South Eastern Health and Social Care Trust

Policy Code: SET/PtCtCare (01) 2022

Title:	**Prevention and management of patient/resident/client falls in Adult Care Settings**			
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Ownership:	**South Eastern Health and Social Care Trust (SET)**			
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Version No.	**3.1**	**Supercedes**	**SET/PtCtCare (22) 2017 V2.1**	
Amendments	**Refer to Policy ' Prevention of Falls and Essential Care after a Fall for all Patient/Clients in the South Eastern Trust' (Version 2.2)** **3.1: Change to Hoverjack location**			
Key words:	**Falls prevention and management**			
Links to other policies	• **Manual Handling Policy** • **Bariatrics – Policy and Procedural Arrangements for the Moving and Handling of Patients and Clients with Extreme Obesity** • **Effective use of Bedrails for all Adult Inpatients and Children in Adult Wards** • **Policy on the Safe & Effective use of Bedrails in Community Settings & Trust Residential Facilities** • **Management of Traumatic Head Injuries in Adults** • **Policy & Procedures for the Reporting and Management of Incidents**			

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

The definition of a fall has been agreed regionally as *"inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects"* (World Health Organisation (WHO) 2018).

From April 2020 to March 2021 inclusive, the SET reported a total of 3313 falls. Falls can be a significant cause of harm (Health and Social Care Board (HSCB) and Public Health Agency (PHA) 2018) and injuries can result in pain and distress (PHA 2011; National Institute for Health and Care Excellence (NICE) 2013). Physical injuries from falls are costly and hip fractures alone account for £1.1 billion in hospital costs every year (excluding social care cost) (Public

Health England 2020). Additionally, they can also leave devastating residual, psychological affects (Stanmore 2015; Leverenz and Lape 2018) such as a loss of dignity (Swann 2011) and a loss of independence and confidence (PHA 2011; NICE 2013). Falls may also lead to an overall fear of falling that is known to increase the risk of further falls (Healey *et al*. 2014).
A person of any age can fall (Swann 2011) but while one third of people aged 65 years or older fall every year, it is considered that 50 percent of those falls are preventable (PHA 2017). Falls and fall-related injuries are a common and serious problem for older people. People aged 65 years and older are at the highest risk of falling, with 30 percent of people older than 65 and 50 percent of people older than 80 falling at least once a year (NICE 2013).

NICE (2017) guide towards a multifactorial approach to falls prevention, as well as a focus on interprofessional/multirole working. By applying this approach, the incidence of falls can be reduced by 20-30% (Royal College of Physicians (RCP) 2012).

In hospital settings, FallSafe, a regionally agreed quality improvement project helps to prevent falls when applied to a person's assessment and plan of care (RCP 2012; Richardson *et al.* 2015).

In community settings, a multifactorial approach should be applied to falls assessment and prevention, similarly to hospital settings.

1.2 **Purpose**

The purpose of this policy is to ensure that an interprofessional/multirole approach is adopted in:

- the prevention of falls in adult care settings.
- the management of all patients/residents/clients who have fallen in adult care settings (inclusive of patients/clients in privately rented/owned homes).

1.3 **Objectives**

The objectives of this policy are:

1. Staff will be aware of their roles and responsibilities in relation to the prevention and management of falls.
2. To identify those who may be at risk of falling through individualised assessment processes and by application of plans of care.
3. The number of falls and injuries from falling in care settings will be monitored and reduced through education and the sharing of learning.
4. Staff will be aware of safe practice when assessing a person who has fallen in order to prevent further harm.
5. Staff will be aware and apply best practice when transferring a person who has fallen in relation to the use of moving and handling equipment and prevention of further harm.
6. Incident reporting and investigation processes will be followed as per Trust policies and regional guidance.

7. Using suitable methods of communication, learning from falls incidents will be shared widely across the Trust and regionally, as appropriate.

2.0 **SCOPE OF THE POLICY**

This is a corporate policy applicable to all wards, departments, Trust care homes and community settings within the Trust to manage and prevent patient/resident/ client falls and provide essential care after a fall.

The principles of this policy can be applied to paediatric patients/residents/clients in adult care settings. Specialist advice however MUST be sought for falls prevention and management of those aged less than 18 years old in an adult care setting.

3.0 **ROLES/RESPONSIBILITIES**

3.1 The organisational structures within the Trust are responsible for ensuring that this policy is brought to the attention of all relevant staff. All staff should adhere and familiarise themselves with this policy and how it will impact on their work activities.

3.1.1 Trust Board and Executive Team

Responsible for ensuring health, safety and risk management arrangements are in place Trust wide.

3.1.2 Assistant Directors/Senior Managers

Responsible for:

- ensuring policy is implemented and adhered to in clinical areas of responsibility.
- monitoring falls rates and sharing learning appropriately.
- ensuring training and/or education needs are identified and met.
- ensuring suitable health, safety and risk management arrangements are in place for their areas of responsibility.

3.1.3 Staff Responsibilities

All staff should:

- adhere to all policies and guidance in relation to the prevention and management of patient/resident/client falls.
- take every opportunity to identify those at risk of falling and take appropriate action relevant to their role e.g. admitting nurse must assess patient/resident for risk of falls.
- work collaboratively with all professions/roles within care settings.
- report patient/resident/client falls within 24 hours of incident using the DatixWeb system.

- identify training needs in respect of policies and procedures and bring them to the attention of their line manager.

3.1.4 Healthcare professionals

Healthcare professionals should:

- assess patient/resident/client needs and undertake preventative interventions to reduce the risk of falling in hospital and community settings, as guided by NICE (2013).
- be aware of the safe management of those who have fallen.
- signpost and/or refer patient/resident/client in all healthcare settings to appropriate professionals/services in relation to falls prevention and management.

3.1.5 Falls Prevention and Management Service

The Falls Prevention and Management Service should:

- lead in the education of staff in relation to falls prevention and management.
- work collaboratively with internal and external stakeholders to develop falls prevention and management pathways and expertise for people living within the Trust geographical area.
- liaise and strengthen links across hospital and community settings.
- monitor and investigate falls incidents, support staff in planning improvement work post incident and share learning Trust wide and regionally, as appropriate.

4.0 **KEY POLICY PRINCIPLES**

4.1 **Assessment of falls risk in all care settings**

4.1.1 All patients/residents/clients should have a:

- falls risk assessment
- moving and handling risk assessment and
- bedrail assessment

completed on admission and updated post transfer to another care setting.

4.1.2 Older people should be routinely asked about falls during assessment with health and social care professionals, and on presentation to hospital (NICE 2017). Baseline mobility and activity levels should also be established.

4.1.3 Arrival/admission to a new care setting may increase the risk of falling therefore patients/residents/clients must be made familiar with their new environment and the facilities within it e.g. call button, nearest toilet.

4.1.4 Falls prevention advice must be made available in written format, with advice dependant on the care setting which the patient/resident/client is in. Advice must be documented in written or electronic records e.g. eDAMS.

4.1.5 All patients/residents/clients should have a review of falls, moving and handling and bedrail (risk) assessments when further risk is identified e.g. when a fall occurs.

4.1.6 Appropriate onward referral to other professionals/services is essential in all care settings if falls risk factors are to be reduced e.g. physiotherapy referral due to unsafe mobilisation, occupational therapy referral for cognitive assessment.

4.1.7 Communication among staff is essential. Patients/residents/clients identified as being at risk of falls should be highlighted in the care setting's safety briefs/opportunities of handover. This includes communicating/highlighting risk on transfer to other care settings/clinical areas.

4.2 **Assessment of falls risk in specific care settings**

Hospital care settings

4.2.1 FallSafe is a quality improvement project containing elements within **Care Bundles A** and **B** that help to prevent falls in the inpatient setting when applied to the patient's care (RCP 2012).

4.2.2 This project has been adopted in inpatient areas and the bundles contain a number of regionally agreed elements that are addressed in care settings to reduce falls risks (Richardson e*t al*. 2015).

4.2.3 All healthcare professionals are responsible for the completion of relevant assessments and plans of care, as well as timely/appropriate review, in relation to prevention and management of falls (within their scope of practice and responsibility). This should be in collaboration and communication with the patient's family/next of kin (NOK)/first contact.

4.2.4 Nursing staff are required to complete admission documentation and plans of care in regionally agreed timeframes within nursing documentation i.e.

- Assessment of person's risk(s) of falling.
- Moving and handling risk assessment and care plan(s).
- Bedrail assessment.

4.2.5 The elements of **Care Bundle A** should be considered for every person admitted into an adult hospital care setting.

