Prevention and Management of Slips, Trips and Falls

Document Summary

This policy provides guidance on prevention and management of slips, trips and falls for patients in CPFT

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1. Introduction to this document

Patient falls are one of the most frequently reported incidents within Cumbria Partnership NHS Foundation Trust. The nature of the patients to whom services are provided and the philosophy which supports active enablement, deems that the risk of the patient falling is ever present. However, it is important that the risk be maintained at a minimum level, whether the patient is admitted following a fall or assessed as being at risk of falling once admitted.

Patients who have fallen prior to admission or who present to hospital following a fall are at high risk of falling whilst an inpatient. Reducing the risks of these falls can be achieved by comprehensive and systematic risk identification and positive co-coordinated multidisciplinary management and intervention.

The evidence base and interventions contained in this policy are specific to patients 65 years and over. However, risk assessment and interventions may be applied to any group or setting and to any fall, including those from a height.

2. Scope

This policy applies to inpatient settings under the control of Trust, and to all work activities undertaken by Trust-employed staff providing direct care, supervision of staff or in support services

The policy is aimed at inpatient settings. The policy describes the expected assessments and interventions that are to be used to assess and manage the risk of falls, the reporting of falls incidents and the management of post falls care effectively. There is reference where possible to community settings, with advice on the management of falls in non-inpatient settings.

3. Introduction

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety agency (2011) states that each year around 282,000 patient falls are reported to the NHS England’s Patient Safety division from hospitals and mental health units.

A significant minority of these falls result in death or in severe or moderate injury. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the
NHS more than £2.3 billion per year. Therefore, falling has an impact on quality of life, health and healthcare costs.

Even “trivial” injuries are not always so “trivial” in their consequence for the older person. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falls can only be prevented or the risk minimized if the reason for a person falling can be identified. This can only be accomplished by thorough assessment and development of an individualised plan of care.

4. **Statement of Intent**

The purpose of this policy is

- ensure that an integrated inter-professional approach is adopted for the management of all patients who are at risk of falling or who have already fallen
- ensure that each individual patient has an adequate falls assessment undertaken and an appropriate management plan initiated and implemented.
- assist clinical decision making about appropriate care and treatment.

5. **Definitions**

- **A fall** is defined as an unintentional or unexpected loss of balance resulting in coming to rest on the floor, the ground or an object below knee level. A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as an acute arrhythmia, a transient ischaemic attack or vertigo. (NPSA 2012)
- **Falls Pathway:** is the algorithm or flow chart that guides the patient journey from admission to discharge
- **Fall Risk Assessment and Management Plan (FRAMP)** – the document to support the risk assessment and management process.
- **Bedside rails** are rails on the sides of beds, sometimes referred to as cot sides, side rails or safety rails
- **Ultra low bed:** (Hi/Lo bed): one that lowers to less than 30cm from the mattress to the floor
- **Falls Alarm:** an early warning system that alerts staff when the patient attempts to stand unsafely or leave the bed without assistance, can be a permanent fixture, a bed sensor or a chair sensor (as assessed as appropriate)
- **Root cause analysis**: a framework for reviewing and analysing patient safety incidents to identify and recommend areas for change.

6. **Duties**

a) **Quality and Safety Leads (inpatients) are responsible for**

   - Leading the implementation of the falls policy.
   - Leading and coordinating an audit programme to monitor the effectiveness of the policy.
   - Providing 6 monthly reports to the Clinical Governance groups.

b) **Training Department** are responsible for

   - Promoting and incorporating falls training in professional, inpatient and support services development

c) **Medical staff** are responsible for;

   - Taking and documenting a falls history, including the assessment of falls and fracture risk factors for all patients screened as at risk of falls on admission and/or following a fall
   - Conducting and documenting a full review of each patient following a fall. The timing will be dependent on the clinical status of the patient and may be immediately following a fall or on the next routine ward visit
   - Liaising with all relevant staff with regard to identified risk factors and management plan

d) **Senior Network Managers/Community Hospital Managers** are responsible for:

   - Supporting line managers to release staff for trainings/meetings
   - Working directly with line managers to address issues raised by falls root cause analysis action plans

e) **Professional Leads** are responsible for:
Identifying training requirements across their areas of practice and ensuring these are addressed in staff development and training

f) **Registered nursing staff** are responsible for:
   - Undertaking and documenting an assessment for a patient on admission
   - Liaising with all relevant staff with regard to identified risk factors
   - Reassessing as required.
   - Reviewing risk factors if the patient sustains a fall and informing all relevant staff/carers in a timely manner.

7. **Arrangements/Detail**

7.1 **Screening and assessment**

It is a requirement to ensure that each individual patient has an adequate falls assessment undertaken and an appropriate management plan initiated and implemented. The evidence-base and interventions contained in this policy are specific to patients 65 years and over or people judged by a clinician to be at a higher risk of falling because of an underlying condition. However, risk assessment and interventions may be applied to any group or setting and to any fall, including those from a height.

The FRAMP is the risk screening and falls prevention and management tool to be used in all inpatient areas. The FRAMP contains all the identified predictors of falls risk as defined by the National Inpatient Falls Audit (NAIP 2015) and is tailored to meet the needs of each individual patient. It also facilitates a shift by shift check of interventions in place to minimise the risk of falling.

Risk prediction tools will NOT be used as there is no evidence base (NICE, 2013).

7.2 **Measures that may be implemented to minimise the risk of falls**
7.2.1 General interventions and environmental checks

All patients must be orientated to the bed, toilet, and bathroom and ward area on admission. Drinks, food, walking aid and belongings must be placed within easy reach of the patient whether in bed or sitting in the chair. There should be clear signs to make it easy for patients to see where bathrooms and toilets are.

The ward environment must be clutter free and clear from obstacles. Floors should be even, clean and no slip. Reviewing the journey that a patient is required to make, for example from the bed to the toilet, avoiding obstacles such as trolleys, chairs and trailing wires are important measures in minimising risk of falls.

Patients must be warned of the potential risk of tripping up over items of equipment eg catheters, drips and drains, when mobilising and request assistance if required.

Appropriate lighting, use of night lights, accessible toilets and bathrooms with handrails and space to stand and turn safely, availability of chairs and perching stools all contribute to an environment that reduces the risk of a patient falling.

