Policy Number
CP42

CP42 Policy for the prevention and management of adult and paediatric inpatient falls.

Contents

Appendices

Falls Team referral forms

1.0 Policy Statement (Purpose / Objectives of the policy)

At RWT falls are the single largest reported incident with differing degree of injury sustained. Falls is one of the four recognised common causes of harm in patients. Falls prevention is a key element in harm free care delivery.

This policy and its appendices outline the Trust's approach to:

- Reducing the number of patient falls;
- Promote independence and well-being for all patients;
- Encourage critical thinking of staff when it comes to assessing risks associated with falls prevention;
- Support patients and staff to make individual decisions about appropriate falls prevention measures;
- Ensuring appropriate clinical action is taken in the event of a patient fall within inpatient, Day case and community settings;

1.2 This Policy and its supporting documents apply to all staff.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

- **A Fall**

  Defined as, "an event whereby unintentionally an individual comes to rest on the ground or another lower level or from a height, with or without loss of consciousness." (World Health Organisation/ Lamb 2005). This includes any slips, trips or loss of balance that are either witnessed or unwitnessed. They may or may not include environmental factors.

- **Arm's length care**

  Requires Nurses, Healthcare Assistants or AHP's to remain within reach of a patient at risk of falling to try to prevent a fall, even when the patient is on a toilet or commode.

- **Bed Rails**

  Medical devices which are rails at the head, foot, or side of a bed designed to reduce the risk of a patient falling from bed. They are **NOT** for the purpose of restraint or confining a patient to bed.

- **Enhanced Care**

  Refers to an increased level of care, a patient, or cohort of patients require due to their complexity or acuity.

- **Measles Chart**

  A local, individualised copy of an inpatient floor map, whereby the precise location of a fall can be pinpointed with a sticker. This can help identify hotspot areas for falls. These can be used within the main inpatient ward areas.

- **Multidisciplinary (MDT) TAGGING**

  A method for ensuring that one or more patients, who are deemed highly likely to fall if left unobserved, have a continuous staff presence. These patients are kept within constant sight of staff to try to prevent them from falling due to lack of supervision.

  The approach to tagging is multidisciplinary and involves Nursing staff, Medical staff and Allied Health Professionals.

- **Multifactorial**

  Defined as 'Having or stemming from a number of different causes or influences'.

- **Targeted toileting**

  Toileting is a primary driver for patient falls in acute hospitals. Targeted toileting is toileting assistance modified to target the most vulnerable times of day or patient populations with radically increased toileting needs.

3.0 Accountabilities/ Responsibilities

3.1 Chief Executive Officer

Is responsible for ensuring the policy is implemented across the Trust.

3.2 Chief Nursing Officer

Is responsible for Quality and Safety assurance processes in relation to patient falls at an organisational level, working in support of both the Chair and Chief Executive. The Chief Nursing Officer is the Director with overall responsibility for the management of risk, clinical governance and for the management of complaints within the Trust in relation to patient falls within inpatient and community settings.

3.3 Trust Falls Prevention Group

Are responsible for the oversight of falls incidents, implementation of improvements in falls prevention across the Trust, and to focus on the reduction in harm to patients from falling.

3.4 Divisional Heads of Nursing and Midwifery

Working with the Governance Managers, are responsible for ensuring appropriate review and sharing lessons learned from Root Cause Analyses (RCA). The Heads of Nursing and Midwifery are responsible for ensuring the policy is implemented in a consistent manner across all areas.

3.5 Medical Staff

Are responsible and accountable, for undertaking a falls risk assessment, of all patients on admission.

For communicating any identified risks to members of the multidisciplinary team.
For ensuring patients with polypharmacy have a timely review of their medications in relation to falls risk and changes communicated to the MDT.

For assisting with the prevention of inpatient falls by understanding the importance of a

multidisciplinary approach to the tagging model when implemented in their areas.

For the timely and appropriate review and treatment of a patient post fall, and for completion of post fall documentation within the medical notes. They are individually responsible for ensuring adherence to the policy.

3.6 Matrons

Matrons are responsible for ensuring compliance with the policy and accurate monitoring of incidents, escalation and prevalence are in place.

Monitoring and oversight of falls incidents, trends and harm from falls, across services under their responsibility.

Reviewing findings from RCAs, agreeing action plans and assuring action closure and improvement. Professional challenge is expected when there are avoidable falls.

3.7 Senior Sisters/Charge Nurses/ Ward managers

Are responsible and accountable for:
Ensuring that they and all their staff are aware of and adhere to the policy and are adequately educated in falls risk assessment and falls prevention.

Monitoring the numbers of falls and harm from falls within their area, including falls trending, disseminating results and driving any required improvements. Ensuring ward environments are tidy and clutter free. Ensuring all appropriate falls documentation is completed on admission, transfer, post fall and as part of the daily documentation and care checks.

Ensure that any audits in relation to Falls assessment and management are completed as required.

Ensuring all staff understand the importance of correct bay tagging and the need to escalate when unable to comply with this.

The Health and Safety team are notified if an environmental hazard (e.g. lack of storage space for essential equipment) or non-compliance with standards (e.g. Unable to follow policy due to circumstances beyond their control) has occurred. Department manager will complete an environmental assessment and submit relevant risks for in inclusion on a local risk register if identified.

The management of nursing staff within their area who do not comply with this policy.

3.8 All Clinical Staff

Are accountable for ensuring all patients are provided with high quality care and for adherence to this policy. Access training and updates and challenge poor practice. Ensuring that any documentation, relevant to that group of staff, is completed in a timely and appropriate manner as to critically assess patient falls risk and plan and implement appropriate falls prevention methods.

Sharing information via safety briefs and safe hands regards patient's risk profile and any relevant changes.

For assisting with the prevention of inpatient falls by understanding the importance of a multidisciplinary approach to the tagging model when implemented in their areas.

Escalation of concerns relating to falls prevention.

4.0 Policy Detail - Falls Prevention

An overview of the falls prevention documentation standard is shown in (appendix 1) but is provided in detail below.

4.1 All patients admitted to an inpatient setting will be risk assessed for their likelihood of falls using the Trust falls risk assessment (appendix 2). The falls risk assessment is in 3 steps and forms part of the nursing risk assessment booklet. Part 1 of the falls risk assessment MUST be completed within **6 hours** of admission by a registered nurse.

4.2 All patients must be reassessed weekly as a minimum whether they are at risk or not using Step 2 of the falls risk assessment (appendix 2).

4.3 Patients should also be reassessed using Step 2, on any change in condition, on transfer to another inpatient area and following an inpatient fall.

4.4 If following step 1 or 2 the patient is deemed to be at risk of falls at any point during their admission, then step 3 (appendix 3) of the falls risk assessment **MUST** be completed and the recommended preventative action/ care planning individualised and implemented.

4.5 If the patient continues to be at risk of falls, Step 3 (appendix 3) must also be reviewed weekly as a minimum as part of their ongoing falls preventative care. This should also be reviewed on any change in condition, on transfer to another inpatient area, and following a fall.

4.6 All patients identified as at risk of falls **MUST** have a bed rail risk assessment completed on admission. The bed rail assessment forms part of the nursing risk assessment booklet (appendix 4). This assessment informs the nurse when bed rails can be appropriately used or avoided dependant on risk.

4.7 If a patient has been assessed as suitable for bed rail use, then daily assessment of the rails and their ongoing suitability **MUST** be assessed and documented on the daily bed rails assessment (appendix 5).

4.8 Lying and standing blood pressure should be performed as soon as possible, if not contraindicated, to identify possible postural hypotension. Refer to appendix 1 of this policy or the Royal College of Physicians Guidelines for taking a lying and standing blood pressure https://www.rcplondon.ac.uk/.

4.9 An underlying cause for postural hypotension should be investigated and treated where possible. The patient must be educated in steps to reduce the risk of falling as a consequence (e.g. sitting for a few minutes longer before standing).

4.10 For children in inpatient areas, the Paediatric Falls Risk Assessment will be completed and pathway followed (appendix 6).

4.11 For adults presenting with a fall to the Emergency Department within the Trust, guidelines in (appendix 7) **MUST** be followed.

4.12 A separate risk assessment will be completed for Women in the Maternity department who are mobilising with an epidural (appendix 8).

4.13 A nursing Intervention plan (appendix 9) **MUST** be fully and accurately completed as per frequency indicated, for all patients at risk of falls.

4.14 At risk patients, where possible, should be nursed in the safest available location of the ward depending on clinical need and risk.

4.15 For at risk patients' staff are responsible for ensuring the patient has safe footwear when mobilising. Patient's own well-fitting footwear is always first choice in falls prevention. For those patients who do not have access to safe footwear then double tread anti- slip socks must be provided by the area.

4.16 Areas with several at risk patients MUST consider cohorting these patients to allow for optimum visibility of that group whilst avoiding any mixed sex accommodation breaches.

4.17 If an area has one or more at risk patients who are highly likely to fall if left unobserved

the multidisciplinary tagging system model should be deployed as soon as the risk has been identified. The enhanced care scoring tool, along with staff clinical judgement, should be used to aid decision making on the level of risk of a patient (appendix 10).

4.18 Where the need for 'Tagging' has been identified then the nurse in charge of each shift is required to identify the staff responsible for tagging the bay during that shift.

4.19 To maintain focus, during a shift the nurse in charge must rotate staff providing arm's length care or tagging a bay so individual members of staff are not providing enhanced care for long periods. This will be based on clinical need, patient need and staff discretion but should not be any longer than a maximum of 2 hours at a time. More frequent rotation is advisable during night hours or if patient care is particularly challenging for staff.

4.20 The member of staff appointed to 'Tag' an area cannot leave the area until he or she has 'Tagged' another staff member to take over. If the staff member responsible for tagging a bay has to perform a duty which would prevent them from maintaining eye contact with their patients (e.g. to go behind curtains to attend to another patient) wherever possible, they must first tag another member of staff to ensure continuous observation is maintained.

4.21 If a member of staff needs to hand over the responsibility for Tagging to another member of staff it should be clearly communicated between the two members of staff. This is particularly important if you are passing Tag responsibility to medical staff or AHPs as they may not have had a full handover of patient risk and need previously.

4.22 The enhanced care scoring tool should also be used, along with the clinical judgement of staff to aid decision making if it is considered that the patient requires 1:1 / arm's length care (appendix 10).

4.23 For those patients who do require 1:1 / arm's length care to prevent them from falling, and who are able to get to a bathroom/ toilet, then arm's length care **MUST** continue to be adhered to throughout all aspects of care delivery.

4.24 For those patients with mental capacity who refuse arm's length support, the risks **MUST** be discussed with the patient and documented. If the patient continues to refuse support following this then a non-concordance risk assessment **MUST** be completed.

4.25 Targeted toileting should be promoted where possible before the shift handover, before mealtimes and before visiting.

4.26 Nursing staff **MUST** provide patients with falls prevention educational information and then ask patients to teach this back to them. The provision of falls prevention education should be documented. This process is repeated until the patient demonstrates comprehension and again if they have a fall. If comprehension cannot be demonstrated the patient will be deemed to have a level of cognitive impairment and further enhanced care assessment **MUST** then take place using (appendix 10).

