FALLS – PREVENTION OF PATIENT FALLS POLICY

POLICY

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Approving Body	• Clinical Outcomes and Effective Care Group		
Date Approved	• 15th June 2023		
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	YES	**NO**	**N/A**
	X		
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Sponsor (Position)	Chief Nurse		
Author (Position & Name)	Leanne Minett – Corporate Matron		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Nursing/ Falls Service		
Position of Person able to provide Further Guidance/Information	Falls Prevention Practitioner		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
The following two documents are available to order for use in practice from Clinical Illustrations, 3650: • Falls Mitigation Care Plan • Record of Assessment following a Fall in Hospital • Falls Pathway for Patients Attending ED	 • April 2019 • March 2019 • March 2023
Template control	**June 2020**

CONTENTS

1.0 INTRODUCTION

Falls are the most reported type of patient safety incident in healthcare. The cost of falling includes distress, pain, injury, loss of confidence, loss of independence. Falls and falls related injuries are a major cause of disability and the leading cause of mortality due to injury in older people in the UK. Falls are associated with increased length of stay, additional surgery and unplanned treatment.

Inpatient falls are common and can be life-changing for patients. An 800-bed hospital will have an average of 1,700 inpatient falls per year costing approximately £2,600 per patient. The cost of treating falls in hospitals in the UK has been estimated at £630 million annually (NHS England). In 2017 approximately 250,000 patients had a fall in hospital (National Audit of Inpatient Falls).

Falls and related injuries are increasingly common, and an important driver of demand for urgent and emergency care. They can negatively affect functional independence and quality of life. Not all falls result in injury Experiencing a fall can also have a significant psychological impact on the individual, such as an increased fear of falling, loss of confidence and independence, or subsequent isolation and depression.

Inpatient falls are the one of the most reported types of patient safety incident within Sherwood Forest Hospitals NHS Foundation Trust, and the Trust is committed to reducing, as far as possible, the number of patients in our care who experience a fall or fall-related injury.

The Trust acknowledges that the risk of patient falls occurring can never be entirely removed, and that in order to achieve successful rehabilitation some patients who are recovering from an acute illness may go through a period of increased risk of falls, as they are encouraged to regain their independence and autonomy. It is important to note that immobility of patients may cause deconditioning.

Nearly 350,000 patients currently spend over three weeks in acute hospitals each year. Many of those are older people who are often frail, and while a short period of treatment in hospital is sometimes necessary, staying too long can leave them vulnerable to infections or deconditioning. Research suggests that more than one in three 70-year-olds experience muscle ageing during a prolonged stay in hospital, rising to two thirds of those aged over 90, which can leave some permanently less mobile or able to perform tasks they could before (NHS England 2019).

2.0 POLICY STATEMENT

The purpose of this policy is to ensure that consistent standards are adhered to in order to reduce the likelihood of an inpatient fall, including reducing the severity of harm experienced should a fall occur.

This clinical document applies to:

Staff group(s)

- All healthcare professionals and staff in the Trust who are involved with patient care

Clinical area(s)

- Trustwide

Patient group(s)

- All patients

Exclusions

- None

3.0 DEFINITIONS/ ABBREVIATIONS

The Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employees of the Trust including those managed by a third party organisation on behalf of the Trust
Datix	The Datix Risk Management System, used by the Trust to report and investigate incidents
Fall	An event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO)
WHO	World Health Organisation
DoH	Department of Health
HCOP	Health Care of Older People
HFCG	Harm Free Care Group
GSU	Governance Support Unit
NHFD	National Hip Fracture Database
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPSA	National Patient Safety Agency
QGL	Quality Governance Lead
FPP	Falls Prevention Practitioner

4.0 ROLES AND RESPONSIBILITIES

4.1 Service Directors and Divisional Directors of Nursing

- The responsibility for ensuring that the policy is applied within clinical areas belongs jointly to the divisional Clinical Directors and the Divisional Directors of Nursing. They are responsible for ensuring that clinical teams have the required knowledge, skills and equipment to enable them consistently to provide safe, effective care

4.2 Clinical Outcomes and Effective Care Group (COEC)

The COEC will meet regularly in accordance with defined Terms of reference and will be responsible for:

- Developing, reviewing and monitoring the application of the Prevention of Patient Falls Policy
- Monitoring and reviewing relevant audit results, analysing incident trends and identifying specific areas that require additional training/support or targeted improvement action
- Evaluating the effectiveness of falls prevention measures within the Trust
- Shared learning related to the prevention of patient falls throughout the Trust

4.3 Falls Prevention Practitioner (FPP)

The Trust will appoint two Falls Prevention Practitioners, who are responsible for:

- Support the provision of regular feedback on falls related issues to the Chief Executive Officer and Trust Board
- Support the Trust's commitment to patient safety, clinical effectiveness and quality of care as outlined in the Quality Strategy
- Support the preparation of an annual report on patient falls to the Trust Board
- Identify, share and implement evidence based best practice for falls prevention
- Promote and develop good professional practice in falls prevention throughout the Trust
- Provide expert advice and support in falls prevention strategies for fellow professionals
- Develop and, where appropriate undertaking audits of falls prevention practice
- Develop and deliver the Trust's falls prevention training requirements

4.4 Matrons

Matrons need to be aware of the rate of falls for the inpatient area they are responsible for and have assurance that ward staff are active in the prevention of patient falls.