All staff have responsibilities to take reasonable care for the health and safety of themselves and others. Spillages should be isolated and cleaned immediately and hazard signs should be displayed.
7.2.2 **Call Bell**

Every patient must be shown how to use the call bell system, and be able demonstrate how it works. The call bell must be in sight and in reach of the patient. Patients must be reassured and encouraged to use the call bell.

If a patient has cognitive impairment, communication problems and/or lacks capacity to use a call bell, there must be a documented alternative plan to ensure patients individualised needs and requirements are met.

7.2.4 **Eyesight and Hearing**

Patients have access to own, clean spectacles and hearing aids that work. ENT/optometry referrals made as required.

7.2.5 **Footwear**

Patient’s footwear must be assessed on admission as appropriately well fitting and non slip, Relatives/or carers should be encouraged to provide appropriate footwear and where that is not possible, wards will need to supply.

7.2.6 **Observation of Patients**

As a minimum, every hour a patient will be seen and needs met, for example toileting offered, providing drinks, ensuring all belongings are close by. Exceptions to this will be within the patient care plan. Checks are recorded on the Skin and Safety Checks (Community Hospitals)

Some patients may need to be positioned in a more observable bed. This may be in bay or a side room close to a nurse’s observation station. If a patient needs to be moved to a side room for a clinical reason i.e. infection prevention, then a risk assessment should be undertaken to ensure the risk of falling is mitigated.

Some patients, who are identified as at high risk of falling, may require enhanced observation in the form of 1:1 nursing.

Some patients who are confused, wandering and are unsteady will be at greater risk of falling and 1:1 nursing may be required. The level of supervision required and provided needs to be recorded in care plan documentation and handed over at each shift change. Any additional staffing requirements needed to meet this need should be escalated to the appropriate manager as soon as is possible.
7.2.7 Pressure Sensor Equipment

The use of pressure sensor equipment as a falls prevention strategy can potentially reduce the risk of a patient falling, if trying to move from the bed or chair without requesting assistance. A chair and/or bed sensor is used to alert staff when a patient is mobilising independently but has been assessed as unsafe to do so. An alarm is emitted when the patient moves from the bed or chair. However, it must be highlighted that there is no guarantee that by using these sensors that a patient will still not fall.

NICE (2015) currently does not include the use of pressure sensor equipment in their guidance as there is currently not a sufficient evidence base to encourage/discourage their use. The use of this type of equipment needs to be assessed on an individual patient basis and the use of such equipment does not negate the need for frequent checks on patients.

7.2.8 Low Profile Beds

Low profile beds can be used if a patient is assessed as “at risk of falling from a bed but bedrails are inappropriate/or unsafe”.

Consideration should be given to the use of low profile beds and patients should be assessed individually to ensure that this is the safest and appropriate method of preventing a patient potentially falling from their bed.

7.2.9 Cognitive impairment and delirium

Clinical staff are able to assess patients for any acute changes in cognitive function by carrying out cognitive tests. Routinely assessing at admission will aid this process. Recent changes or fluctuating cognitive problems can indicate delirium that requires medical attention. (NICE guidance on delirium CG 103)

Patients who are confused and wandering in ward areas can be at risk of falls, so it is important that sources of delirium (such as infection) are identified and treatment commenced. Routine urinalysis must be performed in patients who are either confused or have urinary symptoms during admission, to rule out the possibility of urinary infection causing falls and delirium.

7.2.10 Medication

Patients can be at risk of falling if they are on certain medications which may be sedating, induce confusion or continence problems, slow reaction times, cause symptomatic hypotension or systolic drop on standing. The pharmacist, pharmacy technician or medical staff can be used to review medication likely to increase the risk of falling.
Patients will require completion of a lying and standing blood pressure. The need to complete this measurement will be based on an initial medical assessment on admission to hospital, in addition to investigating underlying causes of unexplained falls or collapse.

| Measurement of lying and standing blood pressure as part of a multi-factorial falls risk Assessment |

**Procedure:**
Identify if you are going to need assistance to stand the patient and simultaneously record a BP.
Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
1. Explain procedure to the patient.
2. The first BP should be taken after lying for at least five minutes.
3. The second BP should be taken after standing in the first minute
4. A third BP should be taken after standing for three minutes
5. This recording can be repeated if the BP is still falling
6. Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented.
7. A positive result is: a. A drop in systolic BP of 20mmHg or more (with or without symptoms)
   b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg. (with or without symptoms)
   c. A drop in diastolic BP of 10mmHg with symptoms (although clinically much less significant than a drop in systolic BP)
8. Advise patient of results and if the result is positive, a. inform the medical and nursing team
   b. take immediate actions to prevent falls and or unsteadiness.
9. In the instance of positive results, repeat regularly until resolved.
10. If symptoms change, repeat the test.

https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-bloodpressure-brief-guide-clinical-staff

A drop of 20mmHg systolic or 10mmHg diastolic may indicate the need for further review of medication and consideration of referral to specialist if symptoms persist. For more information regarding lying and standing see the RCP guidance cited in O’Riordan S, Vasilakis N, Hussain L et al (2017)
7.2.11 **Continence**

Patients can be more at risk of falls if they have urgency or incontinence. A full assessment including urinalysis needs to be undertaken and referral to continence service as appropriate.

A patient who is assisted to use the commode or taken to the toilet, must be risk assessed if left alone for any length of time. The risk assessment must include reviewing a patient’s ability to use the call bell to request assistance and balancing this with privacy, dignity and autonomy of the patient.

Each patient should have a tailored plan to address individual needs and concerns.

7.2.12 **Balance and Mobility**

On admission to CPFT, all patients receive a moving and handling assessment (DIAG) which is periodically reviewed during the patient journey. Physiotherapy staff will review patients who require balance, mobility and strength assessment.

Mobility aids will be provided as appropriate and advice given to both patients and staff of plans to reduce the risk of falls. The FRAMP p4 has a section to document discussion with patient/family re falls interventions in place.

7.3.13 **Patients, relatives and carers**

Relatives and carers can provide vital information in helping prevention of falling. If a patient is at risk of falling, the plan of care should be discussed with the patient and relatives/or carers as appropriate.