4.27 Call before you fall posters (appendix 11) **MUST** be displayed in all inpatient areas.

4.28 An Alert symbol **MUST** be placed at the bedside, ensuring all those involved in the patient's care are aware of their risk of falling. An alert **MUST** also be placed on the safe hands board to identify those patients at risk of falls to all multidisciplinary teams.

4.29 Medical staff are responsible for ensuring a timely medication review is completed to ensure analysis of medications that may contribute to patients falling. This can be evidenced in the medical records preferably at clerking or at the first opportunity to clarify patient's medications with carer or GP.

4.30 Medical staff are responsible for ensuring a cardiovascular review is conducted. The outcome of the reviews and actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's record.

4.31 Medical staff are responsible for ensuring undiagnosed or acute confusion is

documented, investigated and treated. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's record.

4.32 Medical staff are responsible for ensuring an eyesight assessment is carried out if indicated. If more comprehensive or sophisticated assessment is required, referral to Ophthalmology must be considered. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's record

4.33 In line with assessment actions once a referral is received by Therapy Services, the physiotherapist is responsible for ensuring a mobility review is undertaken. Any actions required must be discussed with the multidisciplinary team and clearly documented in the patient's medical records.

4.34 The Registered Nurse is responsible for ensuring a bladder and bowel assessment, including urgency, is done on admission. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's record

4.35 All staff are responsible for ensuring the environment, including bed spaces and main patient walkways remain clutter free at all times.

4.36 All staff are responsible for ensuring that drinks, call bells, mobility aids and personal belongings, including spectacles if required, are left within in easy reach of the patient on completion of care.

4.37 On transfer of care from one clinical area to another, including the Emergency Department and Critical Care, a transfer (SBART form) must be completed. Any identified falls risk **MUST** be clearly handed over to the receiving department. The Falls risk must be then reassessed by the receiving area.

4.38 All Staff to promote activity where possible to prevent deconditioning of the patient by encouraging participation and independence with activities of living such as washing, dressing, walking, standing and maintaining hydration and nutrition (NHS Improvement 2018).

4.39 If a patient has a potential or confirmed infection risk requiring isolation precautions in a side room and has in addition been identified at an increased risk of falls. A multidisciplinary team (MDT) discussion of all risks should take place using clinical judgement. Advice can be sought from Infection Prevention and the Falls lead. Prevention strategies must be put in place to mitigate any risk for the patient and the clinical area.

5.0 Policy Detail - Post Falls Management

5.1 A registered practitioner must undertake appropriate action in the event of a patient fall. Guidance for essential care following a patient fall can be found in (appendix 12) for inpatient areas and (appendix 13) for community settings.

5.2 In the event of an inpatient fall, a full review of risk assessment and care plan **MUST** be carried out.

5.3 All patient falls will be reported through the Trust's incident reporting system **(Datix**) and the falls escalation pathway followed (appendix 14).

5.4 All falls that have occurred should be identified on the local measles chart if applicable to that area (appendix 15).

5.5 All patient falls resulting in harm will be presented to the Trust Falls Accountability Group who will confirm the level of harm, determine if the fall was avoidable or unavoidable and identify any learning and actions required.

5.6 A full root cause analysis (RCA**)** (appendix 16) will be undertaken on all falls resulting in moderate harm or above. The RCA findings will be presented to the Trusts Falls Accountability Group who will determine if the fall was avoidable or unavoidable and confirm that the level of harm sustained is also correct. The RCA will be closed through

the directorate and divisional governance framework.

5.7 Any avoidable falls resulting in moderate or above harm will be reported to the clinical commissioners via the Trust governance framework. Falls resulting in moderate harm or above also require the application of Duty of Candour.

5.8 Falls incident data will be analysed and any trends, patterns or lessons learned will be shared across the organisation via the Fall's prevention group.

6.0 Policy Detail –Discharge

6.1 The AHP / Registered Nurse/ Medical Staff are responsible for discussing with the patient and or carer any environmental or lifestyle issues which may increase the risk of falling following discharge and providing any safety advice.

This may involve notification of risk to the GP, referral to RWT Therapy Services, Community Support Services and / or Community Falls Prevention Services.
See (appendices 17-22) for falls prevention service referral forms for all areas.

These can also be found on the intranet via the link below.
http://trustnet.xrwh.nhs.uk/departments-services/t/therapy-services/referrals-and-protocols/

All discussions and outcomes must be documented in the patient record and discharge letter as appropriate, prior to discharge.

7.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

8.0 Equality Impact Assessment

An initial equality analysis has been carried out and it indicates that there is no likely adverse impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.

9.0 Maintenance

The Falls Prevention Group is responsible for recommending any changes or amendments to the policy and the chair of this group is responsible for ensuring the policy is kept up to date.

10.0 Communication and Training

Heads of Departments are responsible for the communication of the policy to all relevant staff. Training will be provided to the appropriate staff as identified in the OP41 Induction and Training Policy.

11.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Duties (Accountabilities)	Author of Policy	Policy Review	3 yearly	Falls prevention Group
How the organisation assesses the risk of slips, trips and falls involving patients (including falls from height)	Quality Team	Audit of falls risk assessment documentation, Bedrail assessment documentation and patient environment.	Monthly	Falls prevention Group
Incidence of falls and trends.	Chair of Falls Steering Group	Incidents	Monthly	Falls prevention Group
Incidence of Serious Falls	Chair of Falls Steering Group	Incidents	Monthly	Falls prevention Group. Patient Safety Improvement Group.
Monitoring serious falls using RCA tool to analyse cause.	Chair of Falls Steering Group	Trends / Learning	Monthly	Falls prevention Group and Weekly Accountability Meeting

12.0 References - Legal, professional or national guidelines

NICE (2019) surveillance of falls in older people: assessing risk and prevention (NICE guideline CG161) Surveillance report Published: 23 May
2019-surveillance-of-falls-in-older-people-assessing-risk-and-prevention-nice-guideline-cg161-pdf-8792148103909

National Audit of Inpatient Falls (NAIF) (2020) Annual Report Royal College of Physicians https://www.rcplondon.ac.uk/projects/outputs/national-audit-inpatient-falls-naif-2020-annual-report Audit of Inpatient Falls (NAIF) 2020 Annual Report | RCP London

NICE (2019) surveillance of falls in older people: assessing risk and prevention (NICE guideline CG161) Surveillance report.
2019-surveillance-of-falls-in-older-people-assessing-risk-and-prevention-nice-guideline-cg161-pdf-8792148103909

NHS Improvement (2018) Guide to reducing long hospital stays
https://improvement.nhs.uk/documents/2898/Guide to reducing long hospital stays FINAL v2.pdf

NHS (2021) The NHS Patient Safety Strategy [online] Available from;
https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

NHS Resolution (2017) (Our refreshed 2019 to 2022 strategic plan: Delivering fair resolution and learning from harm.
https://resolution.nhs.uk/wp-content/uploads/2020/02/2020-Strategy-Update-Report.pdf

NICE (2019) Head injury: assessment and early management Clinical guideline [CG176] Published: 22 January 2014 Last updated: 13 September 2019;
https://www.nice.org.uk/guidance/CG176
https://www.rcplondon.ac.uk/

Rapid Response Report NPSA/2011/RRR001, Essential care after an in-patient fall
January 2011
Rapid Response Report NPSA/2011/RRR001 Essential care after an in-patient fall
January 2011 .Supporting information
Patient Safety First 2009 The 'How to' guide to reducing harm from falls National Patient Safety Agency: London
CP 66 Enhanced Care Policy
CP 41 Safeguarding Children In Hospital Policy
OP10 Risk Management and Patient Safety Reporting Policy
OP41 Induction and Mandatory Training Policy

OP60 Being Open Policy

CP 53 Safeguarding Vulnerable Adults Policy
The Use of Bed Rails http://www.hse.gov.uk/healthservices/bed-rails.htm
Management of dropped babies whilst inpatient Appendix 17

Part A - Document Control

Policy number and Policy version: CP42 V2.0	**Policy Title** Policy for the prevention and management of adult and paediatric inpatient falls.	**Status:** Final		**Author: Ruth Spedding - Quality Team** **Chief Officer Sponsor: Chief Nursing Officer**
Version / Amendment History	Version	Date	Author	Reason
	1.0	June 2020	Deputy Chief nurse	Review and CP42a and 42b combined into one policy.
	1.1	October 2020	Deputy Chief Nurse for Quality	Current falls policy (July2020) removed and previous falls policy reinstated until launch of new nursing documentation (March 2021) Policy CP42a and CP42b combined into CP42
	1.2	October 2020	Deputy Chief Nurse Quality	Minor amendment to Appendix 9.
	1.3	Jan 2021	Deputy Chief Nurse Quality	Extension applied until May 2021.
	2.0	May 2021	Ruth Spedding Senior Sister Quality	Updated policy to reflect changes in nursing /medical documentation
Intended Recipients: All staff				
Consultation Group / Role Titles and Date: All **members** of Trust Falls Prevention Group, Matrons, Divisional heads of Nursing, Quality Team, AHP lead, Medical Director.				
Name and date of Trust level group where reviewed		Trust Policy Group – July 2021		

Name and date of final approval committee	Trust Management Committee – July 2021
Date of Policy issue	August 2021
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	July 2024 (3 yearly)
Training and Dissemination: Trust Intranet, Senior Nurses Operational Groups. Trust IGR, Pharmacy Governance, Therapy Services Governance.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes**	
To be read in conjunction with: CP66 Enhanced Care Policy CP 41 Safeguarding Children In Hospital Policy OP10 Risk Management and Patient Safety Reporting Policy OP41 Induction and Mandatory Training Policy OP60 Being Open Policy CP 53 Safeguarding Vulnerable Adults Policy Dropped Baby Protocol	
Initial Equality Impact Assessment (all policies): Completed No- Full Equality Impact assessment (as required): Completed NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator8904	
Monitoring arrangements and Committee	Falls Prevention Group Quality Team
Document summary/key issues covered. By use of multifactorial risk assessment and intervention plans, reduce the risk of falls occurring within the Trust. To ensure appropriate care and management takes place following risk assessment or following a fall, in particular those not witnessed.	
Key words for intranet searching purposes	Falls. Falls prevention. Falls assessment. Risk of falls. Care following a fall.
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**No**

Part B **Ratification Assurance Statement**

Name of document: Policy for the prevention and management of adult and paediatric inpatient falls.