- The Matrons need to ensure rapid reviews are taking place following a fall
- Learning from incidents is occurring
- Liaise with the Governance Support Unit and the Falls Prevention Practitioner

4.5 Ward Leaders

All ward leaders are responsible for:

- Collecting data for the monthly Nursing Metrics Audit in line with the Trusts Nursing Audit – Overarching SOP
- Devising action plans in response to the Nursing Metrics data
- Having an awareness of the rate of patient falls for their inpatient area (information available from the FPP)
- Ensure the communication board safety cross is up to date
- Ensure all staff are aware of the Trusts falls policy and their responsibility and accountability for reducing the likelihood of a patient fall
- Ensure that patients at risk of falling are clearly identified on the ward
- Investigate and undertake a timely rapid review of falls incidents

4.6 Nurse In Charge

It is the responsibility of the nurse in charge of the shift:

- to ensure that all staff on the ward - substantive and temporary – are aware of the falls risk assessment and subsequent expectations set out in the Falls Care Plan
- to ensure that patients at risk of falling are clearly identified
- In the event of a fall they are responsible for ensuring appropriate actions are taken (See Appendix C) and that the incident is reported via the Datix system

4.7 Registered Nurses

It is the responsibility of the Registered Nurse to:

- Undertake the Trust's falls risk assessment on each patient within 6 hours of admission on Nerve Centre
- Implement an individualised falls care plan where appropriate
- Involve the relatives/carers of the patient where appropriate in the assessment and care planning

5.0 APPROVAL

Following consultation, this policy has been approved at the Trust's Physical Activity and Falls Group and the Clinical Outcomes and Effective Care Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

Effective falls prevention programmes aim to reduce the number of people who fall, the rate of falls and the severity of injury should a fall occur. Falls prevention strategies should be comprehensive and multifaceted, taking account of research and identified good practice to create safer environments and reduce risk factors. They should promote engineering to remove the potential for falls, the training of health care providers on evidence-based prevention strategies; and the education of individuals and communities to build risk awareness.

Falls management requires an approach that increases patient safety in hospital by identifying patients at risk and implementing interventions that reduce patient falls, including consideration and assessment of environmental risk factors. To reduce falls in older people the most effective approach has been based upon a comprehensive fall evaluation and multidisciplinary approach. Strength and balance exercises and home visit assessments, facilitated by physiotherapists and occupational therapists, are proven to promote patient recovery and independence, with the aim of discharging patients home safely.

The steps outlined in this Policy should be undertaken where applicable to support the prevention of patient falls whilst in hospital. The Trust also proactively works with other agencies, health organisations and professionals at all levels in order to promote effective falls prevention practice.

6.1 Falls Risk Assessment

A Falls Risk Assessment has been developed to guide staff towards identification of key risk factors known to be associated with increased risk of falls.

A falls risk assessment is carried out as part of the admission process. Where possible the risk assessment process should involve the patient, and their family or next of kin to give a much broader perspective to aid the multi-disciplinary clinical team's decision-making process.

When assessing a patient for their risk of falling it is important to take into account the patient's prescribed medications as some are commonly implicated in falls (see Appendix A).

The Falls Risk Assessment must be completed on Nerve Centre by a registered health care professional (i.e. Registered Nurse) within six hours of admission to hospital of any patient over the age of 18.

The Falls Risk Assessment should be completed by a registered health care professional (i.e. Registered Nurse) in the following circumstances:

- Upon internal transfer within 2 hours
- Following a fall within 2 hours
- Following a significant change in the patients overall condition (improvement or deterioration)
- Post operatively
- Every week

If any risk factor is identified, a Falls Mitigation Care Plan (see section 6.6) should be initiated.

If the decision is made not to initiate a falls care plan, the rationale must be documented in the patient's nursing notes, signed and dated by the registered health care professional making the decision.

6.2 Prevention of patient falls in paediatrics

Babies, children and young people are generally at low risk of falls in hospital. Preventative measures should be implemented for patients who are identified as being at an increased risk, e.g. those who do not have a resident parent or carer present; those with sensory or motor impairment; or those with acute illness.

A moving and handling risk assessment should be completed on all patients over 1 year of age as part of the admission documentation. This ensures appropriate handling, transferring and moving for the child during their hospital stay. The assessment must take into account the child's age, size, development stage, any disabilities and any acute or long-term factors.

Appropriate preventative measures include:

- Babies under 1 year should be nursed in incubators, basinets or cots with high level sides
- Children between 1-2.5 years should be nursed in either a cot or a bed dependant on size, development and what they are used to sleeping in at home
- Children over 2 years generally are nursed in beds; all cots and beds should have rails attached; rails should be raised at all times when the child is left alone or if the child is assessed to be at risk of falls

There should be appropriate care and supervision of each child whilst they are on the ward by parents, carers and staff. When using highchairs and pushchairs, seatbelts must be in use at all times. Appropriate doors are installed throughout ward 25 to ensure young children are cared for within a safe environment.

For children with fluctuating conditions - e.g. acute illnesses, epilepsy or post-operative – the risk of falls should be assessed on an on-going shift basis as part of the nursing assessment. This should be documented in the child's nursing records. Where concerns are raised then children should have an individual plan of care which is documented in their records.

In the event of a fall the child or young person should be assessed by a paediatric doctor and actions should be clearly documented in the patient notes.

6.3 Prevention of patient falls in paediatrics

Women who use the maternity service are in the main well and at low risk of falls. However, it is recognised that the health needs of the maternity population are changing and that there are known factors which increase the risk of falls (these are summarised in Appendix B). A plan of care should be implemented for any woman admitted to hospital who is identified as being at significant risk of falling during the antenatal, intrapartum or postnatal stage.

