Falls Policy

Inmind Reference:	CLN01
Category:	Clinical Policy
Version Number:	V2.1
Reviewed on:	February 2019
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Lead Officer:	Director of Nursing
Equality Impact Assessment completed:	Yes

Applicable Legislation/Regulations:
Equality Impact Assessment The Care Act 2014 Care Quality Commission Registration Regulations 2009 Health & Safety at Work Act 1974 Sections 2 and 3 of the Health and Safety at Work etc. Act 1974.The Management of Health and Safety at Work Regulations 1999, Regulations 3 and 5 The Workplace (Health, Safety and Welfare) Regulations 1992, Regulation 12
Codes of Practice:
NICE Clinical Guidance CG161 published June 2013
Purpose:
To guide staff in the management and prevention of falls and give clear direction where variations to procedures may occur.

Version Control Table		
Date Ratified	**Version Number**	**Status**
Feb 2018	V2	Close
Feb 2018	V2.1	Live

Date	**Key Revision**
February 2018	Overall revision to provide more detail regarding falls prevention
February 2019	Revised – no changes

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1.0 The Policy

a) Inmind Healthcare Group is committed to reducing the incidence of falls; however it is recognised that the philosophy of therapeutic risk taking is an important part of our person centred approach to caring for Service Users and residents. The emphasis remains on the importance of empowering service users and residents to maintain mobility as far as possible and to advocate the use of the least restrictive means of combating the incidence of falls. Adherence to this Policy is designed to minimise the risk of falling and to support staff /service users and carers to develop effective care plans following a fall. In Mind recognises that even with our best efforts there will be times when individuals fall.

b) Falls, slips and trips are a major cause of disability. To individual's even minor falls, slips and trips can have significant social, physical and emotional impact.
These consequences include; loss of confidence in moving around safely; a reduction of mobility which can lead to social isolation; loss of independence; loss of work opportunities and control over quality of life.

c) To that end, the company requires that factual and complete records are kept to ensure lessons are learned in order that their recurrence may be reduced or eliminated, to ensure that they are used to inform the overall risk management process and to satisfy legal and regulatory requirements. Staff must therefore follow the procedure that follows.

2.0 The Procedure

2.1 Assessing the risk of falls.

a) A risk screen should be carried out for all service users who are identified at risk of falls (Appendix 2).

b) Where a significant risk of falls is identified for an individual service user, the Nurse in Charge must complete a falls prevention/management risk assessment (Appendix 3).

c) Where a risk of falls has been identified by staff/ significant other, the risk will be discussed at the next multidisciplinary team meeting

d) If any Service users score 4 or more, then a personal risk management plan needs to be completed. This must be reviewed monthly or when a change in need occurs

2.2 Managing Falls – Immediate actions to be taken

a) The Nurse in Charge should undertake a full assessment of the service user for any immediate injuries (Appendix 5) and make a clinical decision about a transfer to Accident & Emergency. Vital signs must be completed (respiratory rate, pulse, blood pressure, temperature, 02 stats, BM and level of consciousness) All observations MUST be charted at the time they are measured. (Appendix 4) Should a service user decline these observations, then this should be clearly documented.

b) If there are no immediate injuries requiring attention staff are to carry out if the service user is able, the '**Get Up and Go Test** (the service user should arise from a chair without using their arms, walk approximately 3 to 4 meters, turn round and return to their seat and sit down). This only applies to individuals who prior to their fall are able to mobilize

c) If the service user is demonstrating no difficulty or unsteadiness when mobilizing, then the Nurse in Charge must carry out further assessments over the next 24 hours using the physical observation chart (Appendix 4).

d) Any service user who has an un-witnessed fall, a head injury or who has difficulty with the 'get up and go test' should proceed for further assessment via Accident & Emergency.

e) The Nurse in Charge should complete an accident/incident form, as per In Minds Management of Untoward Incidents Policy.

f) A review of the fall's risk management plan for the service user should be undertaken immediately by the Nurse in Charge, or in the case where no risk has previously been identified, a falls risk management plan should be completed.

g) The service users care coordinator/family/significant other should be informed.