Name of author: Ruth Spedding Job Title: Senior Sister – Quality

I, the above-named author confirm that:

- The Policy and its Guidelines within presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.
- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.
- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).
- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.
- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.
- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.
- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: Ruth Spedding

Date: 01.06.2021

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN
To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version **CP42 V2.0**	**Policy Title** Policy for the prevention and management of adult and paediatric inpatient falls.	
Reviewing Group		**Date reviewed:**
Implementation lead: Print name and contact details **Ruth Spedding** ruth.spedding1@nhs.net		

Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Update to mandatory training in process	July 2021
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed	Considered and complied with standards	Completed
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	Via normal cascading methods through divisional leads	June 2021
Financial cost implementation Consider Business case development	NA	
Other specific Policy issues / actions as required e.g. Risks of failure to implement, gaps or barriers to implementation	NA	

CP 42 Appendix 1

Trust Overview for Falls Prevention Documentation

A Falls risk assessment **MUST** be completed within **6** hours of admission.
APPENDIX 2 FOR ADULT INPATIENTS OR APPENDIX 6 FOR PAEDIATRIC INPATIENTS

Lying and Standing BP should be documented for all adult patients on admission if condition allows and as per RCP guidance:

-Record BP after lying down for at least 5 mins
-Assist patient to stand
-Measure BP after standing in the **first minute**.
-Measure BP again after patient has been standing for **three minutes**.

Document clinical reasons why standing BP cannot be measured on admission and measure at earliest available opportunity.

Risk factors identified? → No

- ✓ Reassess weekly as a minimum
- ✓ If patient's condition alters
- ✓ If patient is transferred within departments.
- ✓ Following a fall

Yes

REGISTERED NURSE TO COMPLETE:

1) Individualised Falls preventative plan (appendix 3)

Examples of prevention include:

- ✓ Falls Prevention information leaflet given to patient and documented
- ✓ Falls prevention education given to patient via 'teach back 'method and documented.
- ✓ Safe footwear
- ✓ Appropriate mobility aids within reach
- ✓ Call bell within reach
- ✓ Intervention Chart/ comfort round tool (appendix 9)
- ✓ Ensure alert symbol at bedside and on patient status at a glance board
- ✓ Communication of high risk patients at safety huddles and handover
- ✓ Enhanced care tool assessment if patient has confusion / delirium
- ✓ Enhance observation of patient if indicated (e.g. tagging/arm's length care)
- ✓ Offer referral to a Falls Prevention services if required on discharge (appendices 17- 22)

2) Bed Rail Assessment tool (appendix 4)

3) Daily bed rail checks if in use (appendix 5)

Review all falls documentation weekly as a minimum, on any change in patient's condition, if patient is transferred within departments and following a fall.

Patient Name: ..... NHS No: ..... Unit Number: .....

Falls Assessment

Please complete as per instructions on the front of the booklet.

Step 1 - Complete ONCE for all patients on admission

Lying / Standing BP on admission Lying:..... Standing / Sitting:.....

State reason unable to record on admission:.....

Mobility status - tick all applicable	
Admitted following a fall?	
Has fallen in last 12 months?	
Has Impaired Mobility, Gait or Balance?	
Requires Mobility aid to walk?	

Pre-existing conditions - tick all applicable	
Patient prescribed 5 or more medications daily *(Polypharmacy can increase the risk of falls)*	
Delirium, Cognitive impairment or lack of awareness of falls risk	
Medications currently prescribed that will increase the risk of fall *(e.g. sedatives, anxiolytics, opiates)*	
Visual impairment / Blind? *(e.g. glaucoma, macular degeneration / cataracts)*	
Deficit noted on lying / standing BP	
Abnormality noted on manual pulse recording *(must record pulse manually for 1 minute)*	
Patient known Parkinson's Disease *(has implications for unsteady gait and postural hypotension)*	
Patient has unmanaged incontinence	
Alcohol or Drug dependence *(has implications for delirium, unsteady gait & withdrawal effects)*	

If ANY pink boxes are ticked in **STEP 1** the patient is at **risk** of falls and **STEP 3 MUST be completed.**

None of the mobility status questions or pre-existing conditions apply (Please tick).	

Signature: ..... Designation: .....

Site: ..... Date: Time: ..... Stamp:

Step 2 - Assessment - Complete on admission for all patients, post fall, on any change in condition or weekly as a minimum

Answer Yes or NO to the following questions	**Admission**	**2nd Review**	**3rd Review**	**4th Review**
Fallen since admitted to hospital Date of Fall:				
New urinary frequency / urgency or high dose diuretics				
New onset delirium / acute confusion / restlessness?				
Trying to get up unaided when unsafe to do so?				
Any new concerns that the patient may be at risk of falling?				
None of the above risks apply?				
Date:				
Time:				
Signature:				
Name/Stamp/Designation:				

IF ANY pink boxes are ticked in **STEP 2** your patient is at risk of falls and **STEP 3 must** be completed .
If no pink boxes are ticked your patient is currently NOT at risk , continue to reassess as instructed above .

Patient Name: ..... NHS No: ..... Unit Number: .....

Step 3 to be completed if your patient is at risk of falls - Enter Yes / No / N/A		Admission	1st Review	2nd Review	3rd Review
Interventions	Patient nursed in safest location on ward based on risk and clinical need?				
	Falls information leaflet provided to patient and carers?				
	Orientate patient to their surroundings including location of bathroom?				
	Use of call bell explained to patient / carers?				
	Suitable footwear / Anti-slip socks in place?				
	Hi / Low Bed in use?				
	Intentional rounding tool is in use?				
	Alert sign is placed over patient bed space?				
	High risk patient is communicated at Safety Briefings / Safe Hands / handover?				
	Bedrails assessment completed and reviewed as indicated?				
	Increased observation required? (e.g. Hourly checks)				
	'Tagged Bay' nursing in place if indicated?				
	1:1 nurse / patient ratio required? (arm's length care) *(Enhanced care tool can be used as guidance if needed)*				
	Requires supervision whilst using the toilet if identified at risk from enhanced care scoring tool				
	Neurological Observations if post fall completed as indicated?				
Medication Review By Dr. / Pharmacist / Non medical prescriber	Medication Review requested and documented in medical notes **Date requested:**				
	Further medication review requested and documented in medical notes. **Date requested:**	N/A			
Urine Frequency or Urgency	Has a Urinalysis been carried out and appropriate action taken to rule out possible UTI?				
Physiotherapy	Are mobility needs documented and displayed above patient's bed?				
	Requires Physiotherapy assessment for gait, balance or mobility aids? **Date referred:**				
	On-going physiotherapy support in place if required?	N/A			
Occupational Therapy	Requires O.T referral? **Date referred:**				
	On-going O.T support in place if required?	N/A			
Predisposing Conditions	On-going monitoring for signs of sepsis and/or delirium being carried out if required?				
	On-going monitoring of postural hypotension being carried out if required?				
Frailty	Frailty assessment required? **Date requested:**				
Discharge	Follow up in falls clinic / community falls service required?				
	Date:				
	Time:				
	Signature:				
	Name/Stamp/Designation:				

Patient Name: ..... NHS No: ..... Unit Number: .....

Bedrails Assessment

Bed rails assessment to be completed as per instructions at the front of the booklet. If bed rails are in use **reassess daily**. Also reassess if the patient has a fall.

DO NOT use bed rails if the following apply:

- If the patient has the potential to climb out of bed due to their confused state
- To restrain a patient e.g. to keep an agitated patient in bed
- As routine where there is no risk of falls.

Step 1 Use the bedrail risk matrix tool below, to consider the risks and benefits for individual patients. The colour codes should be used as guidance only.

Key - Level of risk		Mobility		
Green	Consider use of bedrails. Risk Assess every 24 hours	Patient is very immobile (bedfast - or hoist - dependant)	Patient is neither independent nor immobile i.e. requires assistance	Patient can mobilise without help from staff
Amber	Consider use of bedrails with care. Risk Assess every 4 hours.			
Red	Bedrails NOT recommended. Risk Assess every 24 hours.			
Cognitive status	Patient is confused, agitated, restless or disorientated	Bedrail may be used with care	Bedrails not recommended	Bedrails not recommended
	Patient is drowsy	Bedrails can be used if required	Bedrail may be used with care	Bedrails not recommended
	Patient is orientated and alert	Bedrails can be used if required	Bedrails can be used if required	Bedrails not recommended
	Patient is unconscious	Bedrails can be used if required	N/A	N/A

Step 2 **Additional Strategies** - to be considered for all patients

Move to observable area to maximise supervision	Crash mat / mattress
Bed in lowest height after care delivery	Review interventional rounding frequency
High / low bed	Body positioning devices e.g. pillows / bed wedges
Completion of the Dementia Care Bundle	None required
Discussion with the patient / carer on strategies used prior to admission	

Complete Step 3 overleaf

Patient Name: ..... NHS No: ..... Unit Number: .....

Step 3 - Bedrail Risk Assessment Outcome

Documentation of Level of Risk Minimum Daily

Date	Time	Ward / Dept	Level of risk (Red, Amber, Green)	Additional strategies in place	Signature / Designation / Stamp

NHS
The Royal Wolverhampton
NHS Trust

Paediatric Falls Risk Assessment

- Document Risk Score in patient notes.
- Risk score should be assessed 1. Daily, 2. When patient condition changes, 3. When transferred to new department/ward, 4. Following a fall incident.
- Falls Risk Assessment must be completed within 6 hours of admission

