glucocorticoids stop.

- Advise three/six monthly review of adherence to therapy.

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**All Patients**

- FBC, ESR (if ESR raised, measure serum paraproteins and urine Bence Jones protein)
- Bone and liver function tests (Ca, P, Alb, phosph, albumin, ALT, AST)
- Serum creatinine
- Additional tests if indicated:
  - Serum TSH
  - Serum 25 OH VITD and PTH
  - Lateral thoracic and lumbar spine X-ray
  - Isotope bone scan
  - Serum testosterone, LH and SHBG, PSA (men)
  - BMD if monitoring required

**Osteoporosis Management**

- First, increased fall risk ≥ household
- Is bone density assessment clinically indicated?
- Yes
- No
- Recalculate fracture risk using Frax
- Measure BMD (DXA scan, hip + spine)
- Fracture risk estimated
- Consider treatment

- Normal T score above -1
- Osteopenia T score -1 to -2.5
- Osteoporosis T score below -2.5

**All Patients**

- FBC, ESR (if ESR raised, measure serum paraproteins and urine Bence Jones protein)
- Bone and liver function tests (Ca, P, Alb, phosph, albumin, ALT, AST)
- Serum creatinine
- Additional tests if indicated:
  - Serum TSH
  - Serum 25 OH VITD and PTH
  - Lateral thoracic and lumbar spine X-ray
  - Isotope bone scan
  - Serum testosterone, LH and SHBG, PSA (men)
  - BMD if monitoring required

---

* Consider treatment depending on age and fracture probability

---

**General measures**

- Reduced dose of glucocorticoid when possible
- Consider glucocorticoid sparing therapy if appropriate or consider alternative route of administration
- Recommend good nutrition esp. with adequate calcium and vit D
- Recommend regular weight bearing exercise
- Maintain body weight
- Avoid tobacco use and alcohol abuse (> government recommendations)
- Assess falls risk and give advice if appropriate

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**Supplied by an educational grant from Servier Laboratories Ltd (2009)**
Ward:

Date:

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>Notes</th>
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<tr>
<td>Number of admissions to ward in last 7 days</td>
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<tr>
<td>Medication review completed within 12 hours</td>
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<tr>
<td>Urinalysis undertaken within 12 hours</td>
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<tr>
<td>Lying and Standing Blood Pressure recorded within 12 hours</td>
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<tr>
<td>Assessed for ultra low bed within 12 hours</td>
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<tr>
<td>Ultra low bed provided within 12 hours if required (put N/A if not)</td>
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<td>Assessed for hip protectors within 12 hours</td>
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<td>Hip protectors provided within 12 hours if required (put N/A if not)</td>
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<td>Footwear reviewed within 24 hours</td>
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<td>Gait and balance assessed within 24 hours</td>
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<tr>
<td>Osteoporosis assessment completed at first MDT meeting</td>
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<td>Commenced treatment at first MDT meeting if required (put N/A if not)</td>
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<td>Neurological observation baseline obtained</td>
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<tr>
<td>ECG recorded</td>
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</table>