4.2.6 Elements of **Care Bundle A** are:

- Patient has history of falls in past 12 months - *all professions should consider this when clinically assessing falls risk of all patients especially those who are cognitively impaired.*
- Patient has fear of falling - *or reported fear of falling.*
- Urinalysis - *consider the possibility of infection causing falls and delirium. Clinical necessity of urinalysis and follow up laboratory sampling should be considered with patient's clinical presentation. Results should be obtained and actioned appropriately.*
- Night sedation - *consider side effects of drugs with sedation effect. Avoid commencing new night sedation if at all possible, considering the balance of risk.*
- Call bell in sight, in reach and working - *if the patient has cognitive impairment, sensory impairment e.g. poor eyesight, alternative means of communication must be considered.*
- Safe footwear - *safe outdoor footwear/slippers should be worn at all times when mobilising.*
- Assessment for a walking aid - *patients admitted out of hours may need to be provided with a walking aid in accordance with regional guidelines for 'The Provision of Walking Frames to Patients Out-of-Hours in Adult Inpatient Wards'. These guidelines are available on the Trust intranet. Patients in receipt of a walking aid out of hours should be assessed by a physiotherapist as soon as possible.*
- Personal items within reach - *consider food/fluids.*
- No slips or trips hazards - *all staff should be vigilant at all times to any potential spills, slip or trip hazards. Consider all environmental factors such as lighting, flooring, safe access to/maintenance of beds and seating, position of mobility aids/equipment, appropriate use of brakes on equipment*.

4.2.7 The elements of **Care Bundle B** should be considered for every person admitted into an adult hospital care setting who is:

- aged 65 years or older.
- aged 50 - 64 who is assessed by a clinician to be at a higher risk of falling because of an underlying condition e.g. dementia, delirium (e.g. post op), post cerebrovascular accident.
- admitted with a fall or has gait disturbances.

4.2.8 Elements of **Care Bundle B** are:

- Cognitive Screening - *to detect impairment e.g. patients with dementia. A screen to identify cognitive impairment should be undertaken using a standardised tool e.g. Abbreviated Mental Test (AMT). Subsequent action should be taken post screening to reduce the risk of falls.*
- Lying & Standing Blood Pressure - *should be taken with a manual sphygmomanometer (if possible or if the automatic blood pressure monitor fails to record) to check for orthostatic (postural) hypotension* (see Appendix A - How to measure lying and standing blood

pressure). *Pulse taken by hand to check for arrhythmias i.e. an irregular heartbeat.*

- Full medication review - *a suitably trained person e.g. a pharmacist should carry out a falls medication review. A falls medication review is an essential step to minimise the risk of falls by optimising the patient's medication regimen. This may include changing, reducing or stopping medicines known to contribute to falls. All medical staff admitting a patient should review current medication. An appropriate and trained staff member must review medications should a patient fall occur* (see Appendix B - Falls Medication Review for patients/residents/clients who have a high risk of falls or who have had a fall).
- Bedrails risk assessment - *consideration should be given to risk of entrapment, the use of mattress/overlays that reduce the height of the bedrail, use of bed rails when someone is confused and bed rail use in relation to deprivation of liberty. Consent for use/conversation in relation to bedrails should be recorded in patient records (conversation with patient, family, NOK, first contact).*

4.2.9 **Age criteria serves as a guide in relation to completion of Care Bundle B. Professional judgement** should be used when considering **any** person in relation to risk of falling, irrespective of age. All risk elements should be reviewed, as applicable and appropriate actions taken.

4.2.10 The below are also falls risks that should be considered and responded to by the appropriate healthcare professional(s):

- Person placement within care setting(s) - *consider balance of risk e.g. infection control status, patient's cognition.*
- Poor fluid/food intake - *consider alongside MUST screening.*
- Alcohol intake and recreational drug use.
- Toileting needs- *should be assessed and appropriate, individualised plans of care put in place to manage needs. Consider intentional rounding.*
- Suitable clothing - *length and material of garments worn may increase risk of falling e.g. material that could cause a patient to slip from seat/bed.*
- Investigation of osteoporosis - *women are at increased risk of certain osteoporodic fractures compared with men (Scottish Intercollegiate Guideline Network 2021). Consideration should be given to bone health review (National Osteoporosis Guideline Group 2018) and fracture risk linked to history of falls (NICE 2017).*
- Pain.
- Delirium.
- Depression.
- Syncope syndrome - *cardiac conditions/symptoms.*
- Medical conditions - *e.g. diabetes and related peripheral neuropathy, cerebrovascular accident affecting balance/physical deficit.*
- Musculoskeletal conditions - *e.g. osteoarthritis.*
- Visual impairment.
- Posture, gait, strength and balance.
- Extended periods of immobility.

- Foot pathology/ pain - *lack of prescribed device to aid mobility.*
- Bed height - *at the lowest position except during direct patient care. Consider low entry/rising beds.*

4.2.11 Following identification of falls risks, an individualised plan of interprofessional/role care should be developed, in collaboration and communicated with the patient, relatives and others involved with the patient's care.

4.2.12 A review of relevant risk assessments and plans of care relating to falls prevention must be completed by nursing staff:

- Weekly if no fall or change to condition/risk has occurred.
- When a patient falls.
- When a patient is found and a fall is suspected (unwitnessed fall).
- When a patient's risk factors or medical condition changes.
- On transfer to another care setting.

4.2.13 Review of relevant risk assessments and plans of care relating to falls prevention must be completed as per regional nursing timeframes.

<u>Community care settings</u>

4.2.14 NICE (2017) guide that people aged 65 years or over who have had 2 or more falls in the past 12 months, or demonstrate abnormalities of gait or balance should be considered at risk of falling. Further, this should lead to a multifactorial falls risk assessment and interventions (NICE 2017).

4.2.15 Common components of successful interventions are:

- Strength and balance training.
- Home hazards assessment and intervention.
- Vision assessment and referral.
- Medication review with modification/withdrawal (NICE 2013).

4.2.16 Due to falls prevention being multifactorial and the responsibility of all staff, onward specialist referrals are advised, as required (NICE 2013).

Care homes

4.2.17 The Northern Ireland Service Framework for Older People (Department of Health, Social Service and Public Safety (DHSSPS 2013), NICE (2013) and the Care Standards for Nursing Homes (DHSSPS 2015) collectively support person-centred assessment and care.

4.2.18 Care staff are required to work in partnership with residents and their families/NOK//first contact, with assessment being an ongoing process whereby prescribed nursing care is reflective of multidisciplinary working where risks are modifiable (PHA 2013).

4.2.19 A falls risk assessment accompanied by appropriate action e.g. onward specialist referral to reduce potential of falls must be carried out as part

of the initial assessment process for all new admissions to Trust facilities. This is particularly relevant to those 65 years old and older.

4.2.20 A falls assessment and plan of care must be completed for every resident by a suitably qualified person with the appropriate level of competencies:

- within 24 hours of admission to care home.
- monthly if no fall or change to condition/risk has occurred.
- if a fall occurs.
- if a fall is suspected (unwitnessed).
- if resident's medical condition has changed/falls risk factors have changed.

4.2.21 The risk of falling cannot be entirely removed for every resident. However, by carrying out an individualised, multifactorial falls assessment, risk factor(s) can be identified and action(s) taken to remove/reduce risk(s) (PHA 2013) (see Appendix C - Measures/ considerations to reduce falls incidents in care homes).

Privately rented/owned home dwellings

4.2.22 Appropriate falls assessment, associated risk assessments and plan(s) of care should be completed for each patient/client, depending on the service they are receiving/role or profession of the staff member. These should be completed within regionally agreed timeframes.

4.2.23 Through anticipatory planning and management of all citizens' needs to promote health and wellbeing/reduce risk, Population Health Management remains a focus in community settings (Department of Health (DoH) 2018).

4.2.24 Many of the risk factors as to why people fall in a private dwelling are similar to other care settings detailed in 4.2 and referenced appendices within (see Appendix D - Intrinsic and extrinsic risk factors of falls in the older person).

4.3 **Management of falls**

4.3.1 Following a fall, a medical/clinical examination is important not only to detect injury but because falls are often a "red flag" for changes in the patient's/resident's/client's underlying medical condition.

4.3.2 The immediate actions to be taken on witnessing a fall or finding a patient/resident/client who has fallen will depend on the scope of practice/experience of the member of staff, the location the fall has occurred in and on resources available for use.

4.3.3 *Initial response/assessment*

4.3.3.1 Always check the surrounding area for signs of danger as you approach the fallen patient/resident/client.

4.3.3.2 Ensure personal safety. Wear personal protective equipment e.g. apron and gloves (as appropriate).

4.3.3.3 Recognise when you will need extra help. Call for appropriate help early.

4.3.3.4 Use the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach to assess and treat the patient/resident/client.

4.3.3.5 Look at the patient/resident/client in general to see if the patient appears unwell.

4.3.3.6 If the patient is unconscious, unresponsive, and is not breathing normally (occasional gasps are not normal), start CPR according to resuscitation guidelines. If there are any doubts about the presence of a pulse start CPR.

4.3.3.7 Complete an initial assessment and re-assess regularly. An initial assessment can identify if there is any pain, loss of sensation, visible injury or limb deformity that could indicate a fracture.

4.3.3.8 Staff not competent in assessing for injuries should seek medical assistance/contact Northern Ireland Ambulance Service (NIAS) as an emergency.