7.3.14 **Environmental Risk Assessment**

Staff working on in-patient wards and relevant support services should be aware of the following:

- The need to have brighter lights and to be able to find the light switch at night time
Beds and chairs must meet be available to meet the needs of each individual in terms of stability, support and height

Special attention needs to be paid to bathroom areas and need to be adapted. The pathway to the toilet and bathroom areas must be clearly marked, lit and free from obstacles

8 Post Falls management

NICE (2015) states that -

Service providers (NHS organisations with inpatient beds, such as district hospitals, mental health trusts and specialist hospitals) ensure that staff have access to and follow a post-fall protocol that includes -

- undertaking checks for signs or symptoms of fracture and potential for spinal injury before moving an older person who has fallen.
- using safe manual handling methods to move older people who have fallen in hospital and have signs or symptoms of fracture or potential for spinal injury.
- timescales for medical examination for older people who fall during a hospital stay.

Healthcare professionals:

- use safe manual handling methods to move older people who fall in hospital and have signs or symptoms of fracture or potential for spinal injury.
- check older people who fall in hospital for signs or symptoms of fracture and potential for spinal injury before moving them.
- medically qualified staff complete medical examinations within the timescales specified in their organisation's post-fall protocol for older people who fall in hospital.
- undertake a multifactorial falls risk assessment for older people who present for medical attention because of a fall, or refer them to a service with staff who are trained to undertake this type of assessment.

The algorithm (appendix 2) must be implemented if a patient falls.

8.1 The key priorities in the management of an inpatient fall are:

- Prompt and accurate assessment of the patient for any sign of serious harm prior to moving them
- Use of appropriate moving aid as required eg rigid scoop if spinal injury or fractured femur suspected
- Completing neurological observations if a patient has sustained a head injury and/or the fall was unwitnessed (NICE Head injury guidance CG56) See Appendix 6.
- Medical review including urgent request for tests/or investigations, prompt follow up of completed investigations
- Timely escalation to acute care for further investigation and specialist care as needed
- Multi-disciplinary review of fall to consider further mitigation of risk needed, and an update of the FRAMP

### STOP and CONSIDER

**Patients on anticoagulant, antiplatelet therapy and/or patients with a known coagulopathy are at an increased risk of intracranial, intrathoracic, intraabdominal haemorrhage**

**There may be late manifestations of head injury up to 72 hours**

**Immediate post falls procedures**

- Do not move patient initially, reassure the patient
- Call for assistance
- Immobilise cervical spine if head and neck injury is reported or suspected using a hard collar
- Check for other potential injuries
- The head, neck, clavicles, shoulders, wrists, hips and ankles should be examined
Identify sites of tenderness/swelling/deformity and range of movement e.g. shortened, externally rotated leg may indicate a hip fracture

Record National Early Warning Score (NEWS) and escalate as per algorithm on NEWS chart.

9 Falls in the community/non in-patient setting

The management of the risk of falling in the community setting is as complex as inpatient settings with the added risk of the clinician not being able to control the environment and/or observe the patient as within our inpatient settings. The key priorities (8.1) are applicable in community settings, only moving the patient once they have been assessed for the level of harm, the recording of observations where possible, establishing a level of consciousness and requesting a medical review/999 dependent of the suspected level of harm. Following the fall incident reporting and clear documentation within the patient record are essential.

All older people (aged over 65 years) in contact with a health care professional should routinely be asked whether they have fallen in the last 12 months; and if so should be asked about the frequency, context and characteristics of the fall

- Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance
- Older people who present for medical attention because of a fall, or report recurrent falls in the past year should be offered a multi-factorial falls assessment.

If a patient presents with an injurious fall, 2 or more falls or unsteady gait, then the Multifactorial falls assessment of risk factors and intervention tool (Appendix 8) must be completed.

Community Teams within CPFT use a multi factorial and osteoporosis risk assessment. This standardises the assessment throughout Cumbria. Ensuring that when a falls risk assessment is required every adult patient where in contact with Nurse, OT or Physiotherapist receives a standard initial falls assessment.
10 Incident reporting and analysis of falls

All patient slips, trips and falls, including bedrail incidents must be reported on the Ulysses reporting system. A record of the fall must be documented in the patient record and a note made of the incident number.

In the event of moderate, severe or fatal harm resulting from an inpatient fall, the incident must be escalated by the ward or department where the fall happened to ensure that a root cause analysis investigation is undertaken, Duty of Candour (CQC 2015) is applied and consideration is to be given to declaring a Serious Incident Requiring Investigation (SIRI) for all falls where severe harm is sustained. (NHS England 2015)

Themes and learning from all investigations will be disseminated through Care Group Governance Structures to ensure the learning is shared across the Networks.

- Training

There is currently no mandatory training associated with this policy. Individual training needs will be identified through annual appraisal and supervision although it is recommended that all clinical staff complete the e-learning package ‘Preventing Falls in Hospital’ accessible via OLMS (Accessible via smartcard e-learning)
- **Monitoring compliance with this policy**

The table below outlines the Trusts' monitoring arrangements for this policy. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

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<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
<th>Group / committee / individual responsible for ensuring that the actions are completed</th>
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<td>Falls for inpatients are monitored by occupied bed days</td>
<td>Ulysses Incident Reporting Method  Every month</td>
<td>Quality &amp; Safety Leads for each Care Group</td>
<td>Monthly</td>
<td>Care Group Clinical Governance Meetings</td>
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<td>Biannual Falls report to TWG  NB: Includes schematic review</td>
<td>Quality &amp; Safety Leads for each Care Group</td>
<td>Biannual report</td>
<td>Trust Wide Governance</td>
<td>Associate Directors of Nursing</td>
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</table>
References/ Bibliography


NICE (2015). Falls in older people; assessment after a fall and preventing further falls. (NICE Quality Standard 86). Available at: https://www.nice.org.uk/Guidance/QS86

NPSA (2011) Essential care after an inpatient fall, Rapid Response Report RRR01, Available at: http://www.nrls.npsa.nhs.uk/alerts/?entryid45=94033


Related Trust Policy/Procedures

Safe and Effective Use of Bedrails POL-001-047

Incident and Serious Untoward Incident and Near Miss Reporting Policy POL/002/006

Implementation of NICE guidance POL/001/030

Promote privacy, dignity & respect policy POL/001/043
Appendix 1 - Managing Inpatient Falls

In Patient Fall

Ward Staff – Assess Patient / Nature of Fall

Immediate actions – ABCDE, procedure as post fall checklist – check GCS + complete NEWS

Consider the following actions

Perform ECG

Witnessed fall WITHOUT visible injury and patient stable.