The following requirements are considered to be the minimum standard for women in maternity care:

- Ensure bed brakes are on and the bed is at the correct height for each individual
- Encourage non-slip footwear in hospital
- Give clear instruction on how to call for help via the call buzzer system
- Minimise clutter in the room
- Ensure essential objects are close to hand if mobility is impaired, e.g. Call buzzer / bedside table
- Encourage women to ask for help if needed
- Continue on-going mobility referrals, e.g. Physiotherapist
- Parents and carers should have safe sleeping practices reiterated to them (refer to SFH guidance and Lullaby Trust leaflet)

For theatre patients, the midwife should remain with the woman in theatre until the spinal is sited (or general anaesthetic) and remain with her until she is positioned safely on the operating table.

In order to minimise the risk of in-hospital newborn falls, it is necessary that midwifery and support staff remain aware of high-risk mothers and implement appropriate strategies for regular monitoring to prevent falls from occurring. Situations in which newborn falls may occur are also included in Appendix B.

See also: Baby falls prevention and management policy

6.4 Prevention of patient falls in the Emergency Department (ED)

For patients presenting to the Emergency Department, the falls risk assessment contained within the ED admission booklet should be used. This includes the following questions:

- Has your patient presented with a fall?
- Is the patient a falls risk? If so why?

If the answer to either of these questions in YES, the following preventative measures should be considered:

- Is the patient nursed in an observable bay?
- Are bed rails in place?
- Is the patient identified with a red plaque (to signify that they are at risk)?
- Has a blue wrist band been applied
- Is there a falls magnet in place?

If the answer to any of these questions is NO, the clinician must document a rationale for the decision.

6.5 Prevention of patient falls in outpatient areas

Due to the relatively low level of risk, there is no mandated requirement to complete a Falls Risk Assessment for outpatients. An assessment of risk should be made according to each patient's clinical need, action taken to minimise any immediate risk and the patient referred onto the appropriate clinical pathway where necessary.

6.6 Falls Mitigation Care plan

A Falls Mitigation Care Plan is designed to reduce the likelihood of a patient falling whilst maintaining their dignity and independence. The Falls Mitigation Care Plan incorporates the Post Falls Care Plan in the same document and can be ordered from Clinical Illustrations.

Before completing the Falls Care Plan:

1. The patient must be asked for their agreement (consent) to care and treatment and be involved in ensuring that this care is individualised to their needs where possible. This will be required to be recorded and documented.
2. The patient is assumed to have capacity unless there are reasons to doubt this
3. If capacity is in doubt, a TWO STAGE TEST should be completed
4. If the patient lacks capacity, this should be followed by completing the BEST INTERESTS check list
5. This information should be used to help personalise and individualise the plan of care
6. All boxes MUST be initialled where the Yes, No or N/A choice is not given
7. Refer to the Royal Marsden Manual of Clinical Nursing Procedures online from the Trust intranet for evidence and references to support the care plan

Patient safety may be compromised if staffing resources do not allow for the appropriate level of care and monitoring of a patient who regularly falls or who has suffered a serious injury following a fall. If this situation arises, the nurse in charge of the ward must escalate their concern and the requirement for additional staff or support by following and utilising the Enhanced Patient Observation Guideline. All such incidents should be reported on Datix and escalated to the relevant Line Manager as soon as practicable.

6.7 Use of Walking Aids

Patients who regularly use a walking aid should have access to the most appropriate type during their admission to hospital. Walking aids must be checked to see that they are fit for purpose. Link trainers identified from each ward will receive training by a Physiotherapist on how to measure for a walking aid and complete equipment safety checks and then cascade this knowledge to other ward staff.

The benefits of providing a patient with their most appropriate walking aid are;

- Promotes independence
- Reduced risk of falls if a patient remains mobile (NICE Guideline CG161)
- Reduced deconditioning from time spent immobile (Pashikanti 2012)
- Reduced incidence of hospital acquired infections (Volman et al, 2014 and Stolbrink et al 2014)

A supply of the most commonly used walking aids will be kept on individual wards for staff to access.

Commonly used mobility aids, such as walking sticks, wheeled Zimmer frames or elbow crutches do not require a Physiotherapist to issue if a patient normally uses them. If a patient can no longer mobilise with their usual walking aid following admission to hospital, then a referral to a Physiotherapist is appropriate.

6.8 Bed Rail Risk Assessment

Bed rails are a safety device designed to prevent a patient from accidentally slipping, sliding or rolling out of bed. If the Falls Risk Assessment indicates that the patient is at risk of falling, a Bed Rail Risk Assessment must also be undertaken and documented in accordance with the Bedrails Policy: Using Bedrails Safely and Effectively.

The following considerations should be taken into account before using bed rails:

- Patients who are confused and mobile enough to climb over the rails should not be given bed rails
- Patients who want to get out of bed without help from staff should not be given bed rails (unless the patient specifically requests them and understands the risks)
- Bed rails are not to be used for restraint purposes in any circumstances
- All decisions to use or not use bed rails should be documented in the patient's notes, giving a clear rationale for the decision

Consideration should also be given to the use of crash mats at either side of the bed to reduce the risk of injury, should the patient climb out of bed and fall. If crash mats are used consider the risk of patients and staff tripping over crash mats placed next to the bed.

6.9 High-low beds

The purpose of a high-low bed is to maintain patient safety and reduce the risk of injury for patients who are at risk of climbing or falling out of bed. Risk factors include dementia, delirium and agitation. Before deciding to use a high-low bed, consideration should be given as to whether bed rails could be used on the patient's existing bed.