2.3 Managing Falls – On-going action to be taken

a) Any service user who has a fall should have their gait and balance assessed formally and consideration should be given to a referral to the relevant physician or 'Falls Team'.

b) Sitting and standing blood pressure should be measured. This should be done on 3 consecutive mornings (if their blood pressure reading is normal for them, once only is sufficient) and after 5 minutes being recumbent the blood pressure should be measured immediately upon standing.

c) Medication should be reviewed at the earliest opportunity or more urgently should a postural drop in blood pressure be identified. Many medications (particularly benzodiazepines, antidepressants and antipsychotics) will increase the risk of falls. A judgement has to be made by the General Practitioner about whether these medications should continue in spite of the risk they may pose for increased falls. Evidence of the above action being taken must be recorded within the case notes

d) All related risk management and care plans must be updated by the service user's key worker.

e) Bedrails may be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of bed. Bedrails used for this purpose are NOT a form of restraint. Bedrails will not prevent a patient from leaving their bed and falling elsewhere and should not be used for this purpose.

f) Consideration is required to reduce potential harm to patients caused by falling from beds or becoming trapped in bedrails. Support patients, carers and staff to make individual decisions around the risk of using and not using bedrails by ensuring compliance with Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

g) All related risk management and care plans must be updated by the service user's key worker.

h) Bedrails may be used to reduce the risk of a patient accidentally slipping, sliding, falling or rolling out of bed. Bedrails used for this purpose are NOT a form of restraint. Bedrails will not prevent a patient from leaving their bed and falling elsewhere and should not be used for this purpose.

i) Consideration is required to reduce potential harm to patients caused by falling from beds or becoming trapped in bedrails. Support patients, carers and staff to make individual decisions around the risk of using and not using bedrails by ensuring compliance with Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

j) The decision to use bedside rails (or not) should be taken by the multidisciplinary team in consultation with the patient (if they have capacity) and their carer whenever appropriate. When no other members of the team are present the registered nurse responsible for the patient should make the decision in their best interests.

2.4 Key Tasks of Updating Risk Management Care Plans:

- Update risk management plans following a review of relevant risk and control measures and risk formulation.
- Update treatment, planning, supervision aspects of the risk management plan on each review.
- Agree timetable for updating plans at the time of initial or last assessment

2.5 Bed Rail Risk Assessment

All types of bed rails/bed rail covers should only be used when a risk assessment, has identified that they might prevent harm to the patient. Whenever possible the patient and patient carer will participate in the risk assessment and the decision communicated to all involved

A specific falls risk assessment will identify additional factors that may need to be taken into consideration.

Generally bed rails should not be used if the patient is agile enough, disorientated and/or deemed likely to climb over them.

The behaviour of individual patients can never be completely predictable and staff will be supported when decisions are made by staff caring directly for the individual in accordance with this policy.

The risk assessment should be recorded in the patients nursing notes documentation and should be:

- Reviewed at regular intervals,
- as the patient's condition changes
- as part of ongoing clinical observations
- if there is any change in the mattress, or if an overlay mattress is used

If there is a risk of the patient trapping their head, body or limbs between the bedrails then specifically designed padded accessories must be properly applied. When they are not available this must be documented and an incident record on and other action to be taken to reduce the risk to its lowest level.

Bed rail covers MUST NOT exceed the length of the bedrail as this will present an entrapment risk.

Prior to use staff should inspect for any signs of damage, faults or cracks and, any identified as defective, must be reported for repair immediately (see maintenance).

Bedrails and bed rail covers should only be used and maintained in line with the manufacturer's instructions for use.

