The Royal Wolverhampton NHS Trust

CP42
Policy for the Prevention and Management of Adult and Paediatric Falls.

Contents

Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

The policy exists to ensure compliance with evidence based, best practice guidance and national regulations as determined by the Royal College of Physicians RCP, National Institute for Health and Care Excellence NICE, Medicines and Healthcare products Regulatory Agency MHRA, National Patient Safety Agency NPSA, NHS Patient Safety Strategy, Patient Safety and Incident Response Framework PSIRF, NHSI, National Audit of Inpatient Falls NAIF and NHS Resolution, to support in the prevention and management of falls, improve patient safety, quality of care, reduce harm to patients and facilitate continual learning and improvements in practice.

The policy provides access to advice and guidance for all staff on the correct practice and procedures in the prevention and management of patient falls.

According to NICE (2019), 250,000 people incur a fall each year.
Having a fall has an impact on the quality of life, health, and healthcare costs, not just for patients but their families too. It can cause pain, loss of confidence, self-isolation, loss of independence, frailty, increased care needs with financial implications for families and carers and mortality. 1 in 3 patients who incur a fractured neck of femur because of an inpatient fall die within 30 days of the fall. Timely and effective risk assessment, preventative care and post falls management can significantly reduce risks to patients and improve outcomes.

2.0 Definitions Fall

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.

Adult Safeguarding Team

A team of specialist nurses who provide expert advice, guidance, and interventions to support staff across the trust. This advice includes the Mental Capacity Act 2025 and Deprivation of Liberty Safeguards 2009.

Bedrails

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 Supervision

The provision of an enhanced level of supervision following a risk assessment by clinical staff, for those patients who are deemed at an increased risk of falls. There are three levels of enhanced supervision, 1 hourly, the provision of a dedicated bay nurse / supervisor (Tagged Bay), and one to one (arm's length care). The required level of enhanced supervision would be determined by individual patient assessment.

Education Academy

A trust team of clinicians and practitioners providing education and training for Trust employees and those new to the organisation.

Electronic Staff Record (ESR)

An electronic system to maintain staff personal information including education and development modules for training purposes.

Health and Safety Executive (HSE)
Britain's national regulator for workplace health and safety

Infection Prevention and Control Policies (IPC)
Policies developed by the Infection Prevention Control team aligning to national guidance and regulations relating to cleaning and decontamination of equipment used within the clinical setting by staff and patients.

Learning Disability Team (LD)
A trust team of specialist learning disability nurses who provide expert advice, guidance, and interventions to support staff across the trust. This advice includes the Mental Capacity Act 2025 and Deprivation of Liberty Safeguards 2009.

Medicines and Healthcare products Regulatory Agency (MHRA)
Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices, and blood components for use in the UK.

National Audit for Inpatient Falls (NAIF)
A continuous national audit programme which reviews all inpatient falls and aims to improve falls risk reduction practice for inpatients.

NHS England (NHSE)
NHS England leads the National Health Service in England with an aim to support the NHS and improve care for patients.

NHS Patient Safety Strategy and Patient Safety Incident Response Framework. (PSIRF)
This strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. The strategy includes a revised Patient Safety Incident Response Framework
Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. Focussing on insight, involvement, and improvement.

NHS Resolution
Provide services to enable fair and timely resolution to concerns relating to practice. This includes datasets and insights that can benefit patients and improve safety and care.

National Institute for Health Care Excellence (NICE)
NICE is an international organisation that scopes evidence, effectiveness, safety, experience, and best practice and develops guidelines for use within the NHS to ensure patients have optimal outcomes and experience.

Nursing and Midwifery Council (NMC)
The independent regulator for nurses and midwives in the UK, and nursing associates in England.

Matrons Forum
A committee of senior nurses, midwives, health visitors and allied health professionals from

Corporate and Directorate teams, formed to discuss key nursing, midwifery and AHP matters, scope options, agree actions and report to the Senior Leaders Forum.

National Patient Safety Agency (NPSA)
A national agency that has now ceased, that was responsible for identifying and reducing risks to patients receiving NHS care.

Royal College of Physicians (RCP)
The Royal College of Physicians is a British professional membership body dedicated to improving the practice of medicine, chiefly through the accreditation of physicians by examination.

Situation, Background, Assessment, Recommendation, Transfer Tool (SBART) A communication tool used within health care to share information relating to a patient being transferred between wards or departments to provide effective handover of pertinent information to ensure seamless continuation of care and highlight key risks and interventions.