A low bed should not be a standalone falls prevention solution and if provided inappropriately could be deemed as restraint. It is important to consider that even when the bed is at its lowest position some patients may still sustain serious injuries such as a head injury.

Patients must be assessed individually to ensure that this is the most appropriate method of preventing potential falls from bed. The decision to use a high-low bed must be recorded in the nursing notes. The patient's family and /or carers should also be informed of the decision.

The use of high-low beds must be reviewed and documented as part of the care planning review process.

If bed rails are not appropriate for a particular patient but concerns remain about the patient's safety due to the risk of them falling out of bed, staff should consider the use of a high-low bed taking account of the following:

- Whilst nursing a patient on a high-low bed, the bed must always be in its lowest position (unless the patient is receiving personal care from staff; then the bed should be raised to ensure staff safety)
- Bed rails are not recommended for use with a high-low bed, with the exception of when the patient is being transported

6.10 Post Fall Care

The process to follow in the event of a patient fall is outlined in Appendix C - Post Fall Protocol Flow Chart.

As part of this process, a patient who has fallen should receive a full assessment using the Record of Assessment Following a Fall in Hospital (green form) that is then stored in the patient's medical notes and provides a detailed record that the patient has been appropriately assessed, actions initiated and reviewed by a Doctor or Night Team Leader. These forms can be ordered via the trust's Forms Management system.

A Post Fall Care Plan is attached to the Falls Mitigation Care Plan and is designed to provide a detailed record that the patient has been appropriately assessed and actions initiated.

Before completing the Post Falls Care Plan:

1. The patient must be asked for their agreement (consent) to care and treatment and be involved in ensuring that this care is individualised to their needs where possible. This will be required to be recorded and documented
2. The patient is assumed to have capacity unless there are reasons to doubt this
3. If capacity is in doubt, a TWO STAGE TEST should be completed
4. If the patient lacks capacity, this should be followed by completing the BEST INTERESTS check list
5. This information should be used to help personalise and individualise the plan of care
6. All boxes MUST be initialled where the Yes, No or N/A choice is not given
7. Refer to the Royal Marsden Manual of Clinical Nursing Procedures online from the Trust intranet for evidence and references to support the care plan

6.11 Falls incident reporting

All patient falls should be reported on the Datix Risk Management System at the earliest opportunity, and wherever possible on the same day the incident occurred, in accordance with the Trust Incident Reporting Policy. This includes a fall from a bed or trolley and falls where the patient is lowered to the floor or rolls onto a crash mat from a low bed.

Reporting a falls incident will also require the reporter to provide additional information in the form of responses to several falls-specific supplementary questions within the Datix incident form.

The Falls Review Process to follow in the event of a patient fall is outlined in Appendix D Falls Review Process Flowchart.

The Trust Falls Prevention Practitioner will be alerted to any falls incidents through the Datix system. Where an injury (e.g. fractured neck of femur) is identified after the incident has been submitted on Datix, the Ward Leader or deputy with support from the Matron should notify the Falls Prevention Practitioner and Governance Support Unit (GSU) as soon as practicable.

For those falls with harm, the clinical team supported by the Matron should undertake a rapid review. This review will aid decision making in regards to escalation to the Divisional scoping meetings / Governance meetings / Serious Incident meetings together with completion of a 72hr scoping report.

Identification and dissemination of learning following root cause analysis of a reported serious falls incident will be carried out by the Lead Investigator in conjunction with the ward or department teams responsible, and the Trust will ensure that recommendations from serious incident investigations are implemented.

Health care providers have a professional duty to maintain an open and honest dialogue with patients and their representatives in the event of a falls incident, in addition to the statutory requirements of the Duty of Candour. It is essential to obtain a patient's consent before informing their representatives of an incident, unless the patient lacks mental capacity in which case the patient's best interests should be considered when making a decision to inform.

6.12 Accountable Handover, transfer and discharge

Patients identified as being at risk of falling must be clearly identified as part of the accountable handover process between shifts, teams or when transferred between clinical areas. Patients who are discharged having been identified as being at risk of falling or who have fallen whilst in the care of the Trust must have that information clearly recorded in their discharge letter.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Audit of Falls Risk Assessment and documentation	Ward leaders	Data collection	Monthly	Clinical Outcomes and Effective Care Group (COEC)
Single Oversight Framework	Corporate Matron	Report	Quarterly	Trust Board
Analysis of trends in reported falls incidents (Datix)	Falls Prevention Practitioner	Falls per 1000 occupied bed days	Monthly	Clinical Outcomes and Effective Care Group (COEC) Physical Activity and Falls Group
Training completion	Training & Development	Register of training attendance	Quarterly	Clinical Outcomes and Effective Care Group (COEC) and Falls Prevention Practitioner

8.0 TRAINING AND IMPLEMENTATION

A programme of formal and informal training is established for multi-disciplinary staff working in the Trust in relation to the prevention of patient falls, including:

- The Falls Prevention Practitioner will develop and monitor delivery of an appropriate falls training programme linked to the Falls Prevention Strategy and this policy; the training will be delivered through a variety of media including induction; annual mandatory training; Falls Study Days; ward based teaching sessions; falls champion study sessions; and workbooks
- Informal guidance, advice and support will be provided by Falls Prevention Practitioner on a small group or individual basis to meet identified patient or staff requirements
- Multi-disciplinary Falls Champion Days will be held quarterly.
- Updates on falls prevention practice, including policy changes, will be shared via the Trust's weekly communication bulletins
- Learning from investigations of falls incidents will be shared via the Learning Matters bulletins