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

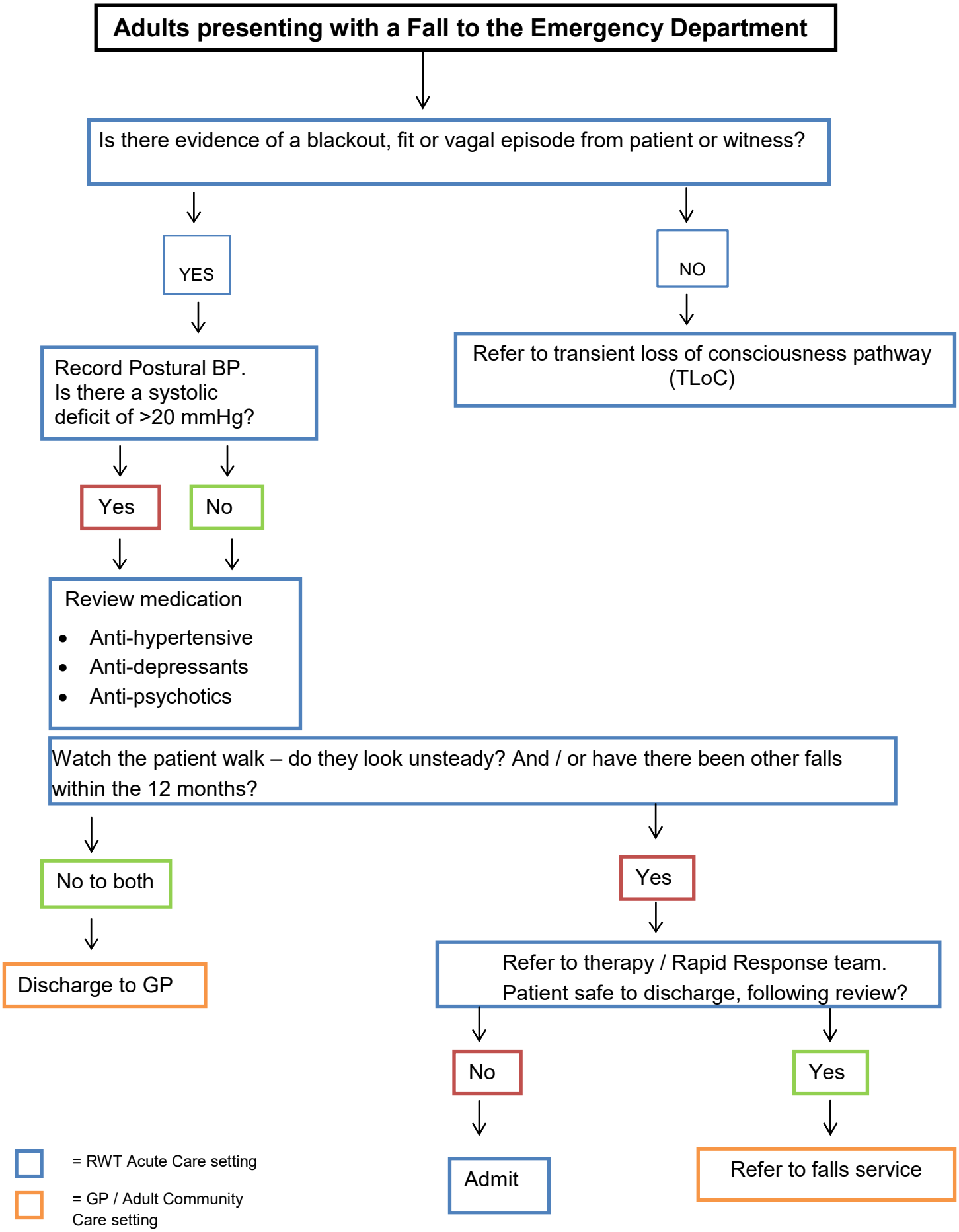
Falls Risk Assessment		Score
Mobility		
	Completely Immobile	0
	Ambulant with no gait disturbance	0
	Ambulant or transfer with assistive device	1
	Ambulant with unsteady gait and no assistive device	1
Mental State		
	Coma/ Unresponsive	0
	Developmentally appropriate and alert	0
	Developmentally Delayed	1
	Disorientated	2
Toileting		
	Nappies	0
	Independent	0
	Needs assistance with toileting	1
	Independent with urinary frequency and/or diarrhoea	1
History of Falls		
	No	0
	Yes before admission (above what is expected for child / young person's developmental stage)	1
	Yes during admission (above what is expected for child/young person's developmental stage)	2
Medication		
	Anticonvulsants, opioids, diuretics, sedatives, bowel prep	1

Date									
Time									
Score									
Signed									

If falls score equal to or greater than 3 commence falls high risk management plan and manual handling risk assessment.

Print ..... Signature ..... Stamp .....

CP42 Appendix 7



Mobilising with an Epidural

Risk Assessment for Mobilising with Epidural

Women with low concentration high volume epidural (prepared mixture – bupivacaine 0.1% with fentanyl 2mg/ml), must undergo a risk assessment for mobilising. This epidural is designed to provide analgesia without significant motor block. It must be noted that some women will develop motor block and if this happens the epidural must be treated as a traditional epidural which will produce a denser block and impair motor function.

Mobilisation where possible must be encouraged.

A risk assessment is appropriate, once the woman has adequate analgesia. The assessment must assess sympathetic, sensory and motor block by the following:

- ☐ Ability to raise each leg off the bed for at least five seconds
- ☐ Ask the woman if she feels capable of weight bearing
- ☐ Ask the woman to place her feet on the floor. If her feet feel like 'cotton' wool' this usually means it is not safe to walk
- ☐ Assess deep knee bending whilst weight bearing

The woman must have two people to support her whilst the assessment is carried out

Following successful completion of this risk assessment the woman can mobilise around the birthing room and use the Combitrac® birthing ball. Care must be taken with any trip hazards, e.g. Drip stands and CTG cables. It may be appropriate to use Telemetry.

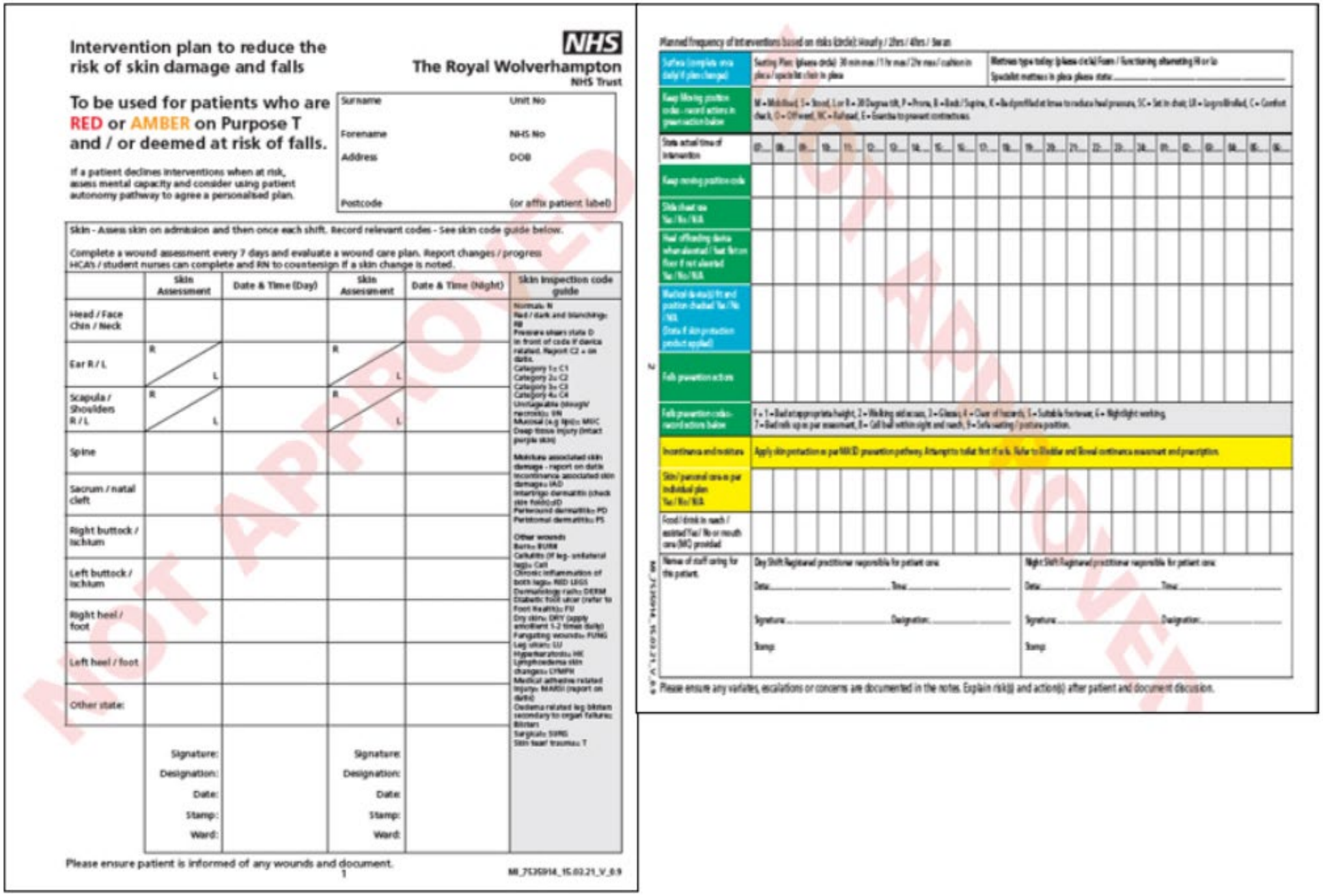
Other requirements:

- ☐ No postural hypotension or symptoms
- ☐ Co-operative mother
- ☐ Supportive birth partner

The woman must not be left alone whilst mobilising – the birth partner must remain with the woman if the midwife has to leave the room.

S Fenner May 2003, R Chandrashekar S Merron January 2008 Reviewed Z Kamarzaman October 2012
Date of first Implementation October 2012
Reviewed May 2021

CP42 Appendix 9



Intervention plan to reduce the risk of skin damage and falls

NHS
The Royal Wolverhampton NHS Trust

To be used for patients who are RED or AMBER on Purpose T and / or deemed at risk of falls.

If a patient declines interventions when at risk, assess mental capacity and consider using patient autonomy pathway to agree a personalised plan.

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Skin - Assess skin on admission and then once each shift. Record relevant codes - See skin code guide below.

Complete a wound assessment every 7 days and evaluate a wound care plan. Report changes / progress HCA's / student nurses can complete and RN to countersign if a skin change is noted.

	Skin Assessment	Date & Time (Day)	Skin Assessment	Date & Time (Night)	Skin inspection code guide
Head / Face Chin / Neck					Normal= N Red / dark and blanching= RB Pressure ulcers state D in front of code if device related. Report C2 + on datix. Category 1= C1 Category 2= C2 Category 3= C3 Category 4= C4 Unstageable (slough/ necrosis)= UN Mucosal (e.g lips)= MUC Deep tissue injury (intact purple skin) Moisture associated skin damage - report on datix Incontinence associated skin damage= IAD Intertrigo dermatitis (check skin fold)= cID Perineum/ dermatitis= PD Peristomal dermatitis= PS Other wounds Burns= BURN Cellulitis (if leg- unilateral legs= Cell Chronic inflammation of both legs= RED LEGS Dermatology rash= DERM Diabetic foot ulcer (refer to Foot Health)= FU Dry skin= DRY (apply emollient 1-2 times daily) Fungating wounds= FUNG Leg ulcers= LU Hyperkeratosis= HE Lymphoedema skin changes= LYMPH Medical adhesive related injury= MARSI (report on datix) Oedema related leg blisters secondary to organ failure= Blisters Surgical= SURG Skin tear/ trauma= T
Ear R / L	R / L		R / L		
Scapula / Shoulders R / L	R / L		R / L		
Spine					
Sacrum / natal cleft					
Right buttock / Ischium					
Left buttock / Ischium					
Right heel / foot					
Left heel / foot					
Other state:					
	Signature: Designation: Date: Stamp: Ward:		Signature: Designation: Date: Stamp: Ward:		

Please ensure patient is informed of any wounds and document.