3.0 Accountabilities

The Chief Nursing Officer is responsible for:

- Leading the falls and deconditioning prevention strategy for the trust, (Eat, Drink, Dress, Move to Improve), with oversight and assurance for the implementation of all associated policies and procedures.

Divisional Heads of Nursing are responsible for:

- Ensuring the falls prevention policy and associated falls prevention risk assessments, care plans and post falls care are implemented and followed in their areas of responsibility.
- Supporting with, or leading incident investigations in line with the trust patient safety incident response framework in the event of any patient safety incidents occurring relating to falls prevention or falls.
- Ensuring there is divisional representation at the monthly Falls Steering Group and any falls shared learning review meetings and forums.
- Ensuring that audits, reviewing of results, and implementing changes to improve practice, quality of care and patient safety are undertaken as per the trust policies.
- Ensuring that their clinical areas have the necessary equipment available and in working order.
- Ensuring strategies to prevent deconditioning Eat, Drink, Dress, Move to Improve are implemented.

Matrons are responsible for:

- Ensuring the falls prevention policy and associated falls prevention risk assessments, care plans and post falls care are implemented and followed in their areas of responsibility.
- Supporting with or leading incident investigations in line with the trust patient safety incident response framework in the event of any patient safety incidents occurring relating to falls prevention or falls.
- Supporting and undertaking clinical audits, shared learning, and development of quality improvement actions to improve practice, quality of care and patient safety.
- Representing their area of responsibility at the monthly Falls Steering Group as

requested by their Divisional Heads of Nursing.
- Representing their area at any falls shared learning review meetings and forums or providing a deputy.
- Sharing falls incident data with their areas of responsibility.
- Ensuring that their clinical areas have the necessary equipment available and in working order.
- Ensuring strategies to prevent deconditioning Eat, Drink, Dress, Move to Improve are implemented.

The Ward/ Department Manager is responsible for:
- Ensuring all staff have access to and have attended education and training relating
- to falls prevention and post falls care including on My Focus for adult nurses and are aware of the principles and practices as outlined in the falls prevention policy.
- Ensuring the falls prevention assessment, care plan and post falls sticker are available for use and all staff receive appropriate education and training in the use of the assessment tool and application of the guidance and post falls care.
- The day-to-day implementation of the policy and associated practices, including post falls care.
- Ensuring that appropriate falls prevention resources and associated equipment is available.
- Ensuring that their clinical areas have the necessary equipment available and in working order.
- Overseeing, escalating, reporting, and undertaking preliminary debriefs following a falls incident.
- Ensuring that staff are aware and applying systems and processes in relation to infection prevention and control policies and upkeep of equipment.
- Timely review of all fall's incidents relating to their area, identify lessons learnt, facilitate shared learning with the team and develop actions for discussion and sharing at any falls shared learning review meetings.
- Supporting in the trust patient safety incident response framework in the event of any patient safety incidents occurring relating to falls prevention of falls.
- Ensuring that local audit is undertaken, reviewing of findings, triangulating with patient incidents, and developing quality improvements with the team.
- Presenting performance data and incident themes and trends to their team and developing actions to mitigate risks and themes.
- Presenting incident findings and learning at divisional safety huddles for discussion and formulating of local improvement plans.
- Managing any nonadherence to this policy in their area.
- Ensuring there is department representation at any Falls Shared learning review meetings and forums.
- Ensuring strategies to prevent deconditioning Eat, Drink, Dress, Move to Improve are implemented.

Clinical Staff, Medical, Nursing AHP's are responsible for:
- Ensuring they are conversant with the falls prevention policy.
- Ensuring they have undertaken any relevant education and training in implementing practices and processes relating to falls prevention and post falls care.
- Ensuring all patients have a falls prevention assessment undertaken on admission, transfer, each shift and change in condition and discuss assessment and the outcome of the assessment with the patient.

- Ensuring falls prevention strategies and care is applied in conjunction with the patient to mitigate any risks.
- Documenting actions clearly in the patient record.
- Escalating any risks or concerns that require additional mitigation and managing and documenting in the patient record.
- Communicating effectively with the team, patients risks and requirements at handover, safety huddles and on transfer.
- Reporting accurately and concisely any falls incidents or near misses involving patients, within the trust patient incident reporting system and the patent record, including any duty of candour responsibilities.
- Implementing appropriate post falls care as outlined in this policy.
- Complying with Infection Prevention and Control policies and procedures relating to decontamination and cleaning of equipment.
- Implementing practice and process improvements as determined from audits and shared learning.
- Ensuring strategies to prevent deconditioning Eat, Drink, Dress, Move to Improve are implemented.