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix E
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix F

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

10.1 Evidence Base:

This policy has been developed in line with the following guidance:

- World Health Organisation (WHO) Falls Fact sheet (September 2016)
- Slips trips and falls in hospital. National Patient Safety Agency (2007)
- National Service Framework For Older People (NSF) (DOH 2001)
- NICE (June 2013) CG 161 The Assessment & Prevention of Falls in Older People (updates CG 21, Nov 2004)
- Royal Hospital for Women (March 2014) Falls Prevention in Maternity Services, Quality and Patient Safety Committee
- Department of Health (Aus) Falls Prevention in Maternity Inpatients. Available from https://ww2.health.wa.gov.au/Articles/F_I/Falls-prevention-in-maternity-inpatients [accessed February 2023]
- Paul SP et al (2011) Newborn Falls in-hospital: time to address the issue. The Practicing Midwife 14(4) pp29-32

- Janiszewski H and Lee L (2014) Guideline for the prevention and management of baby falls whilst being cared for in Nottingham University Hospitals NHS Trust. Available from www.nuh.nhs.uk/handlers/downloads.ashx?id=54771 [Accessed February 2023].
- Safer Sleep for Parents: A guide for parents (Lullaby Trust 2013)
- Royal College of Physicians National Audit of Inpatient Falls 2022
- National Institute of Clinical Excellence quality standard 86 (2017)

10.2 Related SFHFT Documents:

This policy is aimed at reducing the incidence of patient falls whilst in the care of the Trust. It should be read in conjunction with the following related policies and guidance:

- Incident Reporting Policy
- Risk Management & Assurance Policy
- Slips, Trips and Falls Prevention Policy
- Bedrails Policy: Using Bedrails Safely and Effectively
- Head Injury Policy: management of patients following a head injury on hospital premises
- Consent to examination, treatment and care policy
- Enhanced Patient Observation Guideline
- Safe Sleeping Practices – guidelines for Health Professionals advising Parents on Safe Sleeping Practices for their baby
- Baby falls prevention and management policy

11.0 KEYWORDS

Slip; Slips; Trip; Trips; Risk assessment; Falls Care plan; post fall review; incident; fall; process flowchart;

12.0 APPENDICES

Appendix A – Medicines commonly implicated in falls
Appendix B – Risk Factors for Falls in Maternity
Appendix C – Post Fall Protocol Flowchart
Appendix D – Falls Review Process Flowchart
Appendix E – Equality Impact Assessment
Appendix F – Environmental Impact Assessment

Appendix A: Medicines Commonly Implicated in Falls

Suggested action for all medicines causing postural hypotension

- ✓ Check lying and standing blood pressure
- ✓ Review indication.
- ✓ It may not be possible to stop: review doses and consider dose reductions if possible.
- ✓ If taking >1 antihypertensive consider taking at different times.

High Risk	Can commonly cause falls alone or in combination
Medium Risk	Can cause falls, especially in combination
Possible Risk	Possibly cause falls

Medication Group	Commonly Used Medicines	Effects on Risk of Fall	Cautions to Consider if Stopping
Acetylcholinesterase inhibitors	donepezil, galantamine, rivastigmine	Symptomatic **bradycardia** and **syncope**	• Discontinuation will cause a gradual reduction of beneficial effects
Alpha receptor blockers	alfuzosin, doxazosin, indoramin, prazosin, tamsulosin, terazosin	Commonly cause severe **orthostatic hypotension**	• Review indication. • Stopping may precipitate urinary retention in men
Angiotensin converting enzyme inhibitors (ACEIs)	captopril, enalapril, lisinopril, perindopril ramipril	Cause **orthostatic hypotension**	• ACEI have survival benefit in systolic cardiac failure and should be maintained whenever possible
Angiotensin receptor blockers	candesartan, losartan irbesartan, valsartan	May cause less **orthostatic hypotension** than ACEIs	
Anti-anginals	glyceryl trinitrate (GTN) isosorbide mononitrate, nicorandil	A common cause of **syncope** Cause **hypotension** and **paroxysmal hypotension**	• Discontinuation may lead to exacerbation of symptoms • If stopping, withdraw gradually
Anti-arrhythmics	amiodarone, digoxin, flecainide	May cause **bradycardia** and other arrhythmias	• Do not change medication without specialist input.
Anti-cholinergics acting on the bladder	oxybutynin, solifenacin, tolterodine	No data on falls, but may cause **dizziness**, **blurred vision**, **confusion** and **drowsiness**	• Review indication. • Reduce dose if possible.
Anti-cholinergic pain killer	Nefopam	Commonly causes light-headedness, hypotension, syncope, dizziness.	A very poor painkiller. See APC guide. Use paracetamol instead, and consider NSAIDs and opioids (but see below) in addition if needed.
Anti-convulsants	phenyton	May cause permanent cerebellar damage and **unsteadiness** in long term use at therapeutic dose. Excess blood levels can cause **unsteadiness** and **ataxia**	• **CRITICAL MEDICINES DO NOT OMIT OR DELAY DOSES.** • Do not change medication without specialist input. • Consider indication. • Phenytoin, carbamazepine, valproate, phenobarbital and primidone are associated with increased risk of osteomalacia: Consider **vitamin D**
	Carbamazepine, phenobarbital	**Sedation**, **slow reactions.** Excess blood levels can cause **unsteadiness** and **ataxia**	
	gabapentin, valproate	Some data on falls association	

	lamotrigine, pregabalin, levetiracetam, topiramate	Insufficient data to know if these newer agents cause falls	**supplementation** in at-risk patients who are on long term treatment with these medicines.