1

MI_7535914_15.02.21_V_0.9

Planned frequency of interventions based on risks (circle): Hourly / 2hrs / 4hrs / 6hrs

Turning (complete once daily if plan changes)	Turning Plan: (please circle) 30 min max / 1 hr max / 2hr max / cushion in place / specialist chair in place	Mattress type today: (please circle) Foam / Functioning alternating Mor la Specialist mattress in place please state:
Keep moving position codes - record actions in green section below	M = Mobilised, S = Stood, L or R = 30 Degree tilt, P = Prone, B = Back / Supine, E = Re-positioned at times to reduce heel pressure, SC = Sat in chair, LB = Legs re-Bridled, C = Comfort check, O = Off weed, NC = Refused, E = Given toe to prevent contractures	

State actual time of intervention	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
Keep moving position code																														
Slide sheet use Yes / No / N/A																														
Heel offloading device when elevated / heel float on floor if not elevated Yes / No / N/A																														
Medical device(s) fit and position checked Yes / No / N/A (State if skin protection product applied)																														
Falls prevention actions																														
Falls prevention codes - record actions below	1 = Bed at appropriate height, 2 = Walking aid access, 3 = Glasses, 4 = Clear of hazards, 5 = Suitable footwear, 6 = Nightlight working, 7 = Bed rails up as per assessment, 8 = Call bell within sight and reach, 9 = Safe seating / posture position.																													
Incontinence and toileting	Apply skin protection as per MIICD prevention pathway. Attempts to toilet first if safe. Refer to Bladder and Bowel continence assessment and prescription.																													
Skin / personal care as per individual plan Yes / No / N/A																														
Food / drink in reach / assisted Yes / No or mouth care (MC) provided																														

Name of staff caring for this patient	Day Shift Registered practitioner responsible for patient care	Night Shift Registered practitioner responsible for patient care
	Date: Time: Signature: Designation: Stamp:	Date: Time: Signature: Designation: Stamp:

Please ensure any variables, escalations or concerns are documented in the notes. Explain risk(s) and action(s) after patient and document discussion.

The Royal Wolverhampton NHS
NHS Trust

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Enhanced Care Scoring Tool

Instructions for assessing the patient using the ECST: Score each element separately – take the highest score from each element and total all five scores up to identify the enhanced care scoring tool total. **Example:** Psychological factors (e.g. removing critical physiological support) = 3; Cognitive Impairment (patient is wandering) = 2; Distressed Behaviour (trying to get out of bed) = 2; Environment (behaviour requires patient to be isolated) = 3; fall (none) = 0. **ECST score = 10**.

Using the patient ECST score, refer to the guidelines to determine the level of support required.

Element	Score 3	Score 2	Score 1	Score 0
Psychological Factors e.g.	• Patient is a current risk to self • Admission because of self-harm / suicide risk • Irrational behaviour • Attempted to harm others • Patient is removing critical physiological support • Public health issues involved	• Poor compliance with medications and or treatment • Previous suicide attempts • Patient expressing harmful behaviours to self or others. • Patient expressing hopelessness	• Previous self-harm generating on-going concern • Low mood • Background history of mental health issues	• Previous self-harm and not currently generating concern • None this episode
Cognitive Impairment e.g.	• Loss of time, place, person & investigation • Behavioural changes • Inability to rationalise leading to aggression • Carers are expressing concern • Patient is attempting to harm others • Patient has impaired ability to communicate / follow commands or instructions	• Absconding / wandering outside or in the clinical area which impacts on others • Patient has short term memory loss • Removing essential / physiological support lines • Non responsive to distractions such as VERA (Validate, Emotion, Reassure, Activity)	• Low in mood • Withdrawn • Confused but responds to VERA (Validate, Emotion, Reassure, Activity) / distraction.	• Calm • Passively confused
Distressed Behaviour e.g.	• Episodes of physical aggression agitation in the last 24 hours • Threatening self and / or others • Has bizarre behaviour impacting on self or others • Heavy smoker or uncontrolled withdrawal from alcohol • Uninhibited sexual or physical behaviour, causing concern to self and others	• Symptoms of alcohol or drug withdrawal • Verbally aggressive / agitated • Smoker • Withdrawn / uncommunicative • Inappropriately trying to get out of bed • Restlessness compromising safety	• Alcohol / substance abuse not on withdrawal protocol • History of aggression / agitation	• No signs of agitation or aggression
Environment e.g.	• Unable to call for help or use buzzer and isolation necessary • Behaviour requires patient to be isolated	• Distressed at isolation but able to rationalise and be distracted • Not isolated but cannot communicate needs	• Isolated but no risk to self or others • Can communicate and rationalise	• No isolation
Falls e.g.	• Patient has had a fall with moderate to severe harm associated with an on-going risk (e.g. lack of insight / understanding by patient)	• History of falls in the last month • X1 fall as an inpatient with no harm or low harm	• High risk of falling • Admitted following a fall • Falls equipment not effective	• No / low risk of falls

Note: If, in your professional judgement, you feel that a patient requires enhanced observations, then please provide enhanced care. Please follow specialist advice.

Dementia Specialist Nurse - ext. 8454
Learning Disability Specialist Team - ext. 5228
Penn Hospital - tel. 01902 444141
Security - ext. 8222
Safeguarding - ext. 5163
CERL - bleep 7394
Psychiatry Liaison - bleep 3933
Drug & Alcohol Liaison - ext. 4079
CAMHS - tel. 01902 444021

Mi_1439514_13.10.16_V5

Guidelines

Please use these guidelines to determine the level of support / observation required based on your enhanced care scoring tool. Please review score every 24 hours.

ECST SCORE	ACTIONS to be considered:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
0-3	• Patient safe – review daily or if condition deteriorates	Time:	Time:	Time:	Time:	Time:	Time:	Time:
4-7 Green	• Is the patient clinically well? Exclude physical causes for restlessness. • Consider an appropriate environment – side room if necessary, low lights, reduce noise • Consider cohorting patients in a bay • Escalate to nurse in charge and / or bleep holder of clinical area • Review patient at every shift using the ESCT (and more frequently if indicated) • Appropriate specialist referral (see contact details) document in Health Records • Consider falls alarm equipment / low beds • Try to establish and treat underlying cause / unmet needs where possible • Be fully aware of any care management plan / behavioural guidelines • Communicate clearly with the patient and be sensitive to their needs • Utilise distraction strategies / activities • Ensure next of kin are kept fully informed • Review medication • Complete care record and relevant documentation	Signature and designation	Signature and designation	Signature and designation	Signature and designation	Signature and designation	Signature and designation	Signature and designation
8-11 Amber	• Consider enhanced care observations • **Implement all of the above actions** • Consider restrictive physical intervention • Consider tag nursing, following assessment of mental capacity • Escalate to nurse in charge and / or bleep holder / matron of clinical area • Consider psychiatric review • Complete care record and relevant documentation	Stamp:	Stamp:	Stamp:	Stamp:	Stamp:	Stamp:	Stamp:
12-15 Red	• Needs enhanced care observations • **Implement all of the above actions** • Consider security involvement for support and advice • Escalate to nurse in charge / ward manager / bleep holder / Matron / Head of nursing • Consider / consult experts group (see contact details) • Complete care record and relevant documentation	Score:	Score:	Score:	Score:	Score:	Score:	Score:

CP 42 Appendix 11

PLEASE CALL BEFORE YOU FALL

Your safety is important to us.
If you need to get up, use the
call button for assistance.

ESSENTIAL CARE AFTER an INPATIENT FALL

Initial Checks

Abbreviations Key:
ABCDE – Airways, breathing, circulation, disability, exposure
ACVPU – Alert, confusion ,verbal, painful stimuli, unresponsive
GCS – Glasgow Coma Scale

- Check for on-going danger. Call for assistance.
- Do not move patient until assessed.
- Registered practitioner to assess patient immediately.
- Check ABCDE and ACVPU.
- Put out emergency call if indicated.
- Check "top to toe" for injury*
- Assess for any pain in limbs or any obvious deformity
- Assess for any pain in neck or spine
- Establish if patient has hit their head
- Call for a doctor to assess.

Medical review must occur within 1 hour if patient has:

- Obvious limb deformity.
- Patient has Hit Head.
- Pain in neck or spine.

- Record baseline vital signs

If patient has or suspected to have hit head undertake Neurological Observations (GCS) for a minimum of 12 hours as follows:

- ½ Hourly for 2 hours
- 1 Hourly for 4 Hours
- 2 Hourly for 6 Hours
- If GCS drops below 15 at any time after the initial 2 hours – revert back to ½ Hourly observations and request urgent medical review.

Safe Retrieval from Floor

- Return patient to bed/chair following assessment for any obvious signs of injury.
- If Injury suspected, return patient to bed as advised by a medical practitioner.
- Utilise correct manual handling aids as indicated e.g. flat lifting board/scoop, hoist, Hoverjack, hard collar.
- Call for assistance from specialist areas if indicated.

Communication and Documentation

- Complete a DATIX incident form.
- Inform relatives and document fully in patient notes. (Duty of Candour)
- Repeat Falls Risk Assessment and update care plan.

Ongoing care

- Implement falls prevention strategies .(e.g. move patient to higher visibility area of the ward , tagging, revisit patient advice and education , call bell, safe footwear, safety briefings and handover, ECS if indicated)
- Follow agreed clinical management plan (e.g. X-rays, CT scan, immobilisation, analgesia, clean / dress wounds, fluid balance, sepsis screen)
- Continue to observe vital signs /Neuro observations as indicated.
- Referral to community falls prevention services if appropriate and patient agrees.

Appendix 13: Guidance Sheet for Essential Care after Fall within Ambulatory or Community home setting

Guidance sheet for essential care after a patient fall in an ambulatory care environment or their own home
1) INITIAL CHECKS • Check for on-going danger. Call for assistance • Check ABCDE • Do not move patient until assessed • Registered practitioner to assess patient immediately. HCA's will need to contact a registered nurse in their team • Check "top to toe" for injury* • **Contact the GP, Community Urgent Care Team or Ambulance Service (999) for further assessment if the patient has hit their head** • **If the patient has any loss of consciousness or obvious injury call 999 immediately**
2) SECOND CHECKS • **Baseline vital signs** • **Neurological observations** GCS every 30 minutes until GCS is 15 or ambulance crew arrives to take over care
3) SAFE RETRIEVAL • Return patient to bed/chair **only when** you are certain that there are no injuries • Utilise correct manual handling aids/advice
4) CLINICAL MANAGEMENT PLAN • Remain with patient until the Ambulance crew arrives where necessary or when safe to leave the patient
5) COMMUNICATION and DOCUMENTATION • Complete a DATIX incident form if the fall is witnessed or unwitnessed • Inform relatives and document fully in patient record • Communicate with GP to inform them of the fall • **Update care plan and complete falls risk assessment** • **Refer to the Community Intermediate Care Team (CICT) or Community Falls Prevention Service as appropriate**

ABCDE - Airway, breathing, circulation, disability, exposure
ACVPU - Alert, confusion, verbal, painful stimuli, unresponsive
GCS - Glasgow Coma Scale

CP42 Appendix 14

FALLS INVESTIGATION AND ESCALATION PROCESS

The Royal Wolverhampton NHS Trust

All Falls within Trust Reported via Datix

(Includes all Falls, No harm and above, near misses and assisted)

NO HARM FALLS

- Lessons learnt shared with local teams.
- No harm falls learning, by Division, presented at falls prevention monthly meetings.
- Any required action noted and addressed.