Monitor patient.

Medical review next routine ward visit

Witnessed fall WITH visible injury and / or general deterioration since fall.

Medical review required

Unwitnessed fall WITHOUT visible injury and assumed head injury.

Urgent medical review required

Unwitnessed fall WITH injury and assumed head injury.

Urgent medical review required

Suspected spine or hip injury.

Urgent medical assistance required

Daytime refer to duty Dr

Nursing staff

DOCUMENT ALL INTERVENTIONS WITH RATIONALE FOR ACTION TAKEN - All staff.

COMPLETE INCIDENT FORM - Nurse in charge of care of patient or witness to fall.

UPDATE THE FRAMP, INFORM RELATIVES AS APPROPRIATE

HAND OVER INCIDENT TO ONCOMING SHIFT

Glasgow coma scale (all falls where there may be a suspected head injury)

GCS 15 normal continue to monitor every 30 mins for a minimum of 2 hours from time of fall, then hourly for 4 hours, then 12 hourly for 6 hours. If GCS drops, call doctor again.

Note 14 may be the normal score for some patients with a history of cognitive problems
## Appendix 2 – Post falls algorithm (inpatients)

### Does not hit head
- Assess circulation, airway, and breathing.
- Call for assistance.
- Do not move the patient until he/she has been assessed for safety to be moved.
- Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call ward GP or out of hours CHOC/999 dependent on suspected severity of injury. Use hard collar where possible to immobilize cervical spine. Where not available hold head firm. If a fracture of femur is suspected, do not use hoist with sling, use Hoverjack Call Dr/999 immediately.
- Identify all visible injuries and initiate first aid; for example, cover wounds.
- Assist patient to move using safe handling practices.

### Hits head or has unwitnessed fall
- Assess circulation, airway, and breathing.
- Call for assistance.
- Do not move the patient until he/she has been assessed for safety to be moved.
- Examine cervical spine and if there is any indication of injury do not move the patient; instead, immobilize cervical spine, and call ward GP/DR or out of hours CHOC/999 dependent on suspected severity of injury. Use hard collar where possible to immobilize cervical spine. Where not available hold head firm. If a fracture of femur is suspected, do not use hoist with sling, use Hoverjack Call Dr/999 immediately.
- Assess Glasgow Coma Scale (next page).
- Identify all visible injuries and initiate first aid; for example, cover wounds.
- Assist patient to move using safe handling practices.

### Proceed to:
- Record neurologic observations, including Glasgow Coma Scale. Observe for signs indicating stroke, change in consciousness, headache, amnesia, or vomiting.
- Check observations and record NEWS (follow algorithm on NEWS chart)
- Clean and dress any wounds.
- Contact GP and arrange review within 4 hrs (if observations change request urgent review)
- Provide analgesia if required and not contraindicated.
- Arrange further tests as indicated, such as blood sugar levels and x-rays.
- Review current FRAMP and care plans and implement additional fall prevention strategies.
- Complete incident form.

### Observations:
- Continue observations at least every 4 hours for 24 hours or as required.

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### Proceed to:
- Record neurologic observations, including Glasgow Coma Scale. Observe for signs indicating stroke, change in consciousness, headache, amnesia, or vomiting.
- Check observations and record NEWS (follow algorithm on NEWS chart)
- Clean and dress any wounds.
- Contact GP and arrange review within 4 hrs (if observations change request urgent review)
- Provide analgesia if required and not contraindicated.
- Arrange further tests as indicated, such as blood sugar levels, x rays, ECG, and CT scan.
- Review current FRAMP and care plans and implement additional fall prevention strategies.
- Complete incident form

### Observations:
- Record vital signs and neurologic observations at least hourly for 4 hours and then review.
- Continue observations at least every 4 hours for 24 hours, then as required.
- Notify Dr/GP immediately if any change in observations.
**Glasgow Coma Scale**

The Glasgow Coma Scale provides a score in the range 3-15; patients with scores of 3-8 are usually said to be in a coma. The total score is the sum of the scores in three categories. For adults, the scores follow:

**Activity Score**

**Eye opening**

None 1 = Even to supraorbital pressure
To pain 2 = Pain from sternum/limb/supraorbital pressure
To speech 3 = Nonspecific response, not necessarily to command
Spontaneous 4 = Eyes open, not necessarily aware

**Motor response**

None 1 = To any pain; limbs remain flaccid
Extension 2 = Shoulder adducted and shoulder and forearm rotated internally
Flexor response 3 = Withdrawal response or assumption of hemiplegic posture
Withdrawal 4 = Arm withdraws to pain, shoulder abducts
Localizes pain 5 = Arm attempts to remove supraorbital/chest pressure
Obeys commands 6 = Follows simple commands

**Verbal response**

None 1 = No verbalization of any type
Incomprehensible 2 = Moans/groans, no speech
Inappropriate 3 = Intelligible, no sustained sentences
Confused 4 = Converses but confused, disoriented
Oriented 5 = Converses and oriented

**TOTAL (3–15): _______**
Appendix 3 - Post falls guidance (in patient’s own home/clinic setting)

Standard Operating Procedure for management of patients who fall in their own home/clinic setting

Aim:

This SOP provides guidance for community staff for a patient has fallen in their own home/clinic setting

Procedure:

If the patient is still on the floor:

- Check the environment is safe for self, patient and others and take appropriate steps to make safe if possible. If it is not safe to approach the person (e.g. electricity), provide reassurance if the patient is conscious and call the appropriate emergency services for assistance.

- If the environment is safe scan the patient for injuries, check for pain, bleeding, swelling, lacerations, abnormalities or deformities.

- Take the appropriate first aid action if required in line with role and competence. If there are concerns that the patient may be seriously injured (for example shortening or rotation of a limb) do not move the person and call an ambulance. If an ambulance is requested, make the patient as comfortable as possible and give reassurance. (if clinic setting within a hospital – contact the ward staff for advice on use of equipment/hoisting)

- If the person is able, encourage them to turn on to their hands and knees and place a chair or other sturdy object close to them so that he/she can lever him/herself up. If the patient reports pain at any time stop and reassess the need for emergency services assistance.