The Trust Lead for Falls is responsible for:

- Reporting monthly to the Falls Steering Group on performance, themes, trends, incident findings, outputs from the Falls shared learning review meetings/ forums and any new guidance or evidence relating to falls prevention.
- Supporting clinical areas with education and training, implementation and embedding of the fall's prevention quality improvements.
- The revision and update of associated trust education and training modules as appropriate.
- Supporting with falls audits and reviews, providing feedback and support.
- Scoping evidence and benchmarking resources to support quality improvement activities.
- Facilitating the development and implementation of revised practices and support with quality improvements.
- Facilitating and co- chair any Falls Shared Learning Review meetings / forums.
- Supporting and advise with incident reviews.
- Validation of the information for all reported falls and escalate any anomalies or concerns to the Ward Manager and or Matron as appropriate.
- Attending ward meetings if requested and support practice education facilitators in the provision of bespoke training and education sessions as required.
- Collating and providing information and data relating to falls prevalence, themes and performance to departments and provide data for assurance reporting by the Chief Nursing Office to the Quality, Patient experience and Safety Committee and Trust Board.
- Promoting strategies to prevent deconditioning Eat, Drink, Dress, Move to Improve are implemented.

4.0 Policy Detail

4.1 Scope

This policy applies to all acute patient areas and departments in the acute and community settings where trust staff, temporary employees, locums, agency staff, students, and visiting clinicians, are caring for patients. Risk assessment and prevention tools will be adapted for non-inpatient areas such as outpatient departments, the emergency department, ambulatory emergency care, day case units and frail elderly services.

Post falls care and management practices must be applied to all persons within the trust. This includes none admitted care areas such as the outpatient department, imaging, discharge lounge, emergency department, emergency ambulatory care and frail elderly services, day case departments. Departments should use local risk assessment tools to identify and manage attendees at risk of falling.
This policy and associated risk assessments included within it, consider all protected characteristics including disability.

5.0 Exclusions

None

6.0 Falls Prevention

6.1 All patients admitted to an inpatient area or assessment unit will be assessed using the approved trust risk assessment tool. The assessment tool is an evidence based multifactorial risk assessment. This assessment includes a lying and standing blood pressure which 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/. An underlying cause for postural hypotension should be investigated and treated where possible. The patient must be educated in steps to help reduce their risk of falling as a consequence (e.g. sitting for a few minutes longer before standing).

6.2 For all inpatients, a falls risk assessment will be undertaken within 6 hours of admission, on transfer to another clinical area, on change in the patient's condition and as a minimum weekly.

6.3 The initial risk assessment must be undertaken by a registered nurse. Subsequent assessment reviews can be undertaken by a registered nursing associate/ registered nurse. Where assessment has been undertaken by a trainee, the assessment will be reviewed and countersigned by a nursing registrant as per the NMC Code of Conduct.

6.4 If the patient is deemed at risk of falls a trust approved intervention plan must be completed each shift as per frequency indicated. Frequency will be determined by the registered nurse responsible for the care of the patient each shift. The patient should be encouraged to wear their own well-fitting footwear. If the patient does not have appropriate footwear, anti-slip socks must be provided.

6.5 As part of the patient centred risk assessment, assessments for moving and handling and the safe and effective use of bed rails must also be undertaken.

6.6 The use of bed and trolley rails must be in line with Policy CP16 The safe and effective use of bed and trolley rails.

6.7 On admission provide the patient, relative /carer with a keeping safe falls prevention leaflet **Appendix 4** which explains their contributions to reducing the risk of themself falling whilst in hospital.

6.8 All concerns regarding risk factors must be communicated with the multidisciplinary team during handover and safety huddles, to ensure appropriate interventions are put in place by all teams involved to support holistic patient centred care.

6.9 For non-inpatient areas such as day case areas, assessment units, emergency department, frail elderly services and ambulatory emergency care trust approved adapted risk assessment tools can be used.

6.10 Following completion of a thorough and accurate multifactorial risk assessment, a trust approved patient centred care plan must be developed. The care plan must be evaluated and updated on transfer, on changein condition or as a minimum weekly.

6.11 Following completion of all risk assessments, the responsible registered healthcare professional must ensure the patient is in the most appropriate area of the department or ward to reduce the risk of a fall.

6.12 On transfer to another ward or department the risk of falls, along with any enhanced supervision requirements, must be communicated and documented on the trust SBART form to ensure safety and support a seamless continuity of care.

6.13 Call before you fall posters should be displayed in all inpatient areas including toilets and bathrooms.

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

6.15 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.