4.3.3.9 Registered nursing/medical staff/senior care staff or equivalent trained to First Aid Certificate at work level must carry out an immediate clinical assessment to check for signs of serious injury, e.g. fracture, potential head or spinal injury **before the patient/resident/client is moved**. In the community setting staff may need to phone 999 and a triage risk assessment will be completed and advice given by a paramedic from the NIAS.

4.3.3.10 Monitor vital signs early. Observations should be completed by someone suitably trained to detect any potential acute illness that caused the fall and to detect any harm from the fall. Observations include temperature, pulse, respiratory rate, blood pressure, oxygen saturations, and blood glucose.

4.3.3.11 At a suitable opportunity, provide appropriate supportive care for those with a physical injury that is within scope of practice/care setting and as injury would dictate e.g. pressure relief, pain relief.

4.3.4 Fracture and/or spinal injury to patient/resident/client

4.3.4.1 The NICE guidance in relation to spinal injury (NG41) should be followed when managing the fallen person at risk of spinal injury (NICE 2016).

4.3.4.2 For those patients/residents/clients with signs of serious injury or high vulnerability to serious injury, an **immediate** medical

examination is required. Contact medical team/emergency NIAS ambulance as appropriate.

4.3.4.3 **The patient/resident/client should not be moved until they have been fully assessed.** Moving a patient/resident/client with potential spinal injury or suspected fracture before being appropriately immobilised can cause severe harm.

4.3.4.4 **At all stages of assessment, protect cervical spine and avoid moving the remainder of the spine if spinal injury is suspected.**

4.3.4.5 Spinal injury may be indicated by:

- Neck pain.
- Neurological deficit - limbs.
- Position/height of fall.
- Loss of consciousness.
- Possible hip fracture.
- Signs of other bony deformity.
- Suspected or known head injury.
- Change in neurological status – Glasgow Coma Score (GCS).
- Significant soft tissue injury.
- Abnormality in the patient's/resident's/client's normal vital signs/National Early Warning Score (NEWS).
- Chest pain.

4.3.4.6 If patient/resident/client has been immobilised, access to investigation and treatment must take place as soon as possible after the event to avoid the risk of prolonged immobilisation and associated complications.

4.3.4.7 For patients/residents/clients on anticoagulation and/or antiplatelet medicines, seek prompt medical advice.

4.3.4.8 Those aged 65 or older should be considered as high risk of cervical spine injury (NICE 2016).

4.3.5 *Head injury*

4.3.5.1 An immediate medical examination is required for those suspected or known to have sustained a head injury.

4.3.5.2 Neurological observations should be commenced as per NICE clinical guideline (2019) 'Head injury: assessment and early management' (CG176).

4.3.5.3 Neurological observations should be completed for patients/residents/clients with visible or reported head injury, but also where head injury cannot be excluded (e.g. unwitnessed fall).

4.3.5.4 Head injury may be indicated by:

- Loss of consciousness, altered state of consciousness.
- Confusion.
- Amnesia.
- Irritability (change to behaviours).
- Other focal neurological deficit e.g. changes to vision, hearing, one sided alteration i.e. weakness or sensory disturbance.
- Reduced GCS outcome.
- Obvious injury e.g. bleeding and/or bruising to head, swelling, obvious fracture.
- Headache.
- Vomiting.
- Seizure.

4.3.5.5 Staff should refer to the Trust's current Head Injury policies/ NICE clinical guideline 'Head injury: assessment and early management' (CG176).

4.3.5.6 For patients/residents/clients that have fallen outside of hospital settings, phone emergency NIAS ambulance if suspected fracture, spinal or head injury.

4.3.5.7 If a patient falls in Trust grounds but outside of the care setting, an emergency NIAS ambulance must be phoned if injury is suspected.

4.3.5.8 Patients/residents/clients on anticoagulation (e.g. warfarin or a Direct-Acting Oral Anticoagulant (DOAC) who have sustained a head injury should receive prompt medical advice. Medical advice should also be sought for patients/clients/residents on new generation antiplatelet agents and more than one antithrombotic i.e. clopidogrel and similar, not solely aspirin.

4.3.5.9 A more intensive and prolonged schedule of observation may be required for patients/clients/residents who are on anticoagulants or antiplatelets. Direction must be given by medical staff.

4.3.6 *Moving the patient/resident/client post fall*

4.3.6.1 Staff should attend mandatory patient/resident/client moving and handling training and be made aware of the risks associated with the moving and handling of someone who has fallen. Staff will also be provided with the appropriate guidance for moving a patient/resident/client safely following a fall.

4.3.6.2 Specialised manual handling equipment will be provided (within available resources) for moving a patient/resident/client safely following a fall.

4.3.6.3 The initial assessment will determine if there are any suspected injuries requiring immobilisation or the use of specialist lifting equipment.

4.3.6.4 Consider safe retrieval (movement/transfer) in relation to where the patient/resident/client has fallen, including how to access equipment and expertise for patients/residents/clients that require immobilisation and/or flat-lifting.

4.3.6.5 Consider assessed need for pain relief before moving the patient/resident/client (if appropriate). Be aware of equipment available in your area of practice (Appendix E - Using lifting equipment following a fall) (lifting equipment authored and owned by Ergonomics Team).

4.3.6.6 Follow procedure(s) within appendices, depending on where the person has fallen (moving and handling information authored and owned by Ergonomics Team)**.**

- Appendix F - Management of a patient who has fallen in hospital.
- Appendix G - Management of a resident who has fallen in residential care facility.
- Appendix H - Management of a patient/client who has fallen in community (to be followed for those living in privately rented/owned homes).

4.4 **Documentation/Recording of Care**

4.4.1 It is the responsibility of all relevant/appropriate staff to document every patient's/resident's/client's:

- risk of falls.
- assessment and management of falls, inclusive of plan of care.
- falls incident(s).

4.4.2 If a fall occurs, staff responsible for the patient/resident/client should record what occurred and what management took place, inclusive of notification to family/NOK/first contact. This should be recorded contemporaneously. Staff must also reassess falls risks alongside relevant risk assessments and plans of care appropriate to profession/ role/service.

4.4.3 Report and record any incident or near miss via DatixWeb.

4.4.4 All staff should ensure clear and accessible documentation of falls risk/fall incident(s) is completed when patient/resident/client is moving from one care setting to another e.g. on discharge from hospital.

4.5 **Incident reporting**

4.5.1 It is the responsibility of **ALL** staff to report **ALL** falls incidents witnessed, suspected or discovered, including near misses, on the DatixWeb system. These should be recorded within 24 hours of the incident.

4.5.2 All falls should be assessed in relation to severity of harm by staff when completing DatixWeb forms. Following the results of investigations/ changes in the patient's/resident's/client's condition, the initial assessed severity of harm should be reviewed and updated by the reviewer/ approver, as appropriate.

4.5.3 Guidance in relation to detail to be inserted into incident form on DatixWeb is as Appendix I - Information in falls incident form on DatixWeb.

4.6 **The investigation of falls incidents**

4.6.1 The reviewer/approver is responsible for the accurate completion of all falls incidents on DatixWeb.

4.6.2 Any relevant communication and documents relating to a falls incident MUST be uploaded to the incident record on DatixWeb by the relevant staff member(s).

4.6.3 The reviewer/approver for care settings should review all falls that have resulted in insignificant or minor harm and seek analysis/support from the Falls Prevention and Management Service as required (see Appendix J - Post Falls Review and Shared Learning Process when a fall occurs resulting in insignificant/minor harm).

4.6.4 Falls that do not result in moderate to catastrophic harm may still require further investigation. Advice and support should be sought from the Falls Prevention and Management and Risk Management Advisory Services.

4.6.5 **For all falls resulting in moderate, major or catastrophic harm**, the Falls Prevention and Management Service MUST be notified as soon as possible in order to complete investigation processes. This includes if the fall occurs within non-inpatient areas e.g. outpatient department and emergency departments.

4.6.6 **For all <u>inpatient</u> falls resulting in moderate, major or catastrophic harm**, the Falls Prevention and Management Service MUST be notified as soon as possible and the agreed, regional process should be followed (see Appendix K- Post Falls Review and Shared Learning Process when a patient fall occurs resulting in moderate/major/catastrophic harm).

4.6.7 **For all <u>inpatient</u> falls resulting in moderate, major or catastrophic harm**, the Falls Prevention and Management Service will facilitate completion of a post falls review and shared learning (Appendices L and M respectively).

4.6.8 **For those falls that require investigation through the Serious Adverse Incident process**, the Governance facilitator or equivalent will escalate using the approved internal Directorate/department process (see Trust's 'Policy and Procedures for the Reporting and Management of Adverse Incidents').

4.6.9 **The Falls Prevention and Management Service MUST be notified when:**

- there is an increase of falls in any care setting.
- a patient/resident/client is repeatedly falling in a care setting.
- a fall occurs resulting in moderate, major or catastrophic harm.

4.7 **Auditing and shared learning from falls incidents**

4.7.1 Staff should complete a falls audit appropriate to their care setting e.g. FallSafe audit in adult inpatient areas.

4.7.2 The FallSafe bundles contain a number of regionally agreed indicators which Health and Social Care Trusts measure compliance against. The Trust will report outcomes of the FallSafe audit in adult care settings to the PHA and HSCB quarterly.