If the person is unable to get him/herself up with minimal assistance do not attempt to lift them.
• Stay with the patient and provide reassurance.
• Call emergency services if indicated.
• Make the person as comfortable as possible using pillows, cushions, blankets or other supportive objects and provide reassurance.
• Contact as many colleagues as may be necessary to attend and assist.
• Agree on the actions to be taken.
• One staff member to take the lead.
• Using recognised moving and handling techniques move the patient in small stages allowing time between each movement to reassess the patient’s condition and plan the next movement until they are in a position to be transferred to a chair or bed.

If the patient reports pain at any time **stop** and reassess the need for emergency services assistance or contact the patient’s GP or Out of Hours GP service for instruction regarding administration of pain relieving medication.

**THEN:**

• Reassess the patient and take appropriate first aid actions if necessary.
• Record BP lying/sitting/standing if possible.
• Contact the patient’s GP or out of hours’ service to establish if U&Es and FBC blood tests are required and the time frame for the blood to be taken.
• Arrange for a urinalysis to be undertaken at the earliest convenience.
• With the patient’s consent contact their family or carers to inform them of the event.
• Refer to appropriate service for a falls assessment
• Document the outcome of the incident and complete an incident form
Appendix 4 - Hoverjack

Short Guide to raising the fallen patient

- Connect air supply to mains using extension lead if needed.
- Lay out Hovermatt and Hoverjack making sure the chamber with Valve #4 is on the top and the chamber with Valve #1 is against the floor; ensure the 4 red caps are fastened.
- If hip fracture is suspected unravel slide sheet under patient without rolling patient and slide on to Hovermatt. Remove slide sheet. If no suspected fracture the patient can be rolled and Hovermatt placed under them.
- The feet can extend over the matt but the head must not.
- Loosely fasten straps over patient
- Connect the air supply to the Matt and inflate, leave pump connected and running.
- Move the Matt with patient onto Hoverjack, foot end is marked and is the end with valves. Ensure central position.
- Turn pump off and disconnect from Matt.
- Hold pump over valve #1 on Hoverjack turn on and **fully inflate**, a change in tone of the pump can be heard when fully inflated. Continue to inflate in sequence, #2, #3, and #4 turn off pump.
- Use handles on Hoverjack to slide patient next to transfer surface.
- Reconnect pump to Matt, switch on and slide patient on to bed/trolley. Switch off and disconnect.
- To deflate Hoverjack red caps are unscrewed, to avoid a sudden rush of air from the valve some air can be removed by placing a finger into the inlet valve prior to removing the red cap.

**Please ensure that you have received training in the use of the Hoverjack and are familiar with the manufacturer’s directions for use**
### Appendix 5 - Harm Descriptors: a guide

The descriptors in the table below describe the level of harm to be reported against the injury type.

<table>
<thead>
<tr>
<th>Level of harm</th>
<th>Descriptor of harm</th>
<th>Examples of injury per harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>No harm</td>
<td>Fall occurred but with no harm to the patient</td>
<td></td>
</tr>
<tr>
<td>Low/minor harm</td>
<td>Harm requiring minor/first-aid level of treatment only</td>
<td>Bruises, soreness, redness, abrasions, grazes, skin flaps and cuts (without suturing), may need steri strips</td>
</tr>
<tr>
<td>Moderate harm – Duty of Candour applies.</td>
<td>Harm is likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital, but a full recovery is expected</td>
<td>Fractured clavicle, fractured pubic rami, laceration requiring suturing, fractured wrist.</td>
</tr>
<tr>
<td>Severe/Major harm – SIRI to be considered, STEIS reportable.</td>
<td>Harm causing permanent disability; the patient is unlikely to regain their previous level of independence</td>
<td>Head injury-developed or diagnosed with an intracranial bleed/have become unconscious and unresponsive, hip fractures requiring surgery Confirmed spinal injury</td>
</tr>
<tr>
<td>Death – SIRI/STEIS reportable.</td>
<td>Death was the direct result of the fall</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6 – The FRAMP

Cumbria Partnership NHS Foundation Trust

FALLS RISK ASSESSMENT AND MANAGEMENT PLAN (FRAMP)

WARD: __________________________

SURNAME: __________________________
GIVEN NAMES: __________________________
DOB: __________________________
GENDER: __________________________
ADDRESS: __________________________
POSTCODE: __________________________
TELEPHONE: __________________________

On this shift has the patient:
Been admitted or transferred from another ward; or
Had a fall; or Medically deteriorated or improved?

YES TO ANY

NO TO ALL

Confirm previously assessed interventions are in place as per Shift by Shift check on page 3

---

Initial Screen: c Admitted c Ward Transfer c Post Fall c Medical Condition Change
c Previous FRAMP full

Does the patient meet any of the following: Circle Yes or No
1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO
5. Prescribed any medication that may have a sedative effect? YES / NO

Name: __________________________
Date: ____________ Time: ____________ Signature: __________________________

Ward: ________

---

Re-Screen 1: c Ward Transfer c Post Fall c Medical Condition Change

Does the patient meet any of the following: Circle Yes or No
1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO
5. Prescribed any medication that may have a sedative effect? YES / NO

Name: __________________________
Date: ____________ Time: ____________ Signature: __________________________

Ward: ________

---

Re-Screen 2: c Ward Transfer c Post Fall c Medical Condition Change

Does the patient meet any of the following: Circle Yes or No
1. Had a fall in the past 12 months? YES / NO
2. Unsteady when walking/transferring or uses a walking aid? YES / NO
3. Confused, known cognitive impairment or incorrectly answers any of the following: Age, Date of birth, Current year and Place? YES / NO
4. Has urinary or faecal frequency/urgency or nocturia? YES / NO
5. Prescribed any medication that may have a sedative effect? YES / NO

Name: __________________________
Date: ____________ Time: ____________ Signature: __________________________

Ward: ________

---
### Risk Assessment and Individualised Interventions

#### Mobility Risks
- **Does the patient require assistance with mobility/transfer?**
- **Have poor coordination, balance, gait or uncorrected visual impairment?**

#### Functional Ability Risks
- **Is the patient unsteady, disorganised or require assistance when attending to ADLs?**

**Interventions**
- Assess, document and provide mobility aids and level of assistance required.
- Discuss and confirm with the patient what level of assistance they require (including mobility aids), and/or their need to call and wait for assistance.
- Refer to Physiotherapist for a comprehensive mobility assessment.
- Refer to Occupational Therapist (OT) for functional assessment.