6.16 Medical staff are responsible for ensuring a cardiovascular review is conducted if required.

6.17 Medical staff are responsible for ensuring undiagnosed or acute confusion / delirium is documented, investigated, and treated.

6.18 Medical staff are responsible for ensuring an eyesight assessment is carried out if indicated.

6.19 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.

6.20 All staff are responsible for ensuring the environment, including bed spaces and main patient walkways always remain clutter free.

6.21 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.

6.22 All Staff are to promote activity, where possible, to prevent deconditioning of the patient by encouraging participation and independence with activities of daily living such as washing, dressing, walking, standing, and maintaining hydration and nutrition.

6.23 If a patient has a potential or confirmed infection risk requiring isolation precautions in a

side room and has also been identified as an increased risk of falls, a multidisciplinary team discussion should take place and clinical judgement applied. Advice can be sought from the infection prevention team and the falls lead nurse. Prevention strategies must be put in place to mitigate and balance competing risks for the patients and the clinical area.

7.0 Enhanced Supervision

The majority of falls in acute wards are unwitnessed. The enhanced patient supervision process has been adopted by the trust to support patients who have been identified as requiring a higher level of supervision than normal due to the level of risk and vulnerability of falling or sustaining harm from falling.

7.1 In the event of an inpatient being identified as being at risk of falling, one of the approved trust risk assessments for enhanced supervision must be undertaken whilst considering the patient's mental capacity and deprivation of liberty guidance and principles.

- **Appendix 1** (Enhanced Patient Supervision Assessment Tool - **EPSAT**) and
- **Appendix 2** (Enhanced care score- **ECS**)

7.2 Any patient identified and requiring enhanced supervision must be cared for in an appropriate environment according to assessment outcome and where the level of supervision can be assured. Patients on anticoagulation therapy and /or with degenerative bone disease such as Osteoporosis, Rheumatoid Arthritis, and bone cancers or metastatic bone disease are at a much higher risk of severe harm should they fall. These conditions should also be considered when assessing for the correct level of supervision.

There are three levels of enhanced supervision:

- **Intermittent observation** (usually conducted ONE hourly)
- **Uninterrupted line of sight** (also known as tagged bay, stay in bay)
- **Consistent arm's length nursing** (also known as 1:1 minimum)

7.3 The nurse in charge of each shift will be responsible for communicating those patients at risk of falls and requiring an enhanced level of supervision during handover and safety huddles /brief along with the allocation of supervised (tagged) bays and identify the appropriate staff to observe these bays.

7.4 In cases whereby ONE hourly observation of a patient is required, the nurses allocated to care for those patients should agree plans to ensure the correct level of observation takes place during their shift. In the event of further enhanced supervision being required this should be documented, escalated, and actioned in conjunction with the nurse in charge.

7.5 The role of the tagged bay, supervisory nurse should be rotated every 2 – 3 hours or as the nurse in charge decides following risk assessment of the patients, staffing resources and staff breaks.

7.6 In the event of the patient being identified as requiring 1:1 / arm's length supervision, this will be escalated to the matron for the area and appropriate staffing resources identified and put in place to support.

7.7 Where a lack of nurse resource prevents the appropriate levels of supervision being provided, then this MUST be escalated to the matron or on-site manager, mitigating actions taken, documented in the patient record and an incident form recorded.

7.8 In the event of multiple patients within a ward area being identified as requiring 1:1 supervision, the nurse in charge should risk assess the situation and determine best possible mitigation. This may include cohort of several patients requiring 1:1 into a bay with dedicated enhanced supervision. Such circumstances, particularly where staff resources are limited, should be escalated to line managers, and reported within the patient incident system and as a red flag in the "safer staffing" system.

7.9 Staff must ensure they are familiar with the role and responsibilities of providing all levels of enhanced supervision. The member of staff providing enhanced supervision will receive handover for and familiarise themselves with the needs of the patients being supervised.

7.10 If a member of staff needs to leave the supervised patient / patients, they must handover this responsibility to another member of staff before leaving.

7.11 If the staff member recognises or the patient requests some assistance requiring more than one member of staff, they must press a call buzzer to summon assistance and explain to the patient the rationale whilst awaiting assistance.

7.12 If the bay supervisory nurse is required to assist a patient behind a curtain or in a bathroom, where possible they should ask another colleague to temporarily observe the bay.

7.13 The one-to-one nurse will supervise the allocated patient at all times ensuring they are at arm's length whilst best maintaining their privacy and dignity.

AT NO TIME MUST A SUPERVISED BAY/ PATIENT BE LEFT UNATTENDED.