LOW HARM FALLS

- Lessons learnt shared with local teams.
- Senior Sister / Matron to present details of incident and Datix to falls accountability panel to determine avoidability.
- Update
- Any required action / learning noted

Incident lead/ handler to finally approve Datix within 5 working days

Lessons learnt to relevant others via:

- Falls Accountability meetings (action logged)
- Falls Prevention meetings (action logged)
- Local team meetings (action logged)
- Senior nurse meetings
- Quality newsletter
- Trust newsletter

FALLS MODERATE HARM AND ABOVE

- All falls with moderate harm and above are escalated immediately to: rwh-tr.SUIReporting@nhs.net
- Any immediate required action / learning noted and addressed.
- Matron approved RCA to be completed within 48hrs and sent to SI team.
- Senior Sister/ Matron to present RCA at next available falls accountability panel to determine avoidability
- Any required ongoing action / learning noted and addressed.

AVOIDABLE FALL

Where the RCA panel confirm that acts and / or omissions in care have contributed to the root cause of the fall.

Heads of Nursing meeting report to be submitted to: **rwh-tr.SUIReporting@nhs.net** on the day of the meeting.
Consider RIDDOR criteria to confirm whether incident reportable.

Serious incident-SUI reporting team to report incident on STEIS and present at ESERG

Finally approved investigation and action plan must be closed within 45 days of the incident being reported to STEIS

UNAVOIDABLE FALL

Where the RCA panel confirm that no acts or omissions in care are identified

Not a serious incident- Ensure measurable action plan for any lessons learnt is in place.

Heads of Nursing meeting report to be submitted to **rwh-tr.SUIReporting@nhs.net** on the day of the meeting.

Quality team to review RCA findings and patient records to approve final decision or return to a second panel meeting for further discussion.

Incident lead / handler to finally approve Datix within 5 working days of final decision outcome.

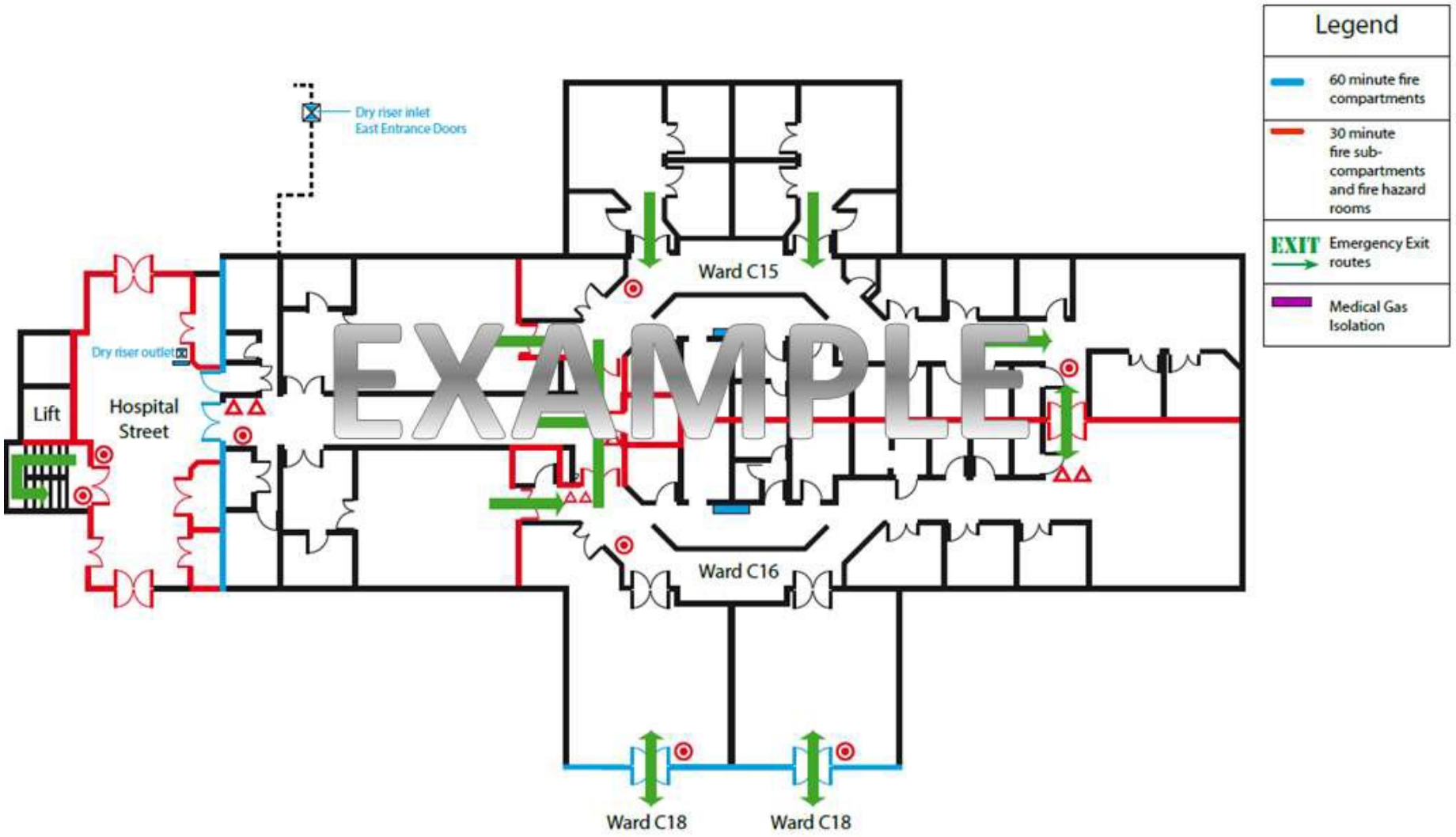
The Royal Wolverhampton NHS

Fire Evacuation Plan Block No. 64

The Royal Wolverhampton NHS Trust

First Floor

C15 & C16



Comprehensive Root Cause Analysis for a Fall	Hospital/NHS number: Datix Number and date: STEIS number and date escalated: Rationale for any delay in escalation: Lead Investigator: Ward Service:

Type Required		**Approval**	**By who**	**Confirmed outcome**	**Date**
Level 1 (Concise)	**48 Hour**	**Accountability meeting**	Panel		
Level 2 (Comprehensive)	**30 Day**	**Directorate**			
		Division			

Is the incident Externally Reportable:	**Yes / No** **If Yes, please identify:**	**Commissioner**	
		Other	
Is this a Never Event?	**Yes/ No**		
STEIS category	Fall		
Duty of candour	Date discussed with patient or relevant next of kin: Was a letter issued, if no state why: Date feedback of investigation:		

48 Hour Report Lead Investigator:
Once signed off by Directorate and Division please add dates and details of who has approved and forward final version to rwh-tr.SUIReporting@nhs.net

RCA Investigation/ 48 Hour Report – Falls Report

To be completed by Senior Nurse/ Matron on identification of incident.

Return the completed report to rwh-tr.SUIReporting@nhs.net by midday on the 2nd working day after the incident

- On completion ensure all guidance text (in green) is deleted

Initial Findings

Incident description and consequences	
Incident description: [*e.g. A 47 year old female patient (Hospital/NHS number) with asthma sustained subdural haematoma following a fall.*]	
Datix no:	
Matron/ senior nurse proposed outcome of incident:	**Avoidable** **Unavoidable** *Delete as necessary*
Incident date:	*[Date of incident, or – if not known – date identified as an incident to the Trust]*
Incident time:	*Time of incident – if not known – time identified as an incident to the Trust]*
Incident location:	*Bathroom, bed space (as noted on measles chart)*
Incident type:	*[See Datix record]*
Directorate/ Specialty:	
Date of investigation:	
Actual effect on patient:	*[Clarify effect (if any) on patient – this must also be described on Datix and categorized as: death, severe harm, moderate harm, low harm or no harm]*
Current status of patient & medical plan:	*Clarify status of patient – this may be already included on Datix]*
Relevant Past Medical History	
Medication	
Social History (where applicable)	

Timeline of events/ chronology

Date/ time	List events, investigations, facts	Source of evidence

Contributory Factors

Investigation – Contributory Factors		YES	NO	Comment
Reporting Factors	Witnessed Fall by whom?			
	Not witnessed fall			
	Is this first fall this admission?			
	Is this a repeat fall? Previous DATIX ID number(s)			
	Outcome of medical investigation recorded (e.g. x-ray)			
	Type of injury			
	Incident form completed? Classification of incident (state)			
Environmental Factors	Is the patient easily observable?			
	Patient buzzer/bell available within reach before fall?			
	If fall from bed, were bedrails were in use?			
	Floor wet?			
	Floor dry?			
	Floor talcum powder?			
	Safe footwear?			
	Walking aid in use?			
	Walking aid in reach?			
	Bed area uncluttered?			
	Lighting – delete as necessary: Daytime – natural light/ electric lighting			

	Night time - electric lighting / night light or complete darkness			
	Toilets/bathrooms with grab rails available at appropriate height?			
Patient Factors	Did the patient have a falls risk assessment completed (Part A)?			
	Is the patient able to mobilise safely unaided?			
	Did the patient have a bed rails assessment?			
	Was a Falls Care plan completed & personalised?			
	Was the patient placed in a high/low bed?			
	Was an enhanced care tool assessment completed?			
	Was tag nursing care recommended? If yes please state if implemented:			
	Was the patient nursed in a bay of cohorted patients?			
	Was arm's length care recommended? If yes was it implemented:			
	Was an alert sign in place over patient bed, on Safety briefing and Safe Hands?			
	Was the patient given the Falls Prevention leaflet?			
	Is there documented evidence of teach back from patient regarding falls prevention tactics?			
	Is a "Please Call Before You Fall" poster displayed?			
	Was the falls intervention checklist completed on intervention chart?			
	Does the patient suffer from incontinence or urgency? State toileting regime			
	Did staff implement essential care after an inpatient fall (CP42b appendix1)?			
	Was a Falls risk assessment (Part A) completed post fall?			
	Was a Medical Staff Falls Assessment (Part B) completed post fall?			
	Was lying/standing and right and left BP taken? Were there any discrepancies (give detail)			
Medical staff Falls assessment (Part B) (to be completed by medical staff)	Medication review e.g. sedatives, psychotropic or medication causing drowsiness (please detail actions taken)			
	Cardiovascular review: Has the patient been or is the patient being treated for cardiovascular illness? (please detail actions taken)			
	Cognitive review: Was the patient confused or			

	disorientated? (please detail actions taken)			
	Visual Review: Does the patient have problems with their eyesight? (please detail actions taken)			
Human Factors – Was care affected by suboptimal staffing levels?	Staffing levels at time of incident: Predicted vs. Actual Location of staff at time of incident (Safe Hands data)			
State current vacancy/sickness/ maternity/capacity factors if relevant	Team expected WTE- Team current WTE at time of incident- Maternity Leave Vacancy Sickness Datix incident number/risk register			
Date of last patient fall with harm				
Number of patient falls in preceding month				
Ward % moving and handling training compliance				
Ward % Preventing Falls in hospital e-learning compliance				
Ward % Falls handbook compliance				

Identified issues

Were there any identified issues or problems (i.e. staffs were not aware patient was confused?)