Appendix 1

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	N/A
Disability	Nil	N/A
Gender Reassignment	Nil	N/A
Pregnancy & Maternity	Nil	N/A
Race	Nil	N/A
Religion or Belief	Nil	N/A
Sex	Nil	N/A
Sexual Orientation	Nil	N/A
Marriage and Civil Partnership	Nil	N/A

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

Appendix 2

Aspects of the History, Mental State Examination and Physical Examination

Relevant for Assessing Risk of Falls on Admission

1. **History**

1.1 A history of falls.

1.2 Multiple medications – especially drugs causing bradycardia and/or hypotension e.g. hypnotics, analgesics, anti-depressants, antipsychotics.

1.3 History suggestive of delirium – sudden onset, fluctuating confusion and disorientation with altered level of consciousness.

1.4 Cardiac arrhythmias.

1.5 Postural hypotension – faintness/syncope on sitting/standing.

1.6 Visual impairment.

1.7 Urinary frequency / incontinence / dysuria.

(1.8 History of osteoporosis – increased risk of fracture if falls do occur.)

(Most of these points would not be included in a standard psychiatric history –except 1.2 which would be included routinely and 1.3 if there is evidence of confusion/cognitive deficit).

2. Mental State Examination (M.S.E)

2.1 Cognitive impairment.

2.2 Altered level of consciousness.

2.3 Agitation / restlessness.

(All should be covered in a standard M.S.E.).

3. Physical Examination

3.1 Temperature.

3.2 Blood pressure – where there have been previous falls there should be lying/standing readings.

3.3 Pulse.

3.4 Signs of dehydration.

3.5 Gait assessment – instability / asymmetry.

3.6 Muscle weakness.

3.7 Vision – visual acuity, visual field defects. (All of these should be covered in a standard physical examination: 3.2 and 3.3 in the cardiovascular examination, 3.5 to 3.7 in the neurological exam and 3.1 and 3.4 in the initial general exam).

Checklist for staff

This guideline indicates interventions that should be considered for each service user identified within the relevant risk category

LOW

• Record all falls in line with IN MIND's Incident reporting procedure and record keeping standards.

• Ensure appropriate footwear available and worn at all times.

• Ensure mobility aids are appropriate, reviewed and in good working order

• Ensure appropriate sensory aids are in good order and worn by patient e.g. glasses.

• Ensure appropriate seating available e.g. correct height and arm support.

• Share falls prevention information with service users, significant other and MDT.

• Promote an awareness of, and encourage safe housekeeping within the home, identifying all hazards and consider completing risk assessments in line with IN MIND's Policy.

• Promote individual gentle exercise and balance training where appropriate

MEDIUM

• Discuss and review clinical presentation, including physical and medical features, along with current management plans and areas of outstanding risk, with the multidisciplinary team ensuring all relevant action is documented and shared with all other members of the team

• Consider care planning in relation to high risk periods of activity, e.g. during periods of personal care, on rising and going to bed, continence pattern, during staff handovers

• Review all medication

• Record full circumstances of all falls and use the information gathered to formulate preventative action including referral to other professionals, e.g. physiotherapist, occupational therapist, specialist falls team.

• Following a full multi-disciplinary team assessment consider the use of protective clothing and equipment such as the use of hip protectors

HIGH

• Review and document risk as changes to service user environment and/ or presentation occur

• Discuss outstanding risks with Consultant, Manager and clinical team ensuring all relevant action is documented and shared with all other team members

• Following the multi-disciplinary team assessment, consider recommending the use of equipment. For example:-

- ❖ Bed/chair and floor pressure sensor pads
- ❖ Mattress and other soft cushioned surface to place on floor during identified periods.
- ❖ Specialist beds which lower to floor level

• Increase frequency of medical review

• Keep carer/next of kin fully involved and updated with treatment plan and risks

• Record full circumstances of all falls and use the information gathered to formulate preventative action including referral to other professionals, e.g. physiotherapist, occupational therapist, specialist falls team.