Medication Group		Commonly Used Medicines	Effects on Risk of Fall	Cautions to Consider if Stopping
Anti-depressants	Dual reuptake inhibitors	duloxetine, venlafaxine	As for SSRIs but also commonly cause **orthostatic hypotension**	• Review indication. • If stopping, may need slow withdrawal. • Consider changing a TCA to an SSRI. Although SSRIs cause falls as much as other anti-depressants in population studies. • Consider specialist referral if further advice needed.
	Monoamine oxidase inhibitors	isocarboxazid, phenelzine, tranylcypromine	All (except moclobemide) cause severe **orthostatic hypotension**. May cause **sleep disturbances**	
	Selective serotonin reuptake inhibitors (SSRI)	citalopram, fluoxetine, paroxetine, sertraline	They do not normally sedate, but can **impair sleep quality**. **Orthostatic hypotension** and **bradycardia** only rarely as an idiosyncratic side effect	
	Tricyclics (TCA)	amitriptyline, clomipramine, dosulepin, doxepin, imipramine, lofepramine nortriptyline	All have some alpha blocking activity and can cause orthostatic hypotension. All are anti-histamines and can cause drowsiness, impaired balance and slow reaction times May double the rate of falling	
	TCA related medicines	mianserin, mirtazapine, trazodone		
Anti-histamines (sedating)		chlorphenamine, hydroxyzine, promethazine	No data, but **sedation** likely to contribute to falls	• Long half lives
Anti-psychotics		chlorpromazine, haloperidol, quetiapine, risperidone, olanzapine	All have some alpha blocking activity and can cause **orthostatic hypotension** May also cause **sedation**, **slow reflexes** and **loss of balance**	• In long term use do not change without specialist input. • Refer to trust guideline for the management of acute confusion/delirium.
Beta blockers		atenolol, bisoprolol, carvedilol, metoprolol, propranolol, sotalol, timolol eye drops	Can cause **bradycardia**, **hypotension**, **carotid sinus hypersensitivity**, **orthostatic hypotension** and **vasovagal syndrome**	• Beta blockers have survival benefit in systolic cardiac failure and should be maintained whenever possible. • Abrupt withdrawal may precipitate rebound tachycardia, consider dose reductions when needed.

Calcium channel blockers	amlodipine, felodipine, lercanidipine, nifedipine	Cause **hypotension** and **paroxysmal hypotension**	• Review indication for use • Discontinuation may lead to exacerbation of symptoms • If stopping, withdraw gradually
	diltiazem, verapamil	May cause **hypotension** and **bradycardia**	
Centrally acting alpha 2 agonists	clonidine, moxonidine	May cause severe **orthostatic hypotension** and **sedation**	• Do not change medication without specialist input. • Withdraw slowly if stopping.

Medication Group	Commonly Used Medicines	Effects on Risk of Fall	Cautions to Consider if Stopping
Diuretics (Loops)	bumetanide, furosemide	Dehydration causes **hypotension** May cause **weakness** secondary to low potassium and sodium	• Stopping diuretics may precipitate CCF. • If no evidence of congestion consider reducing the dose
Diuretics (Thiazides)	bendroflumethiazide, indapamide		
Muscle relaxants	baclofen, dantrolene	**Sedation** and **reduced muscle tone**	No falls data on muscle relaxants. Tend to be used in conditions associated with falls. Withdraw baclofen slowly if stopping.
Opiate analgesics	buprenorphine, codeine, dihydrocodeine, fentanyl, morphine, oxycodone, tramadol	**Sedation**, **slow reactions**, **impaired balance**, **delirium**, **hallucinations** and **postural hypotension**	• Review dose. Start with small doses and titrate slowly. • Use pain ladder to avoid excessive use.
Parkinson's disease medications	amantadine, co-beneldopa, co-careldopa, pramipexole, rasagiline ropinirole, rotigotine, selegiline	**Delirium**, **hallucinations**, **drowsiness** and **orthostatic hypotension**	• **CRITICAL MEDICINES DO NOT OMIT OR DELAY DOSES.** • Do not change medication without specialist input. • Orthostatic hypotension may be part of the disease.
Sedatives and hypnotics	clonazepam, diazepam lorazepam, nitrazepam temazepam, zolpidem, zopiclone	**Drowsiness**, **slow reactions**, **impaired balance**	• Stop if possible, check with GP. • Long term use will need slow withdrawal. • Refer to NICE on use of hypnotics.
Vestibular sedatives Phenothiazines	prochlorperazine	Dopamine antagonist – may cause **movement disorder** in long term use. May cause **postural hypotension** and **drowsiness**	• Review indication for use.
Vestibular sedatives Antihistamines	betahistine, cinnarazine	**Sedation**	• No evidence of benefit in long term use.

This list of medicines and side effects implicated in falls is not exhaustive. In all cases before any medication changes are made, individual patient factors must be considered, and relevant reference sources consulted.

References

Medicines and Falls in Hospital: Guidance Sheet. Produced by the Royal College of Physicians, March 2011. Available online from: https://www.rcplondon.ac.uk/resources/falls-prevention-resources.