Summary of omissions (bullet point)	**Summary of positive assurance (bullet point)**

Barrier Analysis

Were there any controls in place which will or must have prevented this happening?

Current control(s) in place to prevent incident:	**Why the Control Failed:**
Tag nursing in place	*HCA left the bay*

What controls or barriers will be used to prevent the incident happening again?

Root Causes (bullet point)
[Understanding as at 48 hours of underlying causes of the incident – include rationalisation of this understanding]
Recommendations
[List of CLEAR NUMBERED recommendations which address the risk and reduce re-occurrence. These must be succinct not detailed [detail belongs in the action plan [Appendix 1]. Please also number the actions. Recommendations MUST address the root causes identified above. Please review tools available on NPSA website www.npsa.nhs.uk.rca 1. 2. 3. etc.
Actions
Add any further actions identified at the 48-hour stage to the action plan template (Appendix 1) at the end of this document. These must be numbered to reflect the recommendations they aim to implement.
Lessons Learnt and Incidental Findings
Highlight any general learning from this incident or issues that have been identified in the course of the investigation or Table Top Scrutiny meeting that are not directly related to root causes, but which would inform learning and improvement. 1. 2. 3. **Arrangements for shared learning (including scope of sharing and person responsible):** 1. 2. 3.
RCA Lead Investigator Name and Job Title
Add text here
Names and Job Titles of individuals involved in the investigation (including those interviewed and from whom statements have been obtained) ***N.B. NAMES WILL BE REDACTED FROM FINAL VERSION***
Add text here
Scrutiny Meeting Attendees (Names and Job Titles) ***N.B. NAMES WILL BE REDACTED FROM FINAL VERSION***
Scrutiny group agreed – outcome of incident & Comments from scrutiny meeting

Avoidable **Comprehensive RCA to division/** **Comprehensive action plan and duty of** **Candour letter** **Unavoidable** **Confirm level of harm to patient – moderate, severe harm, death** (***Admin to update Datix and inform Governance post Scrutiny meeting)***
Report Date

Action Plan Template

*For **Level 1 (Concise)/ 48 Hour Report** and **Level 2 (Comprehensive)/ RCA** Investigations*

For support see „**Types of Preventative Actions Planned'** – tool at www.npsa.nhs.uk/rca

Please note: The final action plan will be approved by the Divisional Management Team before sending onto the Commissioners for closure. The Healthcare Governance Manager will ensure that the Directorate Management Team receive the finalised version of the report and action plan. The Directorate will then be responsible for ensuring the Implementation Leads are aware of the action attributed to them and the target date for the action to be completed and monitoring all actions through to completion.

No	Root Cause *Please refer to details included on Page 6*	Recommendation to address identified root cause *Please refer to details included on Page 6*	Action/s to implement the recommendation *Please refer to details included on Page 6*	Implementation Lead (Job Title)	Target Date for Completion	State evidence of the completed action
1						
2						
3						
4						
5						

CP42 Appendix17

Falls Prevention Service

Name:

D.O.B: _____

Address: _____

NHS number:

GP:

GP Contact number:

Interpreter required: Yes☐ No☐

If yes, language required:

Patient contact number:

Next of Kin:

NOK Contact number:

Has consent been gained to refer into the Falls Prevention Service? Yes ☐ No☐

Number of falls in last 12 months: ☐

If no falls, please state the falls risks?

Is the service user able to retain information? Yes ☐ No☐

Can the service user attend a clinic for a falls assessment? Yes ☐ No☐

Is the service user able to participate in a 12 week group exercise programme? Yes ☐ No☐

Please select any relevant medical history:

Myocardial infarction☐ Recent surgery ☐ Stroke ☐ Angina ☐ COPD ☐ Diabetes☐
Blackouts☐ Postural hypotension☐ History of cancer☐ Seizures☐

Other relevant past medical history:

If the service user has blackouts, has this been investigated? Yes ☐ No☐
Please supply details:

Reason for falls:
Trip/slip ☐ Home hazard ☐ Dizziness ☐ Knees giving way ☐
Overreaching ☐ Turning ☐ Standing up ☐ Unsteady gait ☐

Are there any known risks? Yes☐ No☐
Please supply detail of risk:

Reason for referral and other relevant information:

Referrers Name and Profession	**Contact number:**	**Date:**
	Email:	**Base:**

Please return completed form back to: rwh-tr.fallsprevention@nhs.net
IF ANY SECTION OF THIS FORM IS LEFT INCOMPLETE, IT WILL BE RETURNED

The Falls Prevention Service is a clinic based holistic assessment of service users who are at risk of falling. Following an assessment, the service user is invited to engage in a home exercise programme or attend one of our group classes held in localities around Wolverhampton. The aims of the service are to **educate** users about their falls risk and **empower** them to self-manage this through exercise and daily activity.

Community Intermediate Care Team (CICT) triage form

rwh-tr.CICTTEAM@nhs.net

Date:	Time triage call:	Enquiry discussed with:
Patients Name:	NHS number:	
Reason for referral/main problem:		
Specific goal of intervention:		
Recent medical history including investigations: (if not available on CWP)		
Rehabilitation potential:		
Consent to referral: Yes ☐ No ☐ Details: **Patient must be informed of referral to service and able to participate with staff**		

Home situation

Lives alone: Yes ☐ No ☐ Details:

House ☐ Flat ☐ Floor ____ Bungalow ☐ Sheltered accommodation ☐ Very sheltered accommodation ☐ Residential home ☐ Nursing home (N.B. not step down bed) ☐

Care package: Yes ☐ No ☐ Details(no of calls / no of carers)

Other support/ family carers:

Other services: HARP ☐ DN ☐

Functional ability

Independently mobile: Yes ☐ No ☐ Details:

Walking Aid ☐ frame ☐ stick(s) ☐ elbow crutches ☐ other:

Stairs: independent: Yes ☐ No ☐

Stair lift: Yes ☐ No ☐ Independent transfer: Yes ☐ No ☐

Bed downstairs: Yes ☐ No ☐ Independent transfer: Yes ☐ No ☐

Personal care needs: Yes ☐ No ☐ Details:

Toileting needs: Yes ☐ No ☐ Details:

Commode: Yes ☐ No ☐ Details:

Meal preparation needs: Yes ☐ No ☐ Details:

Therapy needs: Physio ☐ OT ☐ Details: Equipment in place for discharge: Yes ☐ No ☐ Details:
Nursing needs: If in Hospital Waterlow Score: Pressure Relief Equipment:
Medication management: Self-medicating Yes ☐ No ☐ Details:
Risks or alerts Yes ☐ No ☐ Details:
Accept for home assessment? **Yes ☐ No ☐** **Reason if not accepted -**
Other information/ comments: (e.g. internal steps, patient main carer, etc.)
Triage clinician:

Accepted referrals

Proposed date to commence service:
Access arrangements: Can answer door ☐ Active carer ☐ Key safe ☐ contact for code: **Confirm contact details** Patient ☐ NOK ☐ Other comments re service provision/ safety/ risks:
Priority of referral: High ☐ Routine ☐ Reason if high priority:

CP 42 Appendix 19

Birmingham Community Healthcare NHS Trust
Adults and Community Division

Integrated Multidisciplinary Team Referral

(Patients must be aged 18 or over and registered to a Birmingham GP)

Telephone **0300 555 1919 option 1**
Fax to **0845 340 5770**
Email to **bchc.imtreferral@nhs.net**

(Fax and Emails will only be picked up between the hours of 8:00am – 5:00pm Monday – Friday and 8:00am – 12:00pm Saturday and Sunday)

NOTE: ANY URGENT REFERRERALS SHOULD BE PHONED THROUGH AND NOT FAXED OR EMAILED.
Postal address: SPA, Referral Management, 1 Priestley Wharf, Holt Street, Birmingham. B7 4BN

PRIMARY REASON FOR REFERRAL:

Forename:			**NHS NUMBER:**	
Surname:			**D.O.B:**	
			Gender: M ☐ F ☐	**Disability: Y ☐ N ☐**
Address:			**NOK** **Relationship:** **Contact Details:**	
Postcode:			**Carer / Friend:** **Contact No:**	
Tel. No:				
Living with:	**Access arrangements:**		**Key Safe:**	**Identified hazards?:**
Patient / carer aware of referral: Y ☐ N ☐	**Religion:**	**Ethnicity:**	**1st Language:**	**Interpreter? Y / N**

GP:			**Contact No:**
Practice:			**Check B'ham GP Y ☐ N ☐** C&W ☐ E&N ☐ South ☐
Referrer:	**Referral date:**		**Referrers role:**
Contact No:	**Referral time:**		**Base:**

Urgency of referral: (DISTRICT NURSING ONLY) ☐ **Non Urgent – contact within 24 hours** ☐ **Routine – contact within 48 – 72 hours** ☐ **Other – please state:** **(ALL URGENT REFERRERALS SHOULD BE PHONED THROUGH)**	**Service/s required/Covered (Please Tick)** **District Nursing** ☐ **Case Management** ☐ **Physiotherapy** ☐ **Occupational Therapy** ☐

Reason/s for referral – please tick predominant reason for requested intervention

Fall – non fracture **R54X**	Fall – with fracture **T142**	Post surgery-ortho **Z479**	Post surgery-general **Z489**	COPD **J449**	Respiratory other **J989**	Diabetes **E149**	**I64x** Stroke / CVA Neurology **R298**	End of life **Z515**	Cancer **C80X**	Blood disorder **D759**	Wound Care **Z480**	Dermat-ology **L989**
Heart failure/ IHD **I259**	Eye care **H579**	Ear care **H939**	Leg ulcers **L97X**	Infection – other **A499**	Continence **N329**	Functional deterioration **R53X**	Mental Health **F99X**	OA **M1999**	RA **M0699**	Flu jab / immunisation **Z269**	Carer Crisis **Z749**	XXXXXXXX XXXXXXXX

Patient Name:_____ **NHS Number:**_____

Patient's location at time of referral: Home ☐ Hospital ☐ - Hospital ……
- Ward ……
- Ward contact no……
- Date of admission……
- Reason for admission.....

Discharge planned: Yes ☐ No ☐ Anticipated Date: ……

***Presenting Problems:**

	PHYSIO & OT ONLY (Please answer all questions):-
1.	Access to Property (i.e. patient able to answer door)
2.	Any Hazards at property? (i.e. Pets etc)
3.	Referral Reason?
4.	Is there a diagnosis?
5.	Any Walking Aids?
6.	How do they Transfer?
7.	Any falls recently?