4.7.3 Falls incidents and learning will be reviewed, themed and shared timely with clinical staff, directorates, Trust Falls Working and Steering Groups and via other governance structures.

4.7.4 Shared learning from all adult inpatient falls resulting in **moderate or more severe injury** will be forwarded to the PHA to identify learning, themes and trends across the region. Detail will be added to the below questions:

- What happened?
- Why did it happen?
- What went well?
- What could we improve?
- What have we learnt?

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy is to be implemented in all services. All staff employed by the Trust are required to adhere to this policy. The policy will be circulated electronically to all staff and placed on the Trust's iConnect site.

5.2 Resources

- The SET's Falls Co-ordinator.
- Falls Prevention and Management Service.
- Expert Reference Groups of professionals in the SET.

- Ergonomics Training and Advisory Service.
- Network of trained manual handling assessors.

5.3 **Exceptions**

Healthcare in Prison (HIP) is excluded from this policy. HIP to develop ISO/local policy.

6.0 MONITORING

6.1 It is the responsibility of each ward/unit manager to monitor the incidence of all falls to ensure lessons are learnt, recorded and implemented.

6.2 It is the responsibility of the Governance Facilitator/or equivalent to share learning at the Nursing and Midwifery Governance meetings and/or equivalent in their department. Collaboration with frontline staff should take place to share lessons learnt and help support improvement work.

6.3 It is the responsibility of the Falls Coordinator to share the learning with the Trust's falls groups, Lessons Learnt Sub Committee and the Regional Falls group.

6.4 This policy will be subject to review in line with local audit schedule and amended as required or as a result of any new legislative change.

7.0 EVIDENCE BASE/REFERENCES

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8.0 CONSULTATION PROCESS

- Expert groups.
- Members of the SET Falls Working Group.
- Trust wide.

9.0 APPENDICES / ATTACHMENTS

Appendix A - How to measure lying and standing blood pressure
Appendix B - Falls Medication Review for patients/residents/clients who have a high risk of falls or who have had a fall.
Appendix C - Measures/considerations to reduce falls incidents in care homes
Appendix D - Intrinsic and extrinsic risk factors of falls in the older person
Appendix E - Using lifting equipment following a fall
Appendix F - Management of a patient who has fallen in hospital
Appendix G - Management of a resident who has fallen in a residential care facility
Appendix H - Management of a patient/client who has fallen in community
Appendix I - Information in falls incident form on DatixWeb

Appendix J - Post Falls Review and Shared Learning Process when a fall occurs resulting in insignificant/minor harm
Appendix K - Post Falls Review and Shared Learning Process when a patient fall occurs resulting in moderate/major/catastrophic harm
Appendix L - Post falls review minimun data set for falls resulting in moderate/major/ catastrophic harm
Appendix M - The PHA Shared Learning Template for falls resulting in moderate/major/ catastrophic harm

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

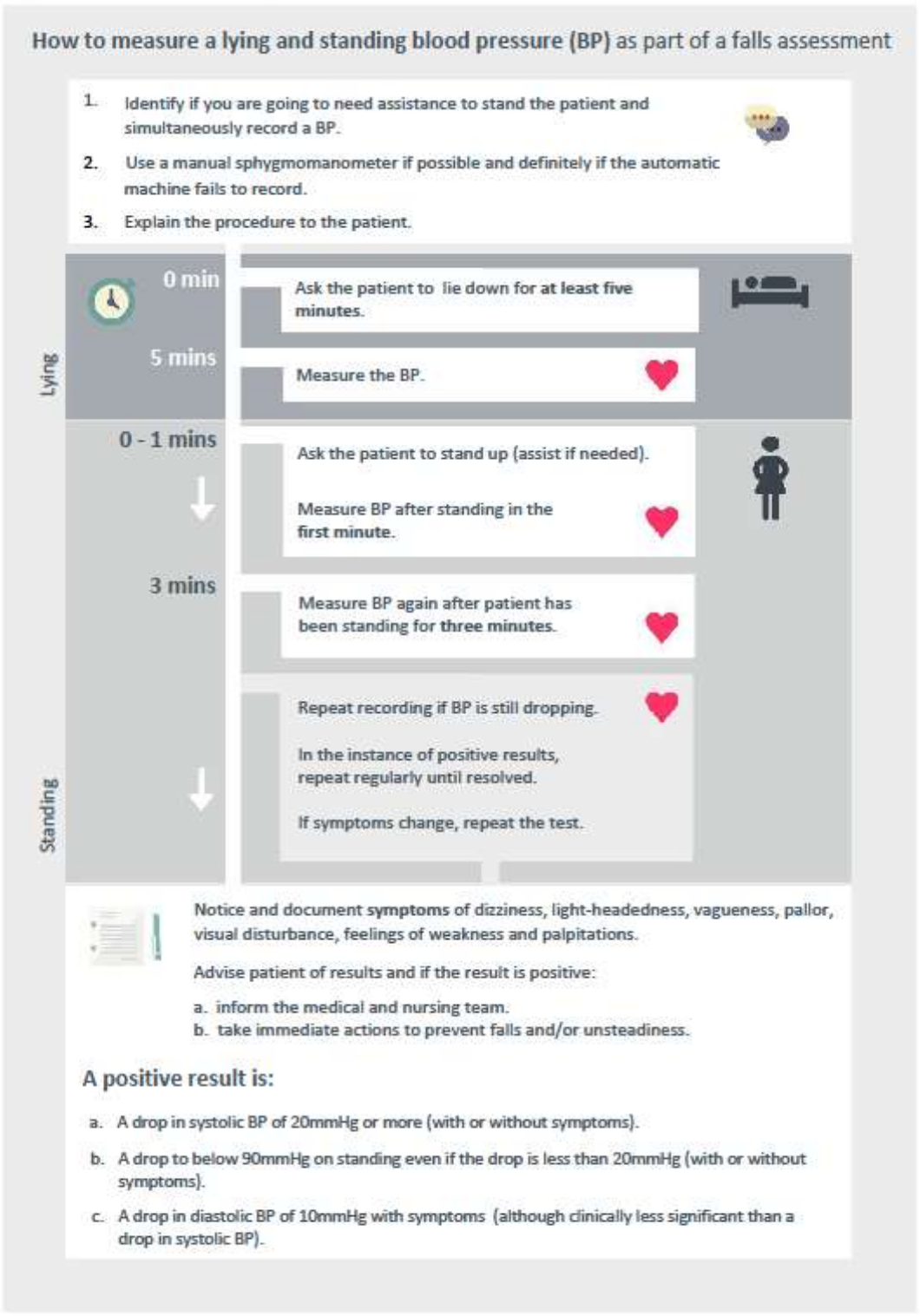
Major impact☐ Minor impact☐ No impact ✓

SIGNATORIES

Policy Name	Author Endorsement	Modified↓	Modified By
P-194: Prevention of Falls and Essential Care after a Fall for all Patient/Clients in the South Eastern Trust	Yes	23/12/2021 03:13 PM	McKee, Gillian

Policy Name	Approval	Modified↓	Modified By
P-194: Prevention of Falls and Essential Care after a Fall for all Patient/Clients in the South Eastern Trust	Endorsed	23/12/2021 03:41 PM	Patterson, Nicki
P-194: Prevention of Falls and Essential Care after a Fall for all Patient/Clients in the South Eastern Trust	Endorsed	23/12/2021 03:41 PM	Martyn, Charlie

Appendix A
How to measure lying and standing blood pressure



Appendix B
Falls Medication Review for patients/residents/clients who have a high risk of falls or who have had a fall.

A suitably trained person should carry out a falls medication review. A falls medication review is an essential step to minimise the risk of falls by optimising the patient's medication regimen. This may include changing, reducing or stopping medicines known to contribute to falls.

The following Medicines Falls Risk Stratification Tool is a list of medicines which have been shown to be commonly associated with falls. Some medicines carry a higher risk than others when used individually or in combination. This list is not exhaustive and only intended to raise awareness.

Some medicines have anticholinergic effects with associated side-effects such as CNS effects (dizziness, ataxia, effects on cognition etc.) and other possible effects such as causing visual problems which can contribute to falls. The anticholinergic burden of medicines can be determined using the AEC or ACB tools detailed.

Almost all medicines acting on the brain or heart can increase risk of falls and should be reviewed to ensure they are appropriate and not causing unwanted side-effects.

Patients/resident/clients taking four or more medicines (polypharmacy) are at an increased risk of falls especially if they include centrally sedating and antihypertensive medicines.

Patients/resident/clients should be involved in the decision making process around changes to their medication to ensure patient-centred care. Ensure any changes to a patient's/resident's/client's medication is communicated effectively.