• Do not advise the use any mechanical restraint to minimise the risk of falls

Individual Falls Risk Assessment – Please complete on admission or if service user condition changes

Appendix 3

Falls Risk Formulation

(Use in conjunction with clinical risk management plan)

History of falls before admission?		**Name** **DOB**
Falls since admission		**Unit**
Tries to walk alone but unsteady / unsafe?		**G.P**
Service user or others anxious about falls?		**Consultant**
Service user has problems mobilizing e.g. falling on rising, incontinence, slipping from chair or other known / unknown reason for falls?		
If yes to any of the questions above , complete falls care plan		

Falls prevention risk management plan	
GOAL : To reduce likelihood of falls whilst maintaining dignity and independence	**State action taken or N/A where no action is necessary**
Eyesight, ensure eyesight is checked; wearing glasses if worn; able to identify pen/key from 6 foot away? If eyesight too poor to identify objects ask GP / Opticians to review. Ensure glasses / hearing aid are worn or within reach.	
Bed and bedrails. Assess the need for bedrails. If likely to fall from bed, ensure bed is at its lowest height, unless this would reduce mobility or independence. Consider use of special low bed	
Medication. Check for medication associated with falls risk, e.g. antidepressants, sleeping tablets, sedation, anti-psychotics Ask Doctor / Consultant to review (do not stop abruptly) Ensure baseline pulse and BP prior to commencement of new medication	
MDT. Ensure all clinical staff, family , significant other, care mangers are made aware of the services users risk, frequency , nature and seriousness of falls (local protocol or pathway would cover expected actions by MDT members e.g. mini mental , osteoporosis check mobility aid review)	

Falls prevention care plan continued	
GOAL : To reduce likelihood of falls whilst maintaining dignity and independence	**State action taken or N/A where no action is necessary**
Footwear. Check footwear for secure fit, non-slip soles, no trailing laces, speak to service user / advocate to look at safe options if replacement is required, consider the use of bed socks for service users that are at risk of falls at night with appropriate risk assessment in place	
Place. Attend to clinical need in most appropriate place for their need, i.e. close to nurses' station , close to toilet (consider other service users' needs as well	
Lighting. Consider lighting best for service user, e.g. bedside lamp left on all night, night light in toilet	
Urinalysis. Perform urinalysis. Send MSU if positive to blood, nitrates or protein.	
Toilet. Does the risk of falls appear to be associated with the service users need to use the toilet? If so, a routine of frequent toilet visits may be helpful in preventing falls	
Lying and standing BP. Check and document lying and standing BP and pulse. If deficits exist , inform doctor, advise service user on slow movement from sitting/ lying to standing position, consider anti embolism stockings	
Nutrition. Does the service user experience dizziness or weakness following poor dietary/ excessive intake of over stimulating foods	
On completion of this risk assessment the nurse in charge must complete a full risk management plan using From 8 from the Clinical Risk Policy. The risk management plan should target those risk and control measures deemed in the assessment to be essential to the alleviation of risk.	
Print name: Signature: Date:	

Appendix 4

Physical Observations Chart

Name ..... **Unit.....**

Date/Time	BP	Pulse	temperature	Respiration Rate Per Minute	02 STATS	BM	Reason for Physical Observations	Signature