7.14 Enhanced supervision requirements must be correctly, verbally handed over between departments on transfer and documented on the SBART form.

7.15 If a patient requires enhanced supervision whilst using the toilet / commode an explanation must be provided to the patient. Supervision must be maintained within arm's length optimising privacy and dignity. The patient has the right to ensure their privacy is maintained and refuse supervision, however an assessment of capacity must be undertaken to assess if the patient understands the risks associated with not being supervised and if a best interest's decision to maintain safety is determined. Close supervision is appropriate to safeguard the patient. Any refusal by the patient following mental capacity assessment or best interest's decisions should be documented within the patient's notes. (A DOLs should be considered). DOLs will only be applicable to those patients who lack capacity around care and treatment decisions, are not free to leave and staff have continuous control over their care and treatment.

8.0 Post Falls Management

In the event of a patient incurring any fall in hospital or a witnessed fall in a community setting imeadiate post falls care must be followed and implemented as per the post falls protocols for inpatients and community settings - **Appendix 5 and 6**. Staff can also use post falls key messages as a reference **Appendix 7.**

A post fall sticker must be used for inpatient falls, as an aide memoir of the immediate post fall actions and secured in the medical notes.

8.1 All falls' incidents including near misses and assisted falls must be accurately

documented in detail within the patient record.

8.2 All falls' incidents including near misses must be reported within the trusts incident management system.

8.3 Duty of candour and compassionate engagement principles must be applied as per policy.

8.4 Following all falls, the clinical team must undertake a debrief, and implement. compassionate engagement at the earliest opportunity to facilitate support for the patient, their relatives and for the clinical team themselves.

8.5 All learning and actions derived from an incident must be shared with the clinical teams and implemented to reduce the incidence of falls and improve patient safety, quality and patient outcomes.

8.6 The trust incident management system must be updated with the findings of the review / Investigation prior to the incident being closed by the handler.
Documented learning will then inform the quarterly thematic review carried out by the falls lead nurse for the trust.

8.7 Teams can use an approved falls review template to aid in the thorough investigation of a fall incident. If a review document is used, then this must be saved as an attachment, to the trust incident report by the handler.

8.8 Any falls Incidents can be called to be presented by the clinical team at a falls shared learning review meeting to promote shared learning, confirm actions required and agree a level of harm, escalating concerns identified appropriately if, not already done so.

9.0 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
6	The trust is currently developing a business case for the trust wide bed replacement programme. This is not as a direct result of this policy but supports the implementation of patient safety practices in respect of the availability of low-rise beds.	No

10.0 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.

11.0 Maintenance

The policy will be reviewed by Chief Nursing Officer, the Head of Nursing – Quality and the trust Falls Lead in March 2027 or earlier pending any outcome of the quality improvement pilots for the nursing risk assessment documentation, enhanced supervision risk assessment, post falls protocol, departmental risk assessment tools and the update to NICE Guideline CG 161. The policy will be stored on the trust intranet. Outdated policies will be archived in line with the trust policy management group guidelines.

12.0 Communication and Training

Dissemination of the policy will be via trust staff communication strategies, targeted emails to all ward managers, senior sisters and matrons, presentation at the Falls Steering Group, Falls Review Groups, senior leaders' forums, shared decision-making groups, face to face education and training sessions for falls prevention. Reference to the policy and its guidance will be incorporated into the mandatory falls prevention ESR training, My focus for adult nurses, on My Academy. Training in the application of this policy and use of the falls prevention risk assessment tool, care plan, post falls protocol and enhanced supervision assessment will be included in any training session developed as part of the nursing documentation review program of work.

Registered and non-registered nurses can attend any face-to-face falls prevention training provided by the lead nurse for falls or Practice education facilitators in addition to accessing the eLearning Falls Prevention and management training for adult nurses within the My Academy modules. The trust will provide training in the use of the patient assessment documentation.

Education and training can also be delivered locally by the practice education facilitator team.