Medicines Falls Risk Stratification Tool

High Risk Medicines These medicines cause falls alone or in combination	
Antidepressants	e.g. Amitriptyline, citalopram, fluoxetine, mirtazapine, sertraline, venlafaxine
Antimuscarinics	e.g. Oxybutynin, tolterodine, solifenacin, trospium
Antipyschotics	e.g. Chlorpromazine, haloperidol, risperidone, quetiapine, prochlorperazine
Benzodiazepines & hypnotics	e.g. Temazepam, diazepam, chlordiazepoxide, zopiclone
Dopaminergic drugs used in Parkinson's	e.g. Levodopa, ropinirole, pramipexole, selegiline
Medium Risk medicines These medicines cause falls especially in combination	
Alpha-blockers	e.g. Tamsulosin, alfuzosin, doxazosin, indoramin, clonidine, methyldopa
ACEIs, ARBs	e.g. ACEIs include lisinopril, ramipril, perindopril ARBs include losartan, candesartan, irbesartan
Sedating Antihistamines	e.g. chlorphenamine, hydroxyzine, promethazine
Anti-arrhythmics	e.g. digoxin, amiodarone, flecainide
Anti-epileptics	e.g. carbamazepine, phenobarbitone, phenytoin, gabapentin, pregablin
Beta-blockers	e.g. atenolol. Bisoprolol, metoprolol, propranolol
Diuretics	e.g. furosemide, bumetanide, bendroflumethiazide,
Opiates	e.g. codeine, morphine, tramadol
Low Risk medicines These medicines possibly cause falls especially in combination	
Antianginals	e.g. glyceryl trinitrate, isosorbide mononitrate, nicorandil
CCB's	e.g. amlodipine, nifedipine, lercanidipine
Oral diabetic drugs	e.g. glibenclamide, gliclazide
Anticholinergic Burden – scoring tools	
AEC calculator	www.medichec.com
ACB calculator	www.acbcalc.com

Note: Information within Appendix B was written and formatted by Medicines Optimisation for Older People Team (MOOP, 2019).

Appendix C
Measures/considerations to reduce falls incidents in care homes

- Falls history.
- Fear of falling.
- Sensory impairment e.g. vision, hearing.
- Nutrition (food and fluids).
- Urinalysis completed to indicate possibility of urine infection - *clinical necessity of urinalysis and follow up laboratory sampling should be considered with resident's clinical presentation. Results should be obtained and actioned appropriately.*
- Management of continence.
- Posture, gait, strength/balance.
- (Im)mobility and use of walking aid.
- Footwear/foot care and clothing.
- Orthostatic (postural) hypotension and hypotension.
- Bed rails use and bed position (in relation to height) - *bed rail alternatives should be considered as applicable e.g. cocoon system (Note: caution/ considerations to bed rail use under 4.2.8).*
- Poor sleep pattern.
- Inappropriate chair/wheel chair height and maintenance.
- Inability to use call bell/ineffective communication between resident and staff. Consider intentional rounding.
- Alert systems to advise of resident movement - *may cause trip hazard.*
- Personal items not accessible e.g. T.V. remote.
- Person placement in care home *e.g. person not visible to staff. Note: apply 4.2.10 regarding balance of risk.*
- Environment - *inclusive of lighting, room placement e.g. bathroom, bedroom, flooring, grip rails, hazards, clutter.*
- Cognition.
- Level of functional ability.
- Hobbies and recreation - *if resident not included in activities of interest, may become unsettled during the day/at certain times of the day e.g. reading at night, access to visitors/pets.*
- Pain.
- Medications *e.g. sedatives.*
- Musculoskeletal conditions.
- Medical conditions *e.g. osteoporosis, infection and sepsis, neurological and cardiac conditions, dementia, delirium, diabetes, depression.*
- Level of frailty using frailty scoring.

Note: This list is not exhaustive

Appendix D
Intrinsic and extrinsic risk factors of falls in the older person (Anthony 2007)

Intrinsic/personal factors	***Extrinsic/environmental factors***
Decreased mobility and strength	Inappropriate or poorly fitting footwear and clothing
Medical conditions e.g. dementia, depression, Parkinson's disease	Inadequate or poor lighting
Impaired gait and balance	Inappropriate use of side rails
Prior history of falls	Steep stairs and lack of grab rails
Medications e.g. sedatives	Slippery floors
Impaired vision	Loose mats and floor covering
Cognitive impairment/delirium	Pets
Poor nutrition/***dehydration***	Height of beds and chairs
Hypotension/***postural hypotension***	Electrical wires and appliances e.g. television
Height of beds and chairs	Uneven pavements/**affected walkways by e.g. weather/ coverage of leaves and moss**
Foot problems such as untrimmed toe nails	Adverse weather such as snow or rain
Infection	Overcrowded public areas
Urinary/faecal incontinence	Public transport e.g. buses which jolt suddenly
Syncope	
Dizziness/vertigo	
Fear of falling (Vieira et al. 2016)	

Note:

1. This list is not exhaustive.
2. Factor is ***bold and italics*** are further considerations to Anthony (2007).
3. Principles can be applied to people of all ages.

Appendix E
Using lifting equipment following a fall

A generic manual handling risk assessment should already be in place and all staff aware of the processes to follow in the event of a fall.

- Assess the situation and take action appropriate to your own level of competency, if an injury is suspected call for help and seek medical attention before trying to move the person. Follow relevant appendices to this Policy (in particular Appendix F,G &H).
- A robust risk assessment must be completed by a competent person before using equipment to ensure that it is appropriate to use and that the equipment suitable and in good working order.
- **Ensure that it is safe to respond**.

1. Emergency Handling Pack

All trust facilities should have access to an emergency handling pack. The pack consists of a small tubular slide sheet, 2 long flat slide sheets with extension handles and an emergency lifting sheet. The lifting sheet has a safe working load (SWL) of 20 stone. The emergency handling pack is normally stored beside the emergency trolley and must be readily accessible for use.

Note: If a manual lift is required in a life threatening situation, a suitable lifting sheet (not a bed sheet) from the emergency handling pack or scoop stretcher should be used.

2. Hoist

All wards and trust facilities that provide health and social care to patients / clients with mobility needs should have access to a hoist and standard hoist slings in a range of sizes.

A hoist and sling can be provided for use in community for dealing with a client who is falling regularly i.e. 3-4 times weekly. Contact District Nursing to arrange.

Horizontal hoisting equipment is now available for use if required in the UHD, LVH and the Downe Hospitals. Please contact the Ergonomics Team to arrange additional training on the use of horizontal hoisting equipment if required. 02891872574

Prior to using hoisting equipment, staff must:

(a) Have received training and know how to use the equipment.
(b) Assess the patient to ensure that it is safe and appropriate to use a hoist.
(c) Check the Safe Working Load (SWL) of the hoist and ensure that the patient's weight is less than this Safe Working Load value (The safe working load should be clearly marked on all lifting equipment).
(d) Ensure that the sling and any other attachments are the correct size and type for the patient.
(e) Check the battery charge levels to ensure that there is adequate charge to safely complete the handling task.
(f) Visually inspect and check that the hoist is in safe working order.
(g) Follow manufacturer's instructions for its safe use.

If hip or pelvis fracture suspected In Hospital setting:

- **Use of hoist with horizontal lifting attachment and stretcher sling or an inflatable device (hoverjack) if available.**
  Do not use standard hoist sling.

In Community setting
NIAS will supply the equipment and take the lead.

If spinal injury suspected:

- **Implements spinal precautions, apply cervical collar, log roll and use hard scoop stretcher/spinal board. Patients who are experiencing or have suspected thoracic, cervical or lumbar fractures should not be lifted on the hoverjack unless in conjunction with the spinal board.**
  Do not use standard hoist sling or a soft stretcher sling.
  In Community setting
  NIAS will supply the equipment and take the lead.

Availability of Horizontal Hoisting equipment in SET	Safe Working Load	Availability
Viking 300 Bariatric Hoist with 4 point detachable loop hanger bar and mesh loop sling. Also has an interchangeable horizontal spreader bar and soft stretcher sling which will allow patients to be lifted in horizontal position	300kg /47stone	Available for use in LVH. Stored in the store room in Ward1B. This hoist is on loan to SET. Please inform the Ergonomics Team 02891872574 when moving this hoist to another ward
Maxisky 600 Hoist with 2 point detachable loop hanger bar. Used with loop slings. Also has an interchangeable horizontal spreader bar and soft stretcher sling which will allow patients to be lifted in horizontal position.	272kg / 43stone with standard hoist spreader bar. The SWL of the horizontal spreader bar will be marked on the bar	The maxisky overhead hoist is available in ICU UHD, in 8 Rooms in each ward in the New Ward Block UHD, The Physio Gym L4 UHD, the OT Assessment Room L5 UHD, Ward 1 and 2, A&E and the Physio Gym in the Downe Hospital. Horizontal attachments for overhead hoists are availa the shared store in Inpatient Ward Block (IWB) L3,L4 L5 and ICU UHD. The horizontal hoist attachment in Ward 1 in the Downe Hospital is compatible with the overhead hoist in Resus, Ward 2 and Physiotherapy Gym in the Downe.
Arjo Hoist with 4 point detachable clip spreader bar. Used with clip slings. Also has an interchangeable horizontal spreader bar and soft stretcher sling which will allow patients to be lifted in horizontal position	200kgs / 31stone with standard 4 point clip spreader bar 160kg / 25stone with horizontal spreader bar	Available for use in UHD. Stored in shared store room in IWB L3 & L6 New Build and ICU. Also available for use in the Downe Hospital Ward 2
6 Oxford Calibre Bariatric Hoists with integrated weigh scale and Bariatric Hammock Slings with integrated weigh scale	381kg/61st	Available for use in UHD. 1 stored in shared store L6 and 1 in shared store L3 IWB UHD. 1 stored in 3D, 4D,5D & 6D ASB UHD (2 slings purchased for each of the these D Wards)
Arjo Tempo Hoist 4 point spreader bar. (These hoist do not have interchangeable spreader bars so cannot provide a horizontal hoist lift)	200kg / 31stone	Bangor OPD and Ards GP Ward
Availability of other lifting	Safe Working Load	Availability