Current service involvement:

Service	calls per wk	Contact	Service	calls per wk	Contact
Day Care			Specialist nurse		
DN			Informal carer		
Family			MOW		
Social worker			Other		
Homecare			Other		

For office use only:

Received via: Phone Fax Post Other	Date received:	Time received:	IMT identified: / If urgent, team member contacted by phone:	Registered on IPM	Transmitted to IMT

CP 42 Appendix 20

Dudley Falls Prevention Service- Professional Referral

Client Details			
Surname:	First Name:		Ethnicity:
Date of Birth:	NHS No:		AIS Pin:
Address:	Postcode:		Contact numbers:
Lives alone: ☐ Yes ☐ No	NOK Contact Details:		
Is an interpreter required?	☐ Yes ☐ No	Language:	
Any safety concerns for home visits? if yes please detail	☐ Yes ☐ No		
GP Name & Practice: Contact Number:			

Referrer details	
Name	Contact Number
Designation/ relationship to client:	Date of referral:

Reason for Referral – please detail as much info as possible

Falls History			
Has client fallen? If Yes how many times?	☐ Yes ☐ No	Have they had any near misses? If Yes how many times?	☐ Yes ☐ No

Are they fearful of falling? ☐ Yes ☐ No

Client reports having: Palpitations ☐ Loss of consciousness ☐ Dizziness ☐ Mechanical fall ☐

Any fractures or injuries sustained (please provide details):

Osteoporosis: ☐ Yes ☐ No

CP 42 Appendix 20

Dudley Metropolitan Borough Council

Dudley Falls Prevention Service- Professional Referral

NHS

Medical History - **please detail as much info as possible including details of any stroke and the dates**

Medication:

(Please detail)

Client reports being on the ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ More than 5 medications

Would Client benefit from a medication review: ☐ Yes ☐ No

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS	None in last 12 months	☐ 2
	One or more between 3 and 12 months	☐ 4
	One or more in last 3 months	☐ 6
	One or more in last 3 months whilst impatient / resident	☐ 8
MEDICATIONS (Sedatives, Anti-Depressants, Anti-Parkinson's, Diuretics, Anti-hypertensive's, hypnotics)	Not taking any of these	☐ 1
	Taking one	☐ 2
	Taking two	☐ 3
	Taking more than two	☐ 4
PSYCHOLOGICAL	Does not appear to have any of these	☐ 1
	Appears mildly affected by one or more	☐ 2
	Appears moderately affected by one or more	☐ 3
	Appears severely affected by one or more	☐ 4
COGNITIVE STATUS (AMTS: Hodkinson Abbreviated Mental Test Score)	AMTS 9 or 10 / 10 **OR** intact	☐ 1
	AMTS 7 – 8 mildly impaired	☐ 2
	AMTS 5 – 6 mod impaired	☐ 3
	AMTS 4 or less severely impaired	☐ 4
Low Risk: 5-11 Medium Risk: 12-15 High Risk: 16-20		Score out of 20
Referral for Physical Activity Intervention only ☐ (must score less than 15/20)		

Dudley Metropolitan Borough Council

Dudley Falls Prevention Service- Professional Referral

NHS

SPA USE ONLY: Outcome :

☐ Tier Zero ☐ Stream 1 ☐ Stream 2 ☐ Stream 3 ☐ Med Review

Making a referral

Email: fallsspa@dudley.gov.uk **Phone**: 01384 814459

Post : Dudley Falls Prevention Service, Brierley Hill Health & Social Care Centre, 2nd Floor , Venture Way, Brierley Hill, DY5 1RU

Please ensure that the above form is completed as thoroughly as possible. Any incomplete referrals will be sent back for further information.

Referrals to be emailed or teams contacted using the below details:
Seisdon : Email: seisdonfalls.management@nhs.net – Tel: 01902 506045
Cannock &Stafford: Goldfax: Email: armitagefalls.management@nhs.net – Goldfax: 01782 276433 Tel: 01543 492490
South East Staffs (BLT): Email: tamworthfalls.management@nhs.net – Tel: 01827 263800

CP42 Appendix 21

Staffordshire and Stoke on Trent Partnership NHS Trust

*Denote Mandatory field

Falls Risk Assessment Tool (FRAT) and Falls Management Service Referral Form

*NHS Number	CISS Number/Unit No.	*Date of Birth
		D D M M M Y Y Y Y

*First name	*Surname

Notes for users:
1. Complete risk assessment form (Part 1) below
2. If the score is greater than 3 then further assessment may be required
3. For referrals to the Falls Management Service complete part 2 of this form and send with a **Generic Demographic Form**

Part 1

Falls in past 12 months			Falls Risk Factors (CIRCLE ALL RELEVANT SCORES)			Balance and Gait (CIRCLE ALL RELEVANT SCORES)		
	Yes	No		Yes	No		Yes	No
3+ Falls	6	0	Takes 4 + Prescribed medicines	1	0	Able to rise from a chair (knee height)	0	3
Fall with injury	6	0	Uses sedatives	1	0	Stops walking when talking	6	0
2 Falls	3	0	History of Stroke	1	0	Reported balance problems	6	0
1 Fall	1	0	Has Parkinson's Disease	1	0	**Total Score:**		
			Problems with eyesight	1	0			

Score 0-2:
- If 'yes' for 4 or more prescribed medications or sedatives – recommend medication review (GP or pharmacy)
- Where appropriate advise the patient to see their optician if they have not had an eye test in the past year

Score 3+ (As above plus):
- Discuss referral to specialist Falls Management Service with the patient and complete part 2 of this form.
- If the patient is diagnosed with Stroke or Parkinson's disease a referral to the relevant specialist service may be more appropriate

Does the patient have a diagnosis of Osteoporosis?	YES/NO/NOT KNOWN
Does the patient have problems with balance related to an existing condition i.e. Meniere's Disease?	YES/NO/NOT KNOWN If yes, please state details below.
Has verbal and written falls prevention advice been provided (Age UK, Staying Steady Leaflet)	YES/NO/NOT APPROPRIATE

*Official Use Only (Referrer Details)		Designation			
Signature		Contact Tel/fax No.	T:	F:	
		Completed by (print name)		Date	

Part 2 (tick all that applies)

Has the patient received Falls Management Services in the past	Yes ☐	No ☐	When:	
Type of Fall	Trip ☐ Slip ☐ Dizzy ☐ Loss of Balance ☐ Over Reaching ☐ Legs gave way ☐			
Unexplained ☐ Loss of Consciousness ☐ Other (please state) :				
Walking aid used?	Type:	Pendant Alarm	Yes ☐	No ☐

Summary (regarding fall history or Risk Factors (ie contributing factors to the fall, injuries, fear of falling etc)

Comments

*Patient Signature		Completed by (print name)		Date	

Seisdon Falls Management Service

Exclusion Criteria

When referring into the Seisdon Falls Management Service please ensure that you have completed the relevant referral forms, the **Generic Demographic Form (GDF)** and a **Falls Risk Assessment Tool (FRAT).** This will enable us to prioritise the referral and ensure an appropriate referral to treatment time.

N.B. Please be aware that the Seisdon Falls Management Service is not a rapid response service and new referrals can be on the waiting list for up to 28 days dependent on their level of need; which will be ascertained by the team via a triage telephone call.

Patients need:

- To be 65 + years of age.
- To be registered with a Seisdon GP (**NOT** Brewood or Essington).
- To be able to mobilise.

N.B If the Patient is residing within a Care Home or Nursing Home a full comprehensive assessment of needs will be completed and recommendations made to keep the patient as safe as is reasonably practicable. Falls Awareness Training will be offered to all Care Homes or Nursing Homes within Seisdon.

Exclusion Criteria

- If a patient has Parkinsons and is under a Seisdon GP it may be of benefit to refer onto the Neuro Rehab Team based at West Park Hospital.
- Wheelchair bound.
- If another team is currently involved i.e. Enablement, Physio Dom, Stroke Team, Neuro Rehab Team.

Cannock and Surrounds Falls Management Service

Exclusion Criteria

- Any adult under 65 years of age (NICE guidance >65 risk of falls)
- Any adults who score less than 2 on the falls screening tool
- Acute episode/exacerbation of illness that requires an acute hospital environment to deliver care needs
- Acute injury/trauma that requires an acute hospital environment to deliver care needs
- Nursing Home patients
- Amputees- to be referred onto the Amputees Clinic, MSFT
- Advanced Dementia patients; for patients scoring 10 or below on the Mini State Mental Examination (MMSE)
- Palliative patients
- Wheelchair bound
- Acute episode of self-harm
- Adults who are under the influence of alcohol/substance misuse
- Patients with a permanent impairment or the functioning of the brail as a result of a brain injury and are unable to live independently.

LABEL NAME:…… DOB:……... HOSPITAL NO.:…… NHS NO.:……...

CP42 Appendix 22

Walsall Healthcare NHS
NHS Trust

Screening Assessment for Falls Prevention

PLEASE ENSURE ALL FIELDS ARE COMPLETED (noting the exclusion criteria overleaf)

Date of referral:		
Service User Name:	Date of Birth:	NHS Number:
Address:		Telephone Number: Mobile Number:

Referrer Name:	Designation:
Department:	Contact Number:

Please state how many falls the patient has had within the last 12 months		
Please list the falls history for the last 12 months:		
Has the patient attended hospital due to a fall? **PLEASE NOTE:** If the patient is currently an inpatient; please refer on point of discharge as per our exclusion criteria overleaf	Y / N	
Was any fall secondary to loss of consciousness?	Y / N	
Was any fall secondary to dizziness? (If YES please provide a recent sitting and standing blood pressure reading)	Y / N	
	Sitting	
	Standing	

Does the patient have severe / significant cognitive impairment?		Y / N
If yes, please provide a 6 CIT or Mini Mental Status Examination (MMSE) Score (please delete as applicable):		6 CIT / MMSE
If we are unable to contact the patient directly, please specify the details of a contact below:		
Name:	Relationship to patient:	Contact number:

LABEL
NAME:……
DOB:……...
HOSPITAL NO.:……
NHS NO.:……...

Walsall Healthcare NHS
NHS Trust

Screening Assessment for Falls Prevention

Method of Referral

- Fully completed Falls Screening Tool and Generic Referral form if required with medical summary
- Please send:
  - Via Post:
    Specialist Falls Team, Rushall Medical Centre, 107 Lichfield Road Walsall WS4 1HB
    Telephone: **01922 604931**
  - Via email
    #Walsall Falls Team (Global email list) **WalsallFallsTeam@walsallhealthcare.nhs.uk**
    Or via an nhs.net account if outside of Walsall Healthcare **walsallfalls.team@nhs.net**
  - If no email facility please fax to: **01922 604913**
- Referrals only accepted from Health / Social Care Professionals
- Mini Mental Status Examination (MMSE) / 6 CIT score requested on all referrals for patients with severe / significant cognitive impairment

Exclusion Criteria

- Adults who are under the age of 60
- Patients who do not have a Walsall GP and live outside of the Walsall borough
- Patients that are medically unstable, including hospital inpatient *
- Further discussion may be required with Falls Team prior to accepting referrals for service users with significant cognitive impairment as determined by Mini Mental Status Examination (MMSE) / 6 CIT Score
- Patients who have been referred to the service on at least two occasions in the previous 12 months and all interventions already completed
- Patients already known to 3 year stroke pathway, neurological rehabilitation service are awaiting confirmation of a neurological condition – signpost back to relevant service area
- Falls directly resulting from misuse of substances i.e. alcohol

* Patients referred who are inpatients are therefore medically unstable; please re-refer on point of discharge