13.0 Audit and Monitoring Arrangements

Criterion	Lead	Monitoring Methods	Frequency	Committee
1. Falls audits, including clinical accreditation audits using the trust audit systems. 2. Single improvement plans 3.Review of outputs from the falls shared learning /review meetings. 4.Trend and theme analysis from oversight of the trust incident reporting system.	The Divisional Matrons and Ward Managers The trust falls lead.	Audits undertaken using the trust clinical audit systems will identify where patients have not undergone a complete and accurate falls risk assessment and/or development of an appropriate care plan. Results from the audits will be shared with the divisional matrons and ward managers to be disseminated to the clinical team for shared learning and actions to be developed. Findings and learning from falls incidents will be collated and shared with the clinical teams for shared learning and actions monitored and managed through the trust patient incident management systems. Outputs from incident reporting and divisional safety huddles will be reviewed and collated into themes and trends to identify trust wide QI projects or identify new areas of focus. Review of outputs from the falls shared learning review meetings will be collated into a data set of thematic prevalence and disseminated to the divisional matrons and heads of nursing for shared learning and action with their clinical team. Themes and trends will be presented at the Falls Steering Group for wider shared learning for consideration for quality improvement projects.	Monthly Weekly or as per audit schedule	Via Monthly divisional fall reports. Divisional safety huddles. Monthly Falls Steering group. Falls Shared review groups.

14.0 References

- Gov.UK (2021) Bed rails: management and safe use
- https://www.gov.uk/guidance/bed-rails-management-and-safe-use

- NICE Clinical Guidelines 161
- https://www.nice.org.uk/guidance/cg161 Quality standard [86]

- NICE Falls Risk Assessment
- https://cks.nice.org.uk/falls-risk-assessment#!scenario

- RCP Lying and standing BP guidance.
- https://www.rcplondon.ac.uk/

- Mental Capacity Act
- Mental Capacity Act 2005 (legislation.gov.uk)

- World Health Organisation April 2021. Falls.

  https://www.who.int/news-room/fact-sheets/detail/falls

- Nursing and Midwifery Council (2015) the Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates
- The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates The Nursing and Midwifery Council (nmc.org.uk)

- East London NHS Foundation Trust quality improvement project. Transfer communication tool.
- SBAR - Situation-Background-Assessment-Recommendation - Quality Improvement - East London

- NHS Patient Safety Incident Response Framework PSIRF Guidance
- B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1-FINAL.pdf(england.nhs.uk)

- NHS System Engineering Imitative for Patient Safety Guidance
- B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf (england.nhs.uk)

Related RWT Policies and Guidelines

- Clinical Guideline GDl01Frequency of Neurological Observation Recording in Adults
- http://intranet.xrwh.nhs.uk/pdf/policies/CorporateSopsProtocolsPractices/Guideline_Frequency_Neurological Observation.pdf

- Health and Safety Policy
- http://trustnet.xrwh.nhs.uk/strategies-policies/corporate-policies-procedures-guidelines/health-and-safety-policies/hs01/

- Infection Prevention Control and decontamination policies
- http://trustnet.xrwh.nhs.uk/strategies-policies/corporate-policies-procedures-guidelines/infection-prevention-and-control-policies/

- Deprivation of Liberty Safeguards Policy
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice- policies/cp02-deprivation-of-liberty-safeguards-dols-policy/

- Policy for the transfer of patients between wards and departments
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp05/

- The safe and effective use of bedrail policy
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp16/

- Mental Capacity Act 9 (2005) policy
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp19/

- Safeguarding adults at risk policy
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp53/

- Policy for care of patients requiring enhanced observation
- http://trustnet.xrwh.nhs.uk/strategies-policies/clinical-policies-procedures-guidelines/clinical-practice-policies/cp66/

Part A - Document Control

Policy number and Policy version: RWT CP41 V3.0	**Policy Title** Policy for the prevention and management of adult and paediatric falls.	**Status:** Final		**Author**: Ruth Spedding Senior Sister Quality **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	Senior Sister Quality	Updated policy to reflect changes in nursing /medical documentation
	2.1	May 2024	Senior Sister Quality	Extension
	3.0	June 2024	Senior Sister Quality	Routine 3 yearly review
Intended Recipients: The document applies to all trust clinical staff in all locations				
Consultation Group / Role Titles and Date: Falls Steering Group June 27th 2024				
Name and date of trust level group where reviewed	TPG - August 2024			
Name and date of final approval committee	Trust Management Committee – September 2024			
Date of Policy issue	October 2024			
Review Date and Frequency	To be reviewed August 2027 or earlier pending the outcome of the trust bed replacement program and procurement of low-rise beds or review of NICE guideline CG161			

Training and Dissemination: Dissemination of the policy will be via staff trust communication strategies , targeted emails to all ward managers, senior sisters and matrons, presentation at the Falls Steering Group, Falls Review Groups , Matron Forum, face to face education and training sessions for Falls Prevention. The corporate quality team will be responsible for dissemination supported by the trust education team.

Publishing Requirements: Can this document be published on the trust's public page: Yes.

If yes you must ensure that you have read and have fully considered it meets the requirements outlined in sections 1.9, 3.7 and 3.9 of OP01, Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines, as well as considering any redactions that will be required prior to publication.