equipment in SET		
The Hoverjack is an inflatable device that will raise a supine person off the floor. The air machine needs to be plugged into an electrical socket.	SWL 544ks / 85stone 	This device is stored in a large plastic wheeled box in ward 4A IWB and 4E ASB UHD A training video is available on the following link: https://www.youtube.com/watch?v=xrLdh1Y_Dwc **Training can also be arranged with the Ergonomics Team 81134/5**
The RAIZER Chair is a portable battery operated lifting device that comes dismantled but can be assembled around a person lying on the floor. It has been designed to enable a single carer to lift a fallen person off the floor but additional help may be required for some service users. This device has been purchased for dealing with falls in Community Setting.	SWL 150kg/ 23st 	There are 4 RAIZER Chairs available. One is stored in each of the following areas. RAVARA Supported Living, Bangor. Mount Alexander Residential Care Home, Comber. Drumlough House, Lisburn. Cedar Court, Downpatrick. Follow your local procedural arrangements for accessing the RAIZER chair. Slide sheets and extension handles are also in the pack to allow someone to moved away from a tight space if required **Training can also be arranged with the Ergonomics Team 81134/5**
Abbreviations: Ulster Hospital (UHD), Lagan Valley Hospital (LVH), Inpatient Ward Block (IWB), Acute Services Block (ASB), Outpatient Department (OPD), Intensive Care Unit (ICU), Occupational Therapy (OT)		

3. Slings

A selection of hoist slings should be available within the Trust. Following use please ensure the hoist slings are properly cleaned and returned to their store area. Alternatively, patient specific slings should be kept in the patient's locker and disposed of following discharge or when soiled. Order details for hoist slings available from Ergonomics Team 0289187257.

Appendix F
Management of a patient who has fallen in hospital

The first person on the scene should check for danger to self and the fallen person. A full body check to assess for injury must be completed BEFORE the person moves/is moved. If unwitnessed fall, the person may have sustained a head injury. If the person has sustained a suspected serious injury or you are concerned, a full assessment by a medic must be completed using ABCDE principles BEFORE attempting to move the person. **Take action appropriate to your level of competence. Call or send for help if required.**

Seek medical assessment /advice before moving someone with a suspected head injury/cervical/spinal injury/pelvic/hip fracture
Injury to cervical spine may be indicated by:

- Neck pain
- Neurological deficit - limbs
- Position/height of fall
- Loss of consciousness
- Possible hip fracture
- Signs of other bony deformity
- Suspected or known knock to head/head injury
- Change in neurological status
- Abnormality in the patient's normal vital signs/National Early Warning Score (NEWS)
- Chest pain

Caution must be taken with those who are on anticoagulation/antiplatelet therapy (may be treated as at high risk of serious harm e.g. head injury). Those aged 65 or older should be considered as high risk of cervical spine injury.

Moving the fallen person following assessment
Follow injury specific pathway below depending on the person's suspected/assessed injury

No apparent injury/minor injury

If person can move independently off the floor or can move with supervision:
Options for moving -

1. Allow the person to move independently off the floor.
2. Supervise person to get up (backward chaining) - 1 or 2 chairs.

If unable to move independently or with supervision:
Use of an appropriate lifting device e.g. hoist & suitable sling/inflatable device.

It may be necessary to move the person for more space - use slide sheets from emergency handling pack.

Medical emergency/cardiac arrest/suspected pelvic/hip fracture

Following assessment and stabilisation -
Medical emergency/cardiac arrest options for moving -

1. Use of a horizontal lifting device e.g. air-assisted (inflatable) device or hoist with stretcher attachment and stretcher sling.
2. Use of hoist and standard sling **as long as the sling provides adequate head and trunk support**, maintaining trunk and head as horizontal as possible. Avoid head-down position due to risk of gastro-oesophageal regurgitation. The hoist sling is inserted using either log-roll technique or by using slide sheets.
3. Manual lifting from the floor is high risk and should only be used as a last resort. It may be required in a life threatening situation where there is imminent danger of death. A suitable lifting sheet from the emergency handling pack or scoop stretcher, if available, should be used in this case. 8 people are required (7 to lift and 1 to position the trolley under patient).

Suspected hip/pelvic fracture:

1. Use of a horizontal lifting device e.g. air-assisted (inflatable) device or hoist with stretcher attachment and stretcher sling.
2. Use of a hard scoop stretcher.
   Do not use a standard hoist sling.

It may be necessary to move the person for more space -use slide sheets from emergency handling pack.

Suspected head/spine injury

Implement spinal precautions and apply a cervical collar.
Following assessment and stabilisation:
Options for moving -

1. Use of a hard scoop stretcher/spinal board in combination with an inflatable device.
2. Use of a hard scoop stretcher/spinal board and a manual lift - 8 people are required (7 to lift and 1 to position the trolley under person).
   Do not use a standard hoist sling or a soft stretcher sling.

It may be necessary to move the person for more space - use slide sheets from emergency handling pack.

Post fall and actions after immediate clinical care

- Report to senior staff member/line manager as soon as possible. Advise family/NOK/first contact.
- Document all care - assessment including body map, plan of care, actions taken, communication (this completion is dependent on the role of the staff member). Update risk assessments. Refer to relevant professional for review, assessment and planning of care.
- Report incident using DatixWeb.
- With consent and for further support, refer the person to the Falls Prevention and Management Service (FP&MS) if the person is 65 years old or older (complete on discharge). If less than 65 years old contact the FP&MS for further support, if required (also see additional guidance within policy, part 4.6.9).
- Falls resulting in moderate or more severe harm MUST be reported to the Falls Prevention and Management Service.

Appendix G
Management of a resident who has fallen in a residential care facility

The first person on the scene should check for danger to self and the fallen person. A full body check, using ABCDE principles to assess for injury must be completed by the Band 5 senior care assistant BEFORE the person moves/is moved. If unwitnessed fall, the person may have sustained a head injury. **Take action appropriate to your level of competence. Call or send for help if required.** Ring 999 and follow instructions from NIAS paramedic if:

- it is a medical emergency/ the person has sustained a suspected head injury/cervical/spinal injury/pelvic/hip fracture
- unsure the person is injured or you are concerned

Injury to cervical spine may be indicated by:

- Neck pain
- Neurological deficit - limbs
- Position/height of fall
- Loss of consciousness
- Possible hip fracture
- Signs of other bony deformity
- Suspected or known knock to head/head injury
- Change in neurological status
- Abnormality in the patient's normal vital signs/National Early Warning Score (NEWS)
- Chest pain

Caution must be taken with those who are on anticoagulation/antiplatelet therapy (may be treated as at high risk of serious harm e.g. head injury). Those aged 65 or older should be considered as high risk of cervical spine injury.

Moving the fallen person following assessment

Follow injury specific pathway below depending on the person's suspected/assessed injury

No apparent injury/ minor injury/denies pain/advised by NIAS to proceed to move person

If person can move independently off the floor or can move with supervision:

Options for moving -

1. Allow the person to move independently off the floor.
2. Supervise person to get up (backward chaining) - 1 or 2 chairs.

If unable to move independently or with supervision:

Use an appropriate lifting device if available in the house e.g. hoist & suitable sling or RAIZER chair to move the person off the floor.

- It may be necessary to move the person for more space. Use slide sheets from emergency handling pack.
- Administer first aid if required and observe resident for 24 hours (including vital signs).
- If unwitnessed fall, the person may have sustained a head injury. Contact GP urgently for advice.

If any change in condition causing concern, ring GP or 999 in the case of a medical emergency.

Consider referral, if appropriate, to district nurse e.g. to treat a minor injury.

Medical emergency

- Ring 999 for ambulance and follow instructions e.g. if possible apply some basic first aid principles - instruct the person NOT to move and hold their head to prevent neck movement.
- Do not move the person prior to arrival of ambulance team unless danger present e.g. fire, flood, bomb, collapsing building or need more space to resuscitate. Use slide sheets from emergency handling pack.