**Medications/Medical Condition Risks**
- Some medications are associated with falls. Has the patient been prescribed:
  - Psychotropic medication e.g. benzodiazepines, antipsychotics, antidepressants?
  - New or old medication that may affect their blood pressure?
- Does the patient take more than 5 medications of any sort?
- Does the patient report dizziness or presenting following a fall/collapse?

**Interventions**
- Liaise with doctor or Pharmacist for review of medication associated with falls.
- If reporting dizziness, check lying/standing blood pressure. If a postural drop >20mmHg systolic present, discuss plan of care with the doctor.
- Educate patient to stand up slowly and wait until dizziness resolves before mobilising.
- If dizziness persists, discuss plan of care with the doctor.

#### Cognitive State Risks
- **Does the patient have:**
  - Previous delirium or known diagnosis of dementia?
  - New or worsening memory impairment, confusion or disorientation?
  - Drowsiness, is easily distracted, withdrawn or depressed?

**Interventions**
- Establish a baseline cognitive screen.
- If result abnormal refer to doctor and/or other specialist teams as required.
- Remain in attendance at all times when the patient is toileting or showering as this is a high risk activity for the patient.
- If agitated commence behaviour observation chart to assist behaviour management plan.
- Avoid use of bedrails due to climbing/entrapment risk and consider low-low bed.
- Set an alarm system in place to alert when patient is trying to get up unaided.
- Re-orientate patient and ask family to assist in orientating and settling patient.
- Increase frequency of patient checks to pro-actively attend to patient needs.

#### Continence/Elimination Risks
- **Does the patient require assistance with toileting?**
- **Have constipation, urinary or faecal frequency/urgency or nocturia?**

**Interventions**
- Monitor/record toileting needs to check frequency, retention or constipation. Use site specific documentation.
- Review toileting needs with patient daily including frequency, patients requirement for continence/toileting aids and assistance required to access toilet facilities.
- Complete urinalysis. If abnormal, discuss with Dr if MSU indicated.

**Patient Requires Interventions Other Than Above (See Page 4)**
## MINIMUM INTERVENTIONS
To be implemented for ALL patients as appropriate

- Provide ongoing orientation for patient to bed area, toilet facilities and ward. Consider bed location.
- Demonstrate the use of call bell, ensure it is in reach and that they can use it effectively.
- Ensure frequently used items including mobility aids are within easy reach of patient.
- Encourage patient to use their aids such as glasses or hearing aids.
- Adjust bed and chair to appropriate height for patient.
- Minimise prolonged bed-rest as it contributes to negative cardiovascular and muscle effects that may lead to falls.
- Place drip stands and all other devices/attachments on exit side of bed.
- Remove clutter and obstacles from room.
- Provide adequate lighting according to patient activities/needs.
- Encourage patient to take adequate fluids and nutrition.
- Optimise footwear where possible - discourage walking in socks/compression stockings or ill-fitting footwear. Bare feet (if there is no infection risk) and non-slip socks are acceptable.
- Educate that all inpatients are at increased risk of falling due to injury / illness / medications.

### SHIFT BY SHIFT CHECK
If the patient has had a FALL or MEDICAL CONDITION CHANGE or WARD TRANSFER re-screen on page 1

#### Instructions:
Please date and initial below to confirm which interventions are implemented each shift.

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<tbody>
<tr>
<td>AM</td>
<td>PM</td>
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<td>AM</td>
<td>PM</td>
<td>ND</td>
<td>AM</td>
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<td>Minimum Interventions ONLY OR</td>
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<tr>
<td>Minimum AND Individualised Interventions</td>
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<tr>
<th>Week 2</th>
<th>Date</th>
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<td>Minimum AND Individualised Interventions</td>
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<tr>
<th>Week 3</th>
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<tbody>
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<tr>
<th>Week 4</th>
<th>Date</th>
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<th>Date</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>AM</td>
<td>PM</td>
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<td>AM</td>
<td>PM</td>
<td>ND</td>
<td>AM</td>
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<tr>
<td>Minimum Interventions ONLY OR</td>
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<tr>
<td>Minimum AND Individualised Interventions</td>
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<td></td>
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</tr>
</tbody>
</table>
### Other Individualised Interventions

Interventions can be added by any member of the multidisciplinary team when discussed with the nurse in charge of care – e.g. Nurses, Allied Health, Doctor, Pharmacists.

<table>
<thead>
<tr>
<th>Name and Designation</th>
<th>Date</th>
<th>Intervention</th>
<th>Date Actioned and by Whom</th>
<th>Date Ceased and by Whom</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Communication and Information to Patients and Carers

This section is for patients identified at risk of falls.

At each screen provide updated information about the risks for falling and plan care in partnership with patient and carer. If unable to discuss e.g. confused/low GCS and no carer, then tick unable.

<table>
<thead>
<tr>
<th>Date Discussed</th>
<th>Staff Member Name</th>
<th>Staff Member Signature</th>
<th>Whom Falls Risk Was Discussed With</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Screen</td>
<td>/ /</td>
<td></td>
<td>Patient ☑ Carer ☑ Unable</td>
</tr>
<tr>
<td>Re-Screen 1</td>
<td>/ /</td>
<td></td>
<td>Patient ☑ Carer ☑ Unable</td>
</tr>
<tr>
<td>Re-Screen 2</td>
<td>/ /</td>
<td></td>
<td>Patient ☑ Carer ☑ Unable</td>
</tr>
</tbody>
</table>

### Important Practice Points

These patients need particular care managing their falls risk.