To be read in conjunction with:

- Policy for Neurological Observations
- Infection Prevention Control and Decontamination Policies
- Safe Moving and Handling Policies and Procedures
- Safe and Effective use of Bed Rails Policy
- Enhanced Care Policy
- Adult Safeguarding Policy
- Mental Capacity Act Policy
- Deprivation of Liberty Safeguards Policy

Initial Equality Impact Assessment (all policies):	**Completed Yes**	**Full**
Equality Impact assessment (as required):	**Completed Not required**	

Monitoring arrangements and Committee	The policy will be monitored and reported to the Falls Steering Group by the Trust lead for falls

Document and Key Issues covered.

To ensure compliance with evidence based best practice, guidance and national regulations as determined by the Royal College of Physicians, National Institute for Health Care Excellence, MHRA, NPSA, NHS Patient Safety Strategy, PSIRF, NHSI, NAIF and NHS Resolution to reduce the number of avoidable inpatient falls to improve patient safety, and quality of care, reduce harm to patients, improve outcomes and facilitate continual learning and improvements in practice.

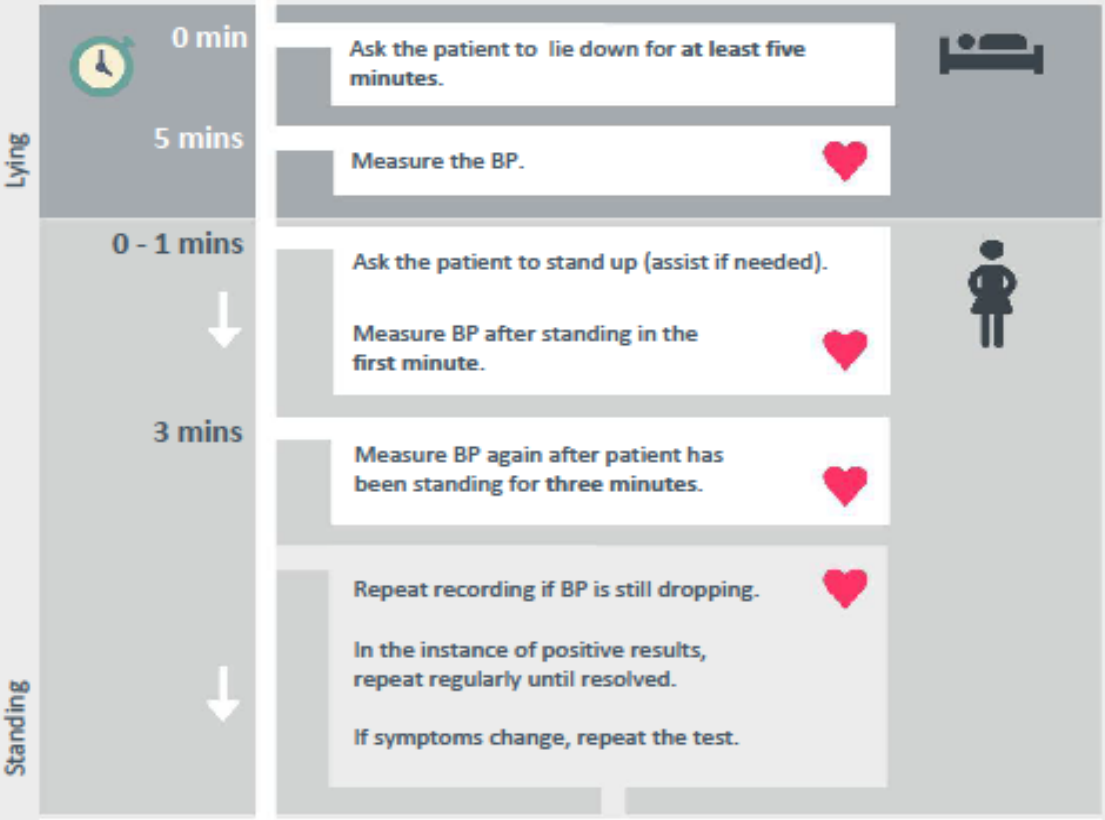
To provide access to advice and guidance for all staff on the correct practice and procedures in the prevention and management of inpatient falls.

Key words for intranet searching purposes	Falls Prevention Falls management. Post Fall management.
High Risk Policy? Definition:	**No**

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

How to measure a lying and standing blood pressure (BP) as part of a falls assessment

1. Identify if you are going to need assistance to stand the patient and simultaneously record a BP.
2. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
3. Explain the procedure to the patient.