Options for moving -

Use an appropriate lifting device e.g. hoist & suitable sling if appropriate **(NIAS will not take the lead when using hoist equipment but will assist if required).**

If suspected head/spinal injury/pelvic or hip injury:

NIAS will direct immobilisation and the move

Do not use standard hoist sling

Manual lifting from the floor is high risk and should only be used as a last resort. It may be required in a life threatening situation where there is imminent danger of death. A suitable lifting sheet from the emergency handling pack or scoop stretcher if available should be used in this case. 8 people are required (7 to lift and 1 to position the trolley under the person).

Post fall and actions after immediate clinical care

- Report to senior staff member/line manager as soon as possible. Advise family/NOK/first contact.
- Document all care - assessment including body map, plan of care, actions taken, communication (this completion is dependent on the role of the staff member). Update risk assessments. Refer to relevant professional for review, assessment and planning of care.
- Report incident using DatixWeb. RQIA reporting processes in relation to falls incidents MUST be followed.
- With consent and for further support, refer the person to the Falls Prevention and Management Service (FP&MS) if the person is 65 years old or older. If less than 65 years old contact the FP&MS for further support, if required (also see additional guidance within policy, part 4.6.9).
- Falls resulting in moderate or more severe harm MUST be reported to the Falls Prevention and Management Service.

Appendix H
Management of a patient/client who has fallen in community

The first person on the scene should check for danger to self and the fallen person. A full body check, using ABCDE principles to assess for injury must be completed BEFORE the person moves/is moved. **If unwitnessed fall, the person may have sustained a head injury.** **Take action appropriate to your level of competence. Call or send for help if required.** Ring 999 and follow instructions from NIAS paramedic if:

- a domiciliary care worker.
- it is a medical emergency/ the person has sustained a suspected head injury/cervical/spinal injury/pelvic/hip fracture
- unsure the person is injured or you are concerned

Injury to cervical spine may be indicated by:

- Neck pain
- Neurological deficit - limbs
- Position/height of fall
- Loss of consciousness
- Possible hip fracture
- Signs of other bony deformity
- Suspected or known knock to head/head injury
- Change in neurological status
- Abnormality in the patient's normal vital signs/National Early Warning Score (NEWS)
- Chest pain

Caution must be taken with those who are on anticoagulation/antiplatelet therapy (may be treated as at high risk of serious harm e.g. head injury). Those aged 65 or older should be considered as high risk of cervical spine injury.

Moving the fallen person following assessment

Follow injury specific pathway below depending on the person's suspected/assessed injury

No apparent injury/ minor injury/denies pain/advised by NIAS to proceed to move person

If person can move independently off the floor or can move with supervision:

Options for moving -

1. Allow the person to move independently off the floor.
2. Supervise person to get up (backward chaining) - 1 or 2 chairs.

If unable to move independently or with supervision:

1. Use an appropriate lifting device if available in the house e.g. hoist & suitable sling.
2. Arrange delivery of RAIZER chair to move the person off the floor.

- **It may be necessary to call for additional assistance.**
- **If during the course of movement the person complains of pain - put them into a position that is comfortable for them and ring 999 for advice.**

- Administer first aid if required and make person comfortable.
- Consider referral, if appropriate, to GP/Minor Injury Unit/ Pharmacist/District Nurse.

Medical emergency

- Ring 999 for ambulance and follow instructions e.g. if possible apply some basic first aid principles - instruct the person NOT to move and hold their head to prevent neck movement.
- Inform line manager or senior staff member as soon as possible and request additional assistance if required.
- **Do not move the person prior to arrival of ambulance team unless danger present** e.g. fire, flood, bomb, collapsing building or need more space to resuscitate. Use slide sheets if available.

Options for moving -

Use an appropriate lifting device e.g. hoist & suitable sling if appropriate **(NIAS will not take the lead when using hoist equipment but will assist if required).**

If suspected head/spinal injury/pelvic/hip injury:

- NIAS will direct immobilisation and the move.
- **Do not use standard hoist sling.**

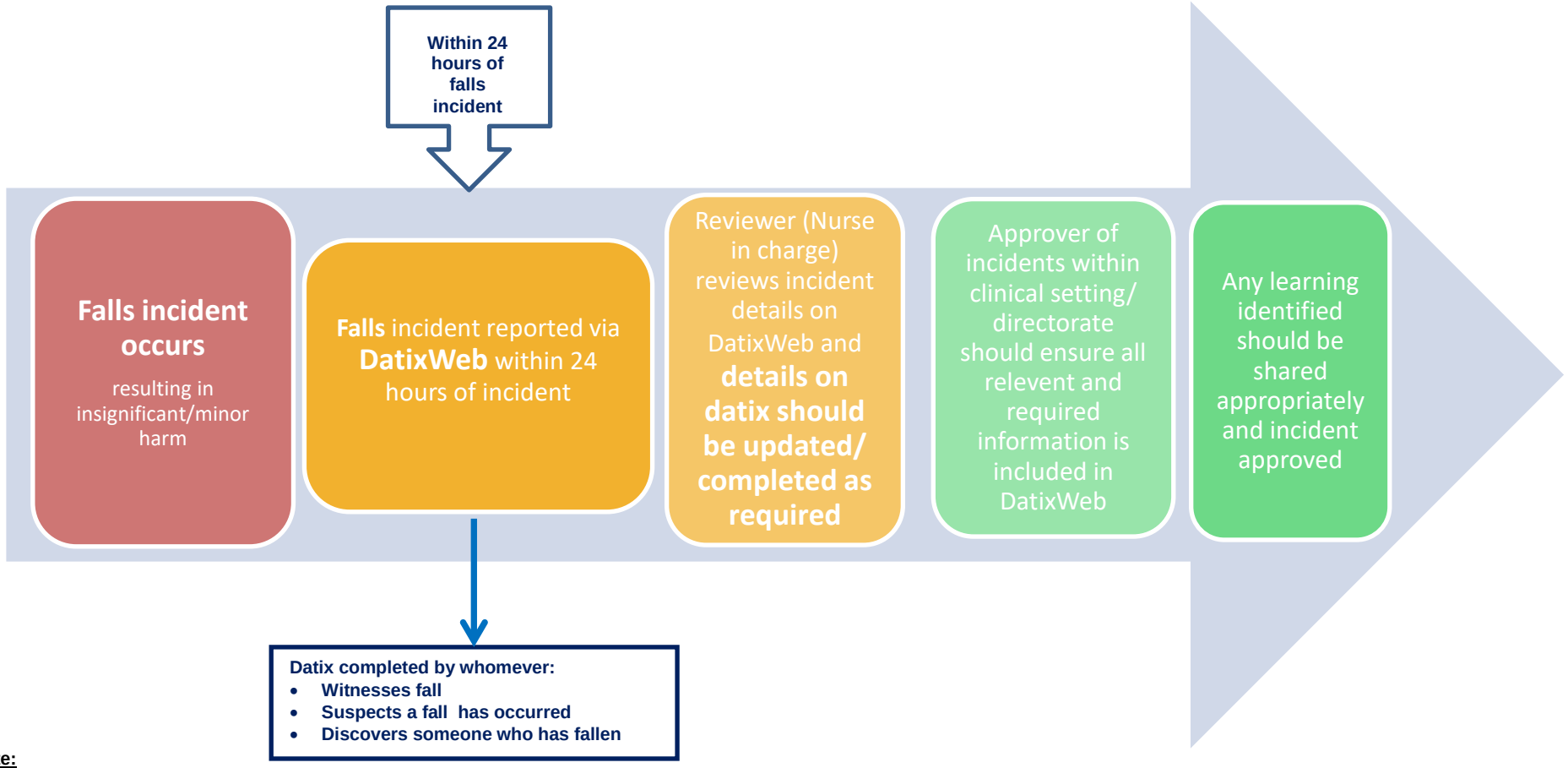
Post fall and actions after immediate clinical care

- Report to senior staff member/line manager as soon as possible. Advise family/NOK/first contact
- Document all care - assessment including body map, plan of care, actions taken, communication (this completion is dependent on the role of the staff member). Update risk assessments. Refer to relevant professional for review, assessment and planning of care.
- Report incident using DatixWeb.
- With consent and for further support, refer the person to the Falls Prevention and Management Service (FP&MS) if the person is 65 years old or older. If less than 65 years old contact the FP&MS for further support, if required (also see additional guidance within policy, part 4.6.9).
- Falls resulting in moderate or more severe harm MUST be reported to the Falls Prevention and Management Service if the person is admitted onto a professional/clinical caseload e.g. district nursing OR if fall occurs in a trust facility.