Appendix B

RISK FACTORS FOR FALLS IN MATERNITY

The following risk factors are known to be associated with an increased risk of patient falls whilst in maternity care:

Antenatal

- Pre-existing medical conditions
- Seizure disorder, e.g. epilepsy
- Mobility problems
- Developmental delay
- Mental health issues
- Obesity
- Acute/Chronic Illness, e.g. Eclampsia / Antepartum haemorrhage (APH)
- Hypotension

Intrapartum

- Epidural/spinal analgesia
- Opioid analgesia
- Severe fatigue
- Falls and trip hazards, e.g. Cardiotocography (CTG) monitor / drip stands / fluid spills
- Acute/chronic illness, e.g. Eclampsia / operative delivery
- Hypotension

Postpartum

- Tiredness
- Lower (uterine) Segment Caesarean Section (LSCS)
- On-going effects of analgesia
- Medication
- Blood loss
- Hypotension

Newborn falls

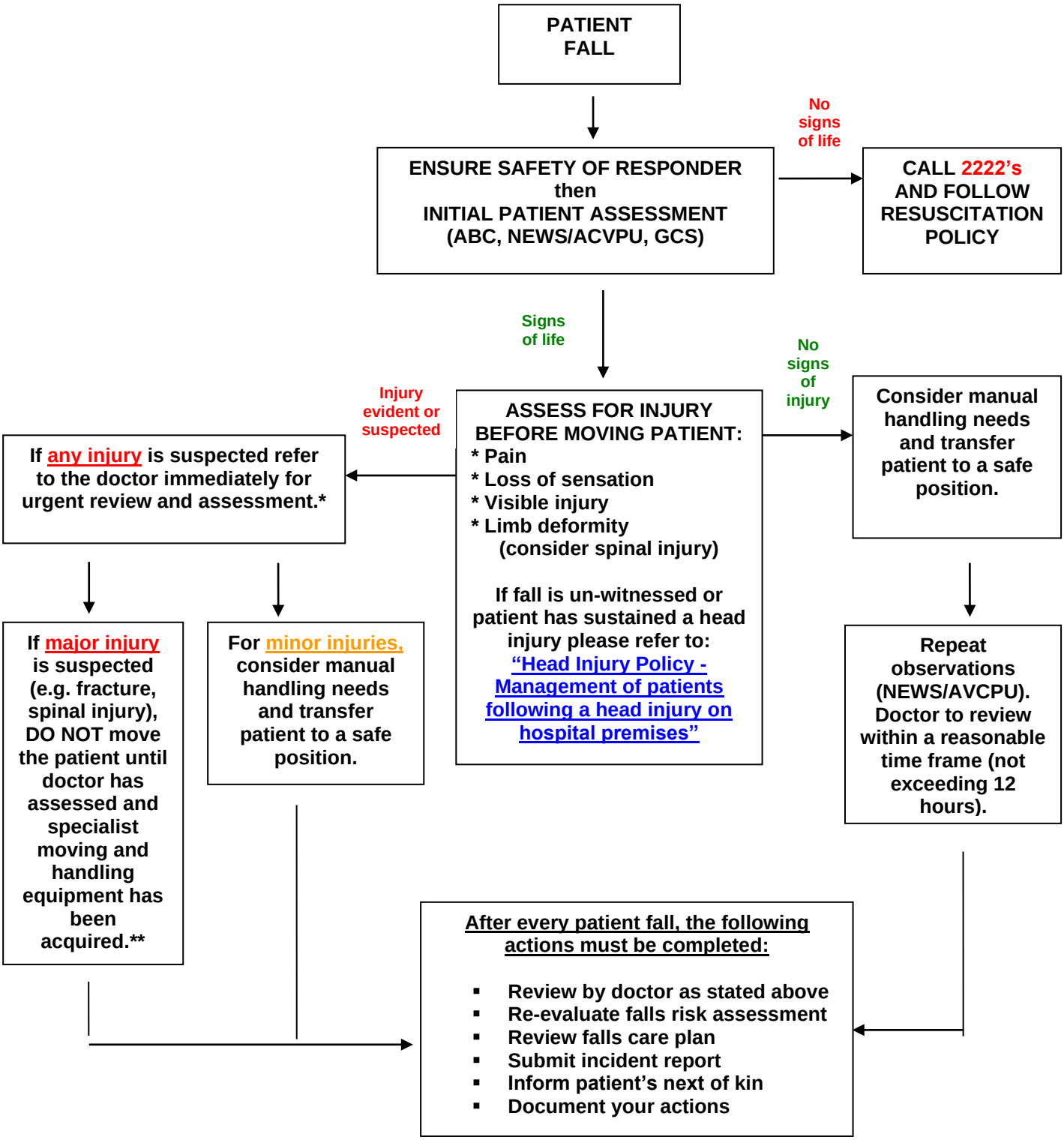
In-hospital newborn falls can be described as an event when a neonate falls to the floor accidentally, either as a result of environmental factors or errors in judgement of the hospital staff or carer.