- Patients on **anticoagulant**, **antiplatelet** therapy and/or patients with a known **coagulopathy** are at an increased risk of intracranial haemorrhage from falls.
  - Alcohol dependent persons, people with liver disease and people with bleeding disorders are considered coagulopathic.
  - NB: Refer to local post-fall management procedure for more information.
- Patients who are known to be **osteoporotic** or who have suffered low trauma fractures in the past are at increased risk of sustaining a fracture even from mild falls.
- Consider discussing with the team, vitamin D supplementation (Cholecalciferol 1000 units/day) for those patients with longer lengths of stay, vitamin D level < 60nmol/L or whom reside in residential care.
Appendix 7 EXTRACT - Head injury: assessment and early management

NICE guidelines [CG176] Published date: January 2014

Community health services and NHS minor injury clinics

1.1.4 Community health services (GPs, ambulance crews, NHS walk-in centres, dental practitioners) and NHS minor injury clinics should refer patients who have sustained a head injury to a hospital emergency department, using the ambulance service if deemed necessary, if any of the following are present:

- Glasgow coma scale (GCS) score of less than 15 on initial assessment.
- Any loss of consciousness as a result of the injury.
- Any focal neurological deficit since the injury.
- Any suspicion of a skull fracture or penetrating head injury since the injury.
- Amnesia for events before or after the injury[^4].
- Persistent headache since the injury.
- Any vomiting episodes since the injury (clinical judgment should be used regarding the cause of vomiting in those aged 12 years or younger and the need for referral).
- Any seizure since the injury.
- Any previous brain surgery.
- A high-energy head injury.
- Any history of bleeding or clotting disorders.
- Current anticoagulant therapy such as warfarin.
- Current drug or alcohol intoxication.
- There are any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected).
- Continuing concern by the professional about the diagnosis. [2003, amended 2007 and 2014]

1.1.5 In the absence of any risk factors in recommendation 1.1.4, consider referral to an emergency department if any of the following factors are present, depending on judgment of severity:
- Irritability or altered behaviour, particularly in infants and children aged under 5 years.
- Visible trauma to the head not covered in recommendation 1.1.4 but still of concern to the professional.
- No one is able to observe the injured person at home.
- Continuing concern by the injured person or their family or carer about the diagnosis. [2003, amended 2014]

**Transport to hospital from community health services and NHS minor injury clinics**

1.1.6 Patients referred from community health services and NHS minor injury clinics should be accompanied by a competent adult during transport to the emergency department. [2003]

1.1.7 The referring professional should determine if an ambulance is required, based on the patient's clinical condition. If an ambulance is deemed not required, public transport and car are appropriate means of transport providing the patient is accompanied. [2003]

1.1.8 The referring professional should inform the destination hospital (by phone) of the impending transfer and in non-emergencies a letter summarising signs and symptoms should be sent with the patient. [2003]
Appendix 8 Multi-Factorial Falls Assessment of risk factors and intervention tools

The following six pages are in landscape as the above named document is printed in Landscape not portrait
MULTI-FACTORIAL FALLS ASSESSMENT OF RISK FACTORS AND INTERVENTION TOOL

To be completed in community and primary care by appropriately trained health care professional

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Address:</th>
<th>Place of Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Forename(s):</th>
<th>Postcode:</th>
<th>GP and surgery:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Age:</th>
<th>Phone no:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Number:</th>
<th>CHI Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guidance: Complete if injurious fall, 2 or more falls or unsteady gait. Does the patient meet any of the following: circle Yes or No

<table>
<thead>
<tr>
<th>Has the patient had a fall in the past 12 months?</th>
<th>YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsteady when walking/ transferring or uses a walking aid?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Confused, know cognitive impairment or incorrectly answers any of the following: age, date of birth, current year and place?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Has urinary or faecal frequency/urgency or nocturia?</td>
<td>YES / NO</td>
</tr>
<tr>
<td>Prescribed any medication that may have a sedative effect?</td>
<td>YES / NO</td>
</tr>
</tbody>
</table>

If YES to one of more of the above questions continue with assessment
<table>
<thead>
<tr>
<th></th>
<th>Personal Risk Factors (please tick)</th>
<th>Yes/No</th>
<th>Consider the following Interventions/ referrals/ signposting options</th>
<th>Actions/ Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>History of falls in the past year?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of falls ................</td>
<td></td>
<td>• Review incident(s), listening for how to prevent further falls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approximate date of last fall.............</td>
<td></td>
<td>• falls diary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any injuries sustained? .................</td>
<td></td>
<td>• personal alarm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If recurrent falls refer to clinic / rehab</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Discuss fear of falling and realistic preventative measures</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taking 4 or more medications per day?</td>
<td></td>
<td>• Identify type(s) of medication being prescribed e.g. anti-depressants, sleeping tablets, tranquillisers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taking drugs that can contribute to falls e.g. anti-depressants, sleeping tablets, tranquillisers, sedatives, diuretics, analgesia</td>
<td></td>
<td>• Ask about symptoms of dizziness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change of meds in last 2/52</td>
<td></td>
<td>• Explain normal changes in sleeping patterns associated with ageing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Referral to GP, community pharmacist, community or practice nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Check compliance with medications</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Balance, Transfers and Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has difficulty moving from bed to chair?</td>
<td></td>
<td>• Assessment and advice on balance, transfers and mobility</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses their arms when rising from a chair?</td>
<td></td>
<td>• Home or group exercise programme to improve mobility and balance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unsteady on their feet, shuffles, takes uneven steps or housebound?</td>
<td></td>
<td>• Changes to home environment to maximise safety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Get up and go test…… unsteady? Holds furniture? Sway on stand? Walk and talk?</td>
<td></td>
<td>• Walking aid assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Referral to physiotherapy, occupational therapy, leisure services or health promotion teams</td>
<td></td>
</tr>
<tr>
<td>Personal Risk Factors</td>
<td>Yes/No</td>
<td>Consider the following Interventions/referrals/signposting options</td>
<td>Actions/Comments</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
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<td>---------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td><strong>4</strong> Continence</td>
<td></td>
<td>• Encourage regular fluid intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Routine urinalysis and temperature check to exclude infection</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow continence pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Referral to community or practice nurse or continence service</td>
<td></td>
<td></td>
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<tr>
<td>Suffers from urgency, frequency and/or incontinence?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>5</strong> Agitation / Confusion</td>
<td></td>
<td>• Further assessment Advise/discuss action plan with carer</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Investigate cause of acute confusion (e.g. Urinalysis, temperature, bloods, respiratory symptoms)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Referral to GP, community or practice nurse or occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short term memory, comprehension difficulties or confusion (sudden onset/acute), which may affect ability to follow advice?</td>
<td></td>
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</tr>
<tr>
<td><strong>6</strong> Loss of consciousness</td>
<td></td>
<td>• Medical review for further investigations e.g. 24hr ECG, carotid sinus massage, tilt testing</td>
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<td></td>
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<td>• Refer to GP</td>
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<tr>
<td>Complains of blackouts, loss of consciousness or unable to recollect mechanism of fall (not due to memory)?</td>
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<tr>
<td><strong>7</strong> Postural Hypotension</td>
<td></td>
<td>• Check lying &amp; standing BP if possible</td>
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<td></td>
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<td>• Review medication</td>
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<td></td>
<td></td>
<td>• Teach how to stabilise self after changing position and before walking</td>
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<td></td>
<td></td>
<td>• Consider raising head of bed if severe</td>
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<td></td>
<td></td>
<td>• Refer to GP</td>
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<tr>
<td></td>
<td></td>
<td>• Consider Dehydration</td>
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<tr>
<td>Complains of dizziness on standing/sitting up?</td>
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<tr>
<td>Lying BP: .../...... Standing BP:....../ ......</td>
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</tbody>
</table>
### Personal Risk Factors