Appendix I
Information in falls incident form on DatixWeb

Time	Must be recorded in 24 hour clock
Location of fall	Must record exact location i.e. toilet, left hand side of bed
History	Has patient/resident/client history of falls
What was patient/resident/client doing when fall occurred (location)	Indicate what the patient/resident/client was doing in the incident coding section i.e. going to toilet, standing up etc.
What contributed to the fall (hazards/risks)	All contributing factors e.g. floor wet, not wearing footwear, confusion e.g. dementia, delirium
Injury sustained (severity of Harm drop down on DatixWeb)	Examples of harm Insignificant - no injury Minor - cut Moderate - fracture Major - spinal or head injury Catastrophic - death
Grading of incident	Falls should be graded by staff according to the Regional Risk Matrix (copy available within DatixWeb)

Appendix J
Post Falls Review and Shared Learning Process when a fall occurs resulting in insignificant/minor harm

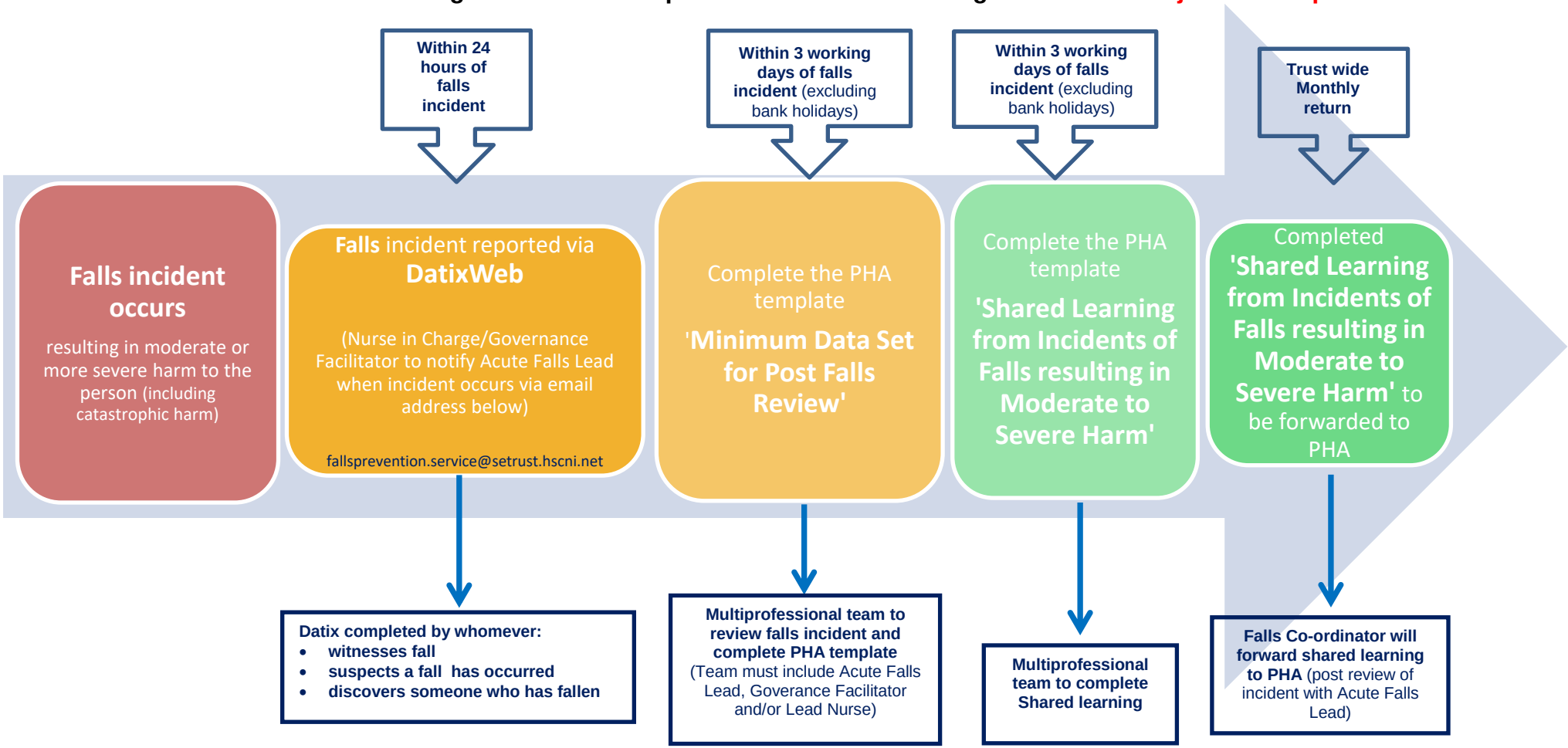


Note:

- All relevant documents must be uploaded to DatixWeb.
- The above must be completed in conjunction with SET processes and policies in relation to incident reporting and escalation.
- Consult with the Falls Prevention and Management Service for analysis/support, as required (guidance within policy, part 4.6.9)

Appendix K

Post Falls Review and Shared Learning Process when a patient fall occurs resulting in moderate/major/catastrophic harm



Note:

- On completion of the PHA incident review and shared learning templates, the Acute Falls Lead will upload all relevant documents to DatixWeb.
- The above must be completed in conjunction with SET processes and policies in relation to incident reporting and escalation.

Appendix L
Post falls review minimun data set for falls resulting in moderate/major/ catastrophic harm

HSC Public Health Agency

Minimum Data Set for Post Falls Review

(Falls resulting in Moderate to Severe Harm)

This is the Minimum Data Set for HSC Trust Post Falls Review as agreed by the Regional Inpatient Falls Prevention Group. **A post falls review should be carried out within 72 hours of the incident being discovered (5 working days at bank holidays)**	
Date Dataset agreed: 14/06/2016	**Agreed**
Demographics & further information	
Date of Post Fall Review	**Agreed**
Lead Reviewer Name	**Agreed**
Lead Reviewer Designation	**Agreed**
Lead Reviewer Contact Tel No.	**Agreed**
Patient Name	**Agreed**
Patient D.O.B.	**Agreed**
Gender	**Agreed**
Hospital No./H&C No.	**Agreed**
Consultant / GP	**Agreed**
Ward/Dept/Location of fall	**Agreed**
Date and time of admission	**Agreed**
Reason for admission	**Agreed**
Diagnosis on admission	**Agreed**
Date & Time of Incident	**Agreed**
Incident Reference No.	**Agreed**
Type of injury (include investigations/ x-rays performed)	**Agreed**
Assessment	
Was a falls assessment carried out within 6 hours of admission? Include Date and Time of Assessment	**Agreed**
If assessment was performed what was the outcome of assessment (action required/taken)?	**Agreed**
Elements of Falls Bundle – Part A & Part B completed: (Y/N) **Falls Bundle Part A** • Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed – if applicable • Avoidance of new prescription of night sedation • Call bell in sight and reach and did patient understand how to use this? • Safe footwear on feet at time of incident • Immediate assessment and provision of walking aids and referral if applicable • Clear communication regarding mobility status	**Agreed**

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HSC Public Health Agency

Minimum Data Set for Post Falls Review

(Falls resulting in Moderate to Severe Harm)

• Personal items within reach • No slips or trips hazards **Falls Bundle Part B** • Cognitive screening • Lying and standing blood pressure record • Full Medication review requested • Bedrails risk assessment	
Is this the patients first fall (this admission)? If no – give number of falls this admission including dates and times of day/night	Agreed
Was the patient assessed for urinary continence/ frequency/ urgency?	Agreed
Any additional contributory factors – e.g. environment, staffing issues, patients clinical condition, previous medical history	Agreed
Do you have documented evidence when the patient's falls assessment / care plan, bed rail & manual handling assessments were last reviewed before the fall: • whenever their condition changed (e.g. deteriorating health, or development of confusion • Following an incident or fall • Transfer to another ward	Agreed
Was the fall witnessed? If yes - by whom? (Staff - provide name and designation/ relative/other patient etc.)	Agreed
Was a body check completed prior to moving patient post fall?	Agreed
What was the immediate post fall management in terms of how the patient moved?	Agreed
Was a falls action plan instigated/reviewed following this fall?	Agreed
Was the incident discussed with patients next of kin? – informed of incident & explanation given – when and to whom?	Agreed
If appropriate, do you have documented evidence that the patient was given written/verbal advice on falls prevention? – Prior to falling as well as after - if so date & time given to patient	Agreed
Multi-disciplinary team meeting required?	Agreed
Has a Post Falls Assessment been completed by medical staff? – date, time & medical staff name	Agreed
Was medical treatment plan implemented? If so, provide details	Agreed
Was the Post Falls Protocol / Process Followed? If no – ensure elements are identified within the shared learning template	Agreed
Following your review of care provided, what do you think were the contributory factors to the falls incident?	Agreed

On completion of the Post Falls Review a shared learning template should be sent to:

falls.learning@hscni.net

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Appendix M
The PHA Shared Learning Template for falls resulting in moderate/major/ catastrophic harm

Shared Learning from Incidents of Falls resulting in Moderate/Major/Catastrophic Harm

Incident Reference Number:	**Date:**

Summary of event

What Happened? ***(include contributory factors such e.g. clinical condition and primary reason(s) for why fall occurred e.g. bed rails not in place)***

Severity of incident: ***(Moderate/Major/Catastrophic)***

Learning points

What went well? ***(Examples of good practice identified e.g. falls risk assessment completed and evidence of timely review)***	***What could we improve?***

What have we learnt?

(What changes have been implemented and when?)

(Who has been informed and how has this been communicated?)

Learning applicable to:

Specific Directorate(s) (specify):		Trust wide	
Other (specify):		Regional	

Approved by:	Designation:	Date approved:

Please submit this form to falls.learning@hscni.net

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