**The Newcastle upon Tyne Hospitals NHS Foundation Trust**

**Management and Prevention of Patient Slips, Trips, Falls Policy**

Effective: October 2009 Review: October 2012

## 1. Introduction

Patient falls account for almost two-fifths of patient safety incident reports to the National Reporting and Learning System (NRLS). The National Patient Safety Agency (NPSA) estimates that a thousand patients sustain a fracture as a result of falls in hospital in England and Wales each year and some patients die as a result of falling (NPSA, 2007).

The Trust is committed to reducing the incidence of falls for patients by raising awareness about preventative assessment and interventions.

## 2. Aim of this Policy

The scope of this policy is to provide guidance to all healthcare professionals who care for patients at risk of falling in order to minimise the harm and maintain safety.

## 3. Roles and Responsibilites

Responsibility for ensuring the application of this policy lies with the Clinical Director of each Directorate, supported by the Directorate Manager and Matron.

## 4. Causes of Falls

Patient falls are complex and influenced by several factors; physical illness, mental health problems, medication, environmental and age-related illness.

The **S**ense **A**mbulation **F**all **E**nvironment **S**upervision **T**rauma (SAFE ST) acronym highlights the categories and causes of patient falls:

**Sense**
Visual Impairment
Hearing impairment
Medication
Confusion
Disorientation
Agitation

**Ambulation**
Gait
Balance
Transfer problems
Walking aids
Ill fitting footwear

**Fall**
History of Falls
Medical equipment

**Environment**
Incontinent
Assistance in toileting
Constipation
Urinary Tract Infection
Environmental hazards
Trauma

**Supervision**
Disorientation in unfamiliar
Observation

**Trauma**
Injuries/Fracture

The NPSA (2007) recommend that each patient at risk of falling should receive a multifaceted clinical and environmental assessment to identify interventions that could reduce the risk.

## 5. Risk Assessment

A risk assessment should be completed on all patients that are admitted to the Trust (within 12 hours) using the risk assessment and intervention tool agreed for use in the Trust (Appendix 1). If the patient is found to be at risk of a fall, agreed interventions should be implemented according to the identified tool and reassessment should occur weekly, unless clinical presentation changes or the patient falls and immediate reassessement should take place.

## 6. Training

The training requirements for clinical staff are identified in the Mandatory Training Policy.

## 7. Monitoring

Compliance with this policy will be monitored by the Nurse Specialist Patient Safety who from analysis of falls incident reports will monitor the number and type of patient falls including risk assessment and carry out spot check audits of risk assessment documentation. The Clinical Governance and Quality Committee will receive quarterly reports and identify actions to be taken and monitor these through to completion.

**Author:** Nurse Specialist Patient Safety

**Reference**

NPSA, The third report from the Patient Safety Observatory: *Slips, trips and falls in hospital.* 2007.
http://www.npsa.nhs.uk/nrls/alerts-and-directives/directives-guidance/slips-trips-falls/

**SAFE (ST) Falls Assessment and Intervention Tool**

Complete the tool for **ALL** patients. Was the patient admitted following a fall? Yes/No (If **Yes** this patient is a falls risk)

F: Fall W: Weekly review * delete as appropriate

| | | On Admission | | | F/W* | | F/W* | | F/W* | | F/W* | | F/W* | | F/W* | | F/W* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Risk Factor | Assessment Trigger | √ | Date/Time Sign | Intervention | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign |
| Senses | Visual Impairment | | | Ensure spectacles are accessible, clean and worn as required | | | | | | | | | | | | | | |
| | | | | Ensure appropriate lighting and free from obstruction | | | | | | | | | | | | | | |
| | | | | If unexplained deterioration or recent change to vision ask medical staff to assess | | | | | | | | | | | | | | |
| | Hearing Impairment | | | Ensure hearing aids are worn and functional | | | | | | | | | | | | | | |
| | | | | Medical staff to assess and examine ears if appropriate | | | | | | | | | | | | | | |
| | Confusion Disorientation or Agitation | | | Regular and repeated (x3 daily) cues to improve personal orientation[1] | | | | | | | | | | | | | | |
| | | | | Review of neurological state including Six Item Screen and patient's medication - Box A | | | | | | | | | | | | | | |
| | | | | Nurse in an observable area, consider sensor alarms ,low level bed (specify)………………Date ……….. | | | | | | | | | | | | | | |
| | | | | If patient is displaying unexplained or challenging behaviour consider referral to Care of the Elderly (CoE)/FASS or old age psychiatry (specify) ………………… | | | | | | | | | | | | | | |
| Ambulation | Gait Balance or Transfer problem | | | Refer to physiotherapy | | | | | | | | | | | | | | |
| | | | | Requires supervision of 1 or 2 staff to transfer or mobilize (specify) ……………………………………… | | | | | | | | | | | | | | |
| | | | | Use of hoist/one way slide sheet (specify) ……….. | | | | | | | | | | | | | | |
| | | | | Assess and provide stable footwear | | | | | | | | | | | | | | |
| | | | | Assess and treat pain on movement | | | | | | | | | | | | | | |
| | | | | Assess nutritional status including MUST | | | | | | | | | | | | | | |
| | Uses walking aids | | | Refer to physiotherapist | | | | | | | | | | | | | | |
| Falls | Falls/collapse in six months OR History of fall on admission | | | Measure lying and standing blood pressure - Box B | | | | | | | | | | | | | | |
| | | | | Medical staff to perform full falls assessment - Box C | | | | | | | | | | | | | | |
| | | | | Consider referral to CoE/FASS if fallen 3 or more times in last 3 months | | | | | | | | | | | | | | |
| Environment | Using medical equipment | | | Medical staff to review the requirement of medical equipment (Eg. Infusion/oxygen) | | | | | | | | | | | | | | |
| | Incontinent or Needs assistance toileting | | | Devise appropriate continence care plan, assess distance and hazard to toilet and refer to continence advisor if appropriate | | | | | | | | | | | | | | |
| | Total | | | | | | | | | | | | | | | | | |