Appendix 5 **Body Map and Checklist**

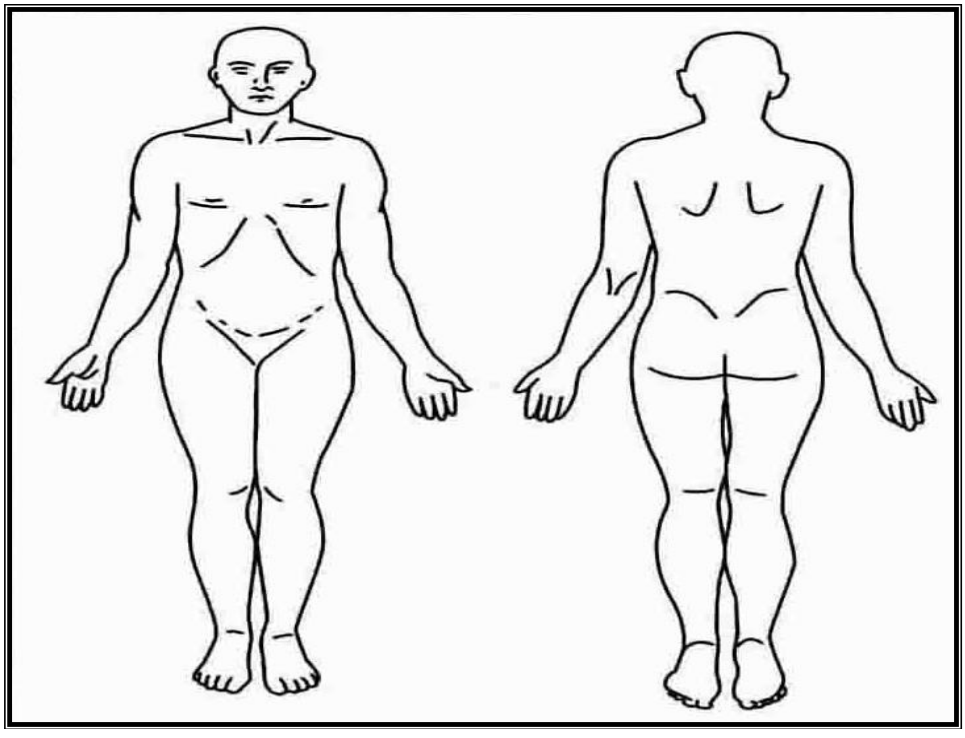
A soft touch pat-down check of the service user must be completed prior to attempting to move the service user unless this increases the immediate risk of injury.

Service User Name: . . . . . Time: . . . . . Date: . . . . . .

Body check following fall (Please indicate injury free using a tick)	**Injury free**	**Comment if required**
Ankle (left & right)		
Lower leg (left & right		
Upper leg (left & right		
Abdomen / lower back		
Hands (left & right)		
Lower arms (left & right)		
Upper arms (left & right)		
Chest / upper back		
Shoulders (front & back)		
Neck		
Face / ears		

Please use this body map to indicate any marks, bruises or abrasions which are a result of this incident.

In addition, identify any existing scars, bruises, marks or abrasions which are close to the marks from this incident to enable future reference and injury differentiation. A full report should be completed in the clinical record and an accident/ incident form should be completed.



Appendix 6

Reference	Location
The Essential Standards of Quality and Safety, Outcomes.	http://www.cqc.org.uk/sites/default/files/documents/guidance_about_compliance_summary.pdf
Management of health and Safety at Work. Management of Health and Safety at Work Regulations 1999. Approved Code of Practice L21 (second edition). HSE Books 2000. ISBN 0 7176 2488 9	http://www.qub.ac.uk/safety-reps/sr_webpages/safety_downloads/successful_h&S_management.pdf
Successful health and safety management HSG65 (second edition). HSE Books 1997. ISBN 0 7176 1276 7	http://paulthorn.co.uk/healthandsafety/Care%20Homes/hsg225.pdf
Health and safety in care homes HSG220. HSE Books 2001. ISBN 0 7176 2082 4	http://www.hse.gov.uk/pubns/books/hsg220.htm
Workplace health, safety and welfare. Workplace (Health, Safety and Welfare) Regulations 1992. Approved Code of Practice L24 (twelfth edition). HSE Books ISBN 0 7176 0413 6	http://www.healthandsafetyworksni.gov.uk/workplace_health__safety_and_welfare_acop.pdf
Lighting for communal residential buildings LG09.	ISBN 0 9534158 0 5 (www.cae.org.uk)
Visibly Better Accreditation Scheme for Residential and Nursing Homes. Royal National Institute for the Blind 2000.	Published by the Chartered Institution of Building Services Engineers 1997. ISBN 0 900953 84 5 (www.cibse.org) RNIB Community House, 46-50 East Parade, Harrogate HG1 5RR tel. 01423 509395
Handling home care HSG 225. HSE Books 2001. ISBN 0 7176 2228 2	HSE books, PO Box 1999, Sudbury, Suffolk, CO10
9. A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. HSE books 1999. ISBN 0 7176 2431 5	