<table>
<thead>
<tr>
<th>No</th>
<th>Consider the following interventions/referrals/signposting options</th>
<th>Actions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Explain possible short &amp; long term risks of falls from alcohol due to dulling of neurological capacity and explain referral options</td>
<td></td>
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<tr>
<td>No</td>
<td>Explain risk to bone health</td>
<td></td>
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<tr>
<td>No</td>
<td>Referral to GP, Practice nurse or health promotion</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>No</td>
<td>• Explain risk to bone health</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>• Referral to GP, Practice nurse or health promotion</td>
<td></td>
</tr>
</tbody>
</table>

### 8 Alcohol

- Any concerns re alcohol excess consumption?

### 9 Nutrition and Hydration

- Loss of weight? Poor food/fluid intake? Body weight less than 9 stone (57kg)?

- Explain importance of a well balanced diet and adequate hydration for good health & well being

- Explain importance of calcium & Vitamin D for bone health (see osteoporosis section)

- Nutritional assessment e.g. MUST tool

- Consider referral to dietician, practice or district nurse or health promotion

### 10 Vision

- Unable to recognise a key/ pen held a bed length away (with glasses if worn)?

- Unable to see print clearly (with glasses if worn)?

- Recently started wearing bifocals/varifocals?

- Explain risks of falls from blurring or misjudging distances

- Recommend caution in new situations and on uneven surfaces

- Check glasses are clean

- Advise annual eyesight tests (free for over 60’s)

- Signpost to optician

### 11 Hearing

- Difficulty hearing conversational speech (with hearing aid if worn)?

- Examination of ears by appropriately trained professional and treat as appropriate

- Check if hearing has been tested and corrected as far as possible

- If hearing aid is worn, check it is correctly worn and working

- Referral to GP, community or practice nurse or social services
<table>
<thead>
<tr>
<th>Personal Risk Factors</th>
<th>YES/NO</th>
<th>Consider the following Interventions/referrals/signposting options</th>
<th>Actions/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Footwear/Foot care</strong></td>
<td></td>
<td>• Advice on suitable footwear&lt;br&gt;• Check foot care e.g. toenails, painful bunions, oedema&lt;br&gt;• Referral to podiatry&lt;br&gt;• Refer to Age Uk for toe nail cutting</td>
<td></td>
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<tr>
<td>Look at feet and footwear&lt;br&gt;Difficulty with foot care affecting mobility/ inappropriate footwear?</td>
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<tr>
<td><strong>Reduced Confidence/ Coping Strategies</strong></td>
<td></td>
<td>• Advice leaflets re. personal alarms&lt;br&gt;• Referral for home or group exercise programme on discharge, OT/Physio&lt;br&gt;• Discuss potential coping strategies&lt;br&gt;• Teach how to get up off floor by appropriately trained professional&lt;br&gt;• Referral to occupational therapist, physiotherapist, Home call/ Carelink or telecare</td>
<td></td>
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<tr>
<td>Fear of further falls, have they changed their lifestyle due to falls?&lt;br&gt;Unable to get up off floor?&lt;br&gt;Unable to summon help?</td>
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<tr>
<td><strong>Osteoporosis Risk Factors:</strong></td>
<td></td>
<td>• Check if patient is currently on medication for osteoporosis e.g. bisphosphonate, calcium and vitamin D.&lt;br&gt;• If the patient is currently on bisphosphonates check they are taking them regularly and according to correct protocol&lt;br&gt;• Clients with one or more risk factors may warrant further assessment and/or treatment – the more risk factors, the higher the risk of osteoporosis.&lt;br&gt;• Dietary and Lifestyle advice&lt;br&gt;• Referral/signposting to GP to highlight osteoporosis risk or problems with medication compliance.&lt;br&gt;• Frax, q Fracture tool</td>
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<td>Does the person have any history of the following:&lt;br&gt;Fracture after a minor bump or fall &gt;age 50yrs e.g. wrist, hip, vertebra, humerus?&lt;br&gt;Oral corticosteroid therapy e.g. Prednisolone (for more than 3 months)&lt;br&gt;Early menopause/hysterectomy under the age of 45 years, amenorrhoea?&lt;br&gt;Associated diseases e.g. gastrointestinal disease, liver disease, hyperparathyroidism&lt;br&gt;Family history of osteoporosis/ maternal hip fracture&lt;br&gt;Loss of height, kyphosis, low body mass index (&lt; 19kg/m²)&lt;br&gt;Smoking&lt;br&gt;High caffeine&lt;br&gt;Parkinsons&lt;br&gt;Antipsychotic medications</td>
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<tr>
<td>Personal Risk Factors</td>
<td>Yes/No</td>
<td>Interventions/referrals/signposting options</td>
<td>Actions/Comments</td>
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<tr>
<td>Environmental risk factors</td>
<td></td>
<td>Advice re: safety in the home</td>
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<td>Consider need for further environmental assessment if problems highlighted</td>
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<td>Provision of equipment/adaptations as required</td>
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<td></td>
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<td>Consider need for fire safety check</td>
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<td>Referral to occupational therapist</td>
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<td>Pets, mop up spills</td>
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<td>Loose rugs/carpets</td>
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<td>Lighting</td>
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<td></td>
<td></td>
<td>Clutter</td>
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</tbody>
</table>

Name of Assessor ____________________________  Designation: ____________________________  Signature of Assessor: ____________________________

Date: ____________________________  Contact No: ____________________________  Place of Work: ____________________________

Reproduced for use in Cumbria with permissions from South Tees Falls Team

This screening tool has been adapted from the Queen Mary and Westfield College Assessment of Predisposition for Falling in Older Patients, published in the Guidelines for the prevention of falls in older people, 2000.