If **Yes** is answered to any assessment Triggers Interventions must be completed
Complete the section below and reassess patient if a fall occurs

| Risk Factor | Assessment Trigger | √ | Date/Sign | Intervention | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign | Date | Sign |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Super-vision | Observation required | | | Reassess bed location/frequency of observations | | | | | | | | | | | | | | |
| | | | | Inform nurse in charge complete Datix incident form Incident Number…………………………….. | | | | | | | | | | | | | | |
| Trauma | Injuries Fractures | | | Medical staff to review and treat any injuries | | | | | | | | | | | | | | |
| | | | | Assess and treat pain | | | | | | | | | | | | | | |
| | Total | | | | | | | | | | | | | | | | | |

If 4 or more triggers are identified the patient is a high falls risk

If less than 4 Triggers are identified then the patient is not deemed at high risk, however clinical judgement should always supersede a low score

Patients should be review weekly unless clinical presentation changes or the patient FALLS and immediate reassessment should take place

[1]British Geriatric Society Clinical Guidelines

**Box A**

Consider underlying causes e.g. Infection, Metabolic Disturbance, Drug/Alcohol/Nicotine withdrawal/Muscular disorders

Perform assessment of neurological state including GCS, Six Item Screen and review medication

**Six Item Screen (Managing Delirium Guidance)**

1. Give 3 words to remember: lemon, key, ball.
2. Check day, month, year (1 point each).
3. Test recall of 3 items (1 point each).

**Medications**

Does the patient's medication induce any of the following side effects:

- Confusion
- Impaired postural stability
- Hypotension
- Parkinsonian symptoms
- Visual impairment
- Hypoglycaemia
- Peripheral Neuropathy
- Vestibular damage

Consider the following medications:

- Sedatives
- Analgesia
- Anti-cholinergic

Consider referral to CoE/Old Age Psychiatry or CT Head

Sedation[1] may be necessary for:

- essential investigation/treatments
- preventing patients endangering themselves or others
- relieving distress in highly agitated or hallucinating patients

**Box C**

- Consider if the current illness/condition has contributed to the fall
- Assess neurological status (GCS)
  - refer to head injury guidelines
  - consider CT head
- Assess mental state - see Box A
  - Consider CoE/ old age
  - Psychiatry opinion
- Assessment for injuries or fractures
  - If recent fracture: refer to local osteoporosis guidelines
- Review current ECG (look for bradycardia or AV block)
  - review cardiovascular medications)
  - consider referring to cardiology or FASS
- Review lying and standing BP- see Box B
  - review cardiovascular medications
  - consider referring to FASS
- Review neurological medications: especially sedative drugs e.g. Benzodiazepines / other sleeping tablets. Discontinue new or short term sedatives, but use caution if longer term sedative or psychotropic medication- seek advice from CoE/ psychiatry if necessary
- Review indication for and risk / benefits of ongoing anticoagulation e.g. warfarin in atrial fibrillation. Ask for specialist advice if in doubt.

**Box B**

**Definition**

Orthostatic hypotension is defined as a fall in BP>20mmHg systolic or>10mmHg on standing. It is often transient and usually occurs in the first minute. It can cause dizziness, faintness or falls in susceptible people. It may be due to a patient's condition or a side effect of medication.

**Technique**

- Explain the procedure to the patient
- Ensure the patient has been lying down for at least 5 minutes
- Select an appropriate BP cuff size and use a manual or electronic BP monitoring equipment
- Record lying systolic and diastolic BP
- Leave the BP cuff in place and stand the patient up and measure BP (15-30secs)
- Repeat systolic and diastolic BP at 1 minute after standing
- Ask the patient about their symptoms and documents these, including timing in relation to the BP measurement performed
- If unable to obtain readings document reasons

**If the patient has a definite drop on standing or even symptoms without a drop in BP, consider referral to the Falls and Syncope Service, RVI (FASS) or a referral to Care of the Elderly (ext 31683)**

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

**IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

| Policy Title: | Management and Prevention of Patient Slips, Trips, Falls Policy | Policy Author: | Nurse Specialist Patient Safety |
|---|---|---|---|
| | | Yes/No? | You must provide evidence to support your response: |
| 1. | Does the policy/guidance affect one group less or more favourably than another on the basis of: | | This policy does not discriminate against any individual on the basis of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability. |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| | • Disability – learning difficulties, physical disability, sensory impairment and mental health problems. | No | |
| 2. | Is there any evidence that some groups are affected differently? | | |
| 3. | If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? | No | |
| 4(a). | Is the impact of the policy/guidance likely to be negative?<br>*(If "yes", please answer sections 4(b) to 4(d)).* | NA | |
| 4(b). | If so can the impact be avoided? | | |
| 4(c). | What alternatives are there to achieving the policy/guidance without the impact? | | |
| 4(d) | Can we reduce the impact by taking different action? | | |

| **Comments:** | **Action Plan due (or Not Applicable):**<br><br>**NA** |
|---|---|

Name and Designation of Person responsible for completion of this form: Jo Coward Nurse Specialist Patient Safety Date: 10/12/2009

Names & Designations of those involved in the impact assessment screening process: Clinical Governance and Quality Committee

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

*For advice on answering the above questions please contact Helen Lamont, Deputy Director Nursing & Patient Services, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.*