The following are situations where newborn falls may occur:

- During delivery – compounded by quick delivery /instrumental delivery and large volumes of fluid / blood
- During transport – either in the arms of someone who may fall themselves; or during transport in an insecure cot
- Postpartum period – high risk mothers / analgesia / limited mobility post LSCS

Appendix C

POST FALL PROTOCOL FLOWCHART

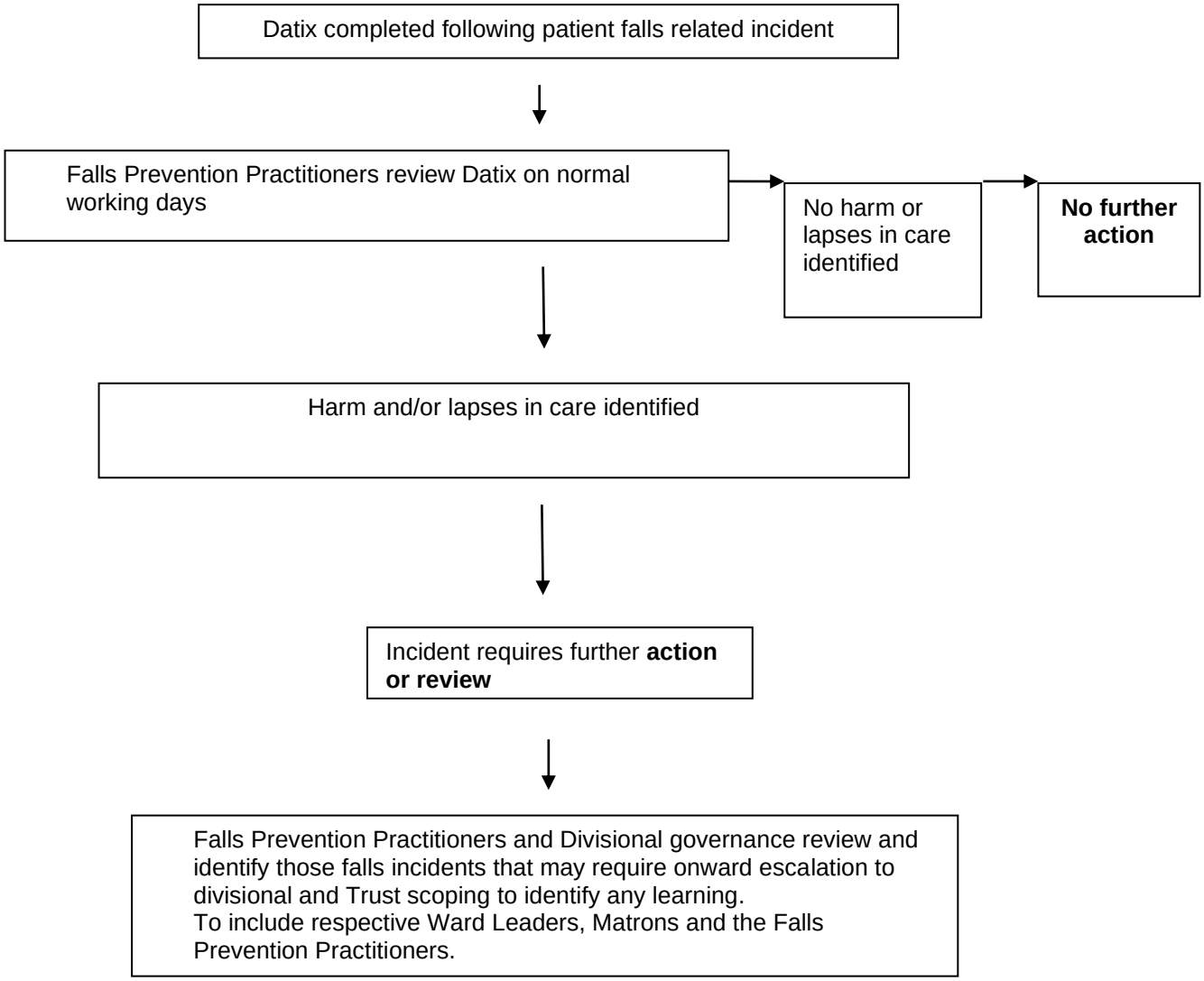


***For patients in community hospitals who require immobilising due to a suspected fracture or spinal injury – dial 999 for ambulance crew to transfer patient to ED. Patient is not to be moved until ambulance arrives. Patients who require transfer to secondary care for any injury are to be transferred via ambulance.**

**** Specialist moving and handling equipment (e.g. flat lifting equipment) is available for use by staff at King's Mill Hospital Resuscitation back up point. If you require other items such as hard collars, etc. you must contact ED or the Duty Nurse Manager.**

Appendix D

FALLS REVIEW PROCESS FLOWCHART



Assurance

Falls Prevention Practitioners will arrange to meet with ward or department areas where there are wards demonstrating high numbers of falls, frequent lapses in care or a sudden increase in falls

Where there are areas of concern (Eg. wards demonstrating high numbers of falls, frequent lapses in care or a sudden increase in falls) these will be taken to a **Falls Confirm and Challenge Meeting**.

Chaired by the Chief Nurse / Deputy Chief Nurse. To include Ward Leaders, Matrons and Heads of Nursing for those ward areas attending.

Any queries please contact Falls Prevention Practitioners KMH Extension 3782

APPENDIX E – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Falls – Prevention Of Patient Falls Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 3rd April 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	Availability of this policy in languages other than English	Alternative versions can be created on request	None
Gender	None	Not applicable	None
Age	None	Not applicable	None
Religion	None	Not applicable	None
Disability	Visual accessibility of this document	Already in font size 12.Use of technology by end user. Alternative versions can be created on request	None
Sexuality	None	Not applicable	None
Pregnancy and Maternity	None	Not applicable	None
Gender Reassignment	None	Not applicable	None

Marriage and Civil Partnership	None	Not applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?

- **None**

What data or information did you use in support of this EqIA?

- **None**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **None**

Level of impact

Low Level of Impact

Name of Responsible Person undertaking this assessment:
Leanne Minett

Signature:
L. Minett

Date:
3rd April 2023

APPENDIX F – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	