Notice and document **symptoms** of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations.

Advise patient of results and if the result is positive:

a. inform the medical and nursing team.
b. take immediate actions to prevent falls and/or unsteadiness.

A positive result is:

a. A drop in systolic BP of 20mmHg or more (with or without symptoms).
b. A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms).
c. A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP).

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Enhanced Patient Supervision Assessment Tool

NHS:
HSP:
DOB:
Name:
Gender:
Affix small label here

- All adult patients must have a falls risk assessment admission
- If a patient is identified as being at risk of falling an supervision assessment must be undertaken and actions taken and documented
- Assessment to be completed each shift, on transfer and on change in condition

In the event of multiple patients being identified as requiring 1:1 supervision consider a cohorted bay with appropriate dedicated supervision.

Clinical Presentation	Score
Cognitive Behaviour concerns / Confusion / Delirium	+2
Taking risks against advice / Aggressive behaviour	+2
Unsteady when standing/mobilizing **(e.g., Risk of tripping / losing balance)**	+1
Any previous falls within the last 12 months **(Anywhere)**	+1
Urinary or faecal incontinence or urgency **(And not bedbound)**	+1
Known Postural hypotension	+1
Sensory Deficit or Communication issues	+1
In-patient fall during this admission	+1
Completely immobile / unconscious or Patient does not try to move without asking for assistance of staff and has safety precautions in place	- 3

Level 1 Not at Risk	≤ 0	General Regular Observation / Intervention	Carried out 2 hourly
Level 2 Low Risk	1-2	Intermittent observation / Intervention	Carried out 1 hourly
Level 3 Medium Risk	3-5	Uninterrupted line of sight	Staff must stay in bay or in sight of patient
Level 4 High Risk	≥ 6	Consistent observation at arm's length	1:1 Supervision

Extra consideration should be given to those patients that:
- Have considerable, recognised degenerative bone disorder
- Those on regular oral Anticoagulant medicines

- Enter patients total score overleaf
- If score = 3 or above the appropriate actions must be completed

- If the total score does not reflect the patients' requirements clinical judgement should be used and level of observation should be agreed and documented following discussion with Band 6 or above

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Enter Total patients Score										
If score = >3 **Complete all actions below once each shift (min):**	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Is the patient receiving enhanced level Supervision as the score indicates? →										
If patient requires 1:1 supervision, staffing resource has been requested via speciality matron / on call manager										
If patient is **NOT** receiving the enhanced supervision as indicated document reason code as below: **A = Clinical Judgement overrides score.** This must have been agreed with Band 6/7 at each assessment. **B = Patient refusal.** This must be documented in medical notes. **C = Other** Document clear reason in medical notes.										
Consider MCA, referral to OPMH, Adult safeguarding or Non concordance care plan.										
Supervision requirement recorded in "safer staffing" tool										
Escalation to Senior Nurse / Speciality Matron or on call manager If unable to identify staffing resource to provide the correct level of supervision required by patient ?										
Daily Incident report has been completed if ward unable to provide the correct level of supervision required by the patient?										
Name and Signature										
Designation and Stamp										
Date										
Time										

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Enhanced Care Scoring Tool

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

To be completed for any patient who you feel is at risk of harming themselves or others, is confused or is physically frail and at risk of harm.

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

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	Level of observations and actions to be considered: Blue - General Observation Green - 15-30 minute intervals Amber - Within eyesight Red - Within arms length	*Example*																	
		Date: 13.01.19		Date:		Date:		Date:		Date:		Date:		Date:		Date:		Date:	
0-3	• Patient safe – review daily or if condition deteriorates	Time: 09:00		Time:		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 overleaf) document in Health Records • Try to establish and treat underlying cause / un-met 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	Signature and designation **A. Nurse** **Staff Nurse**		Signature and designation		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 • Document in patient notes the actions you have taken including any referrals and commence any relevant care plans	Stamp: **A. Nurse** **00AB00Z**		Stamp:		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 overleaf)	Score: **9**	Level of Observation: **Amber**	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:	Score:	Level of Observation:

Appendix 4 Falls leaflet

Your Patient Journey

Ward: .....

Telephone number: .....

Keeping you Safe whilst in Our Care

Communication on admission
Any concerns however small, any help you may need, anything you don't understand.

Family and Carers
Family and Carers can be contacted to support with your care

Hand washing
After toileting and before meals, for you and for staff.

Allergies or Intolerances
Do you have any reaction to medication, food, plasters that cause rashes, redness or swelling

Medication
Let the Doctor or Nurse know about all your medications

Call before you fall
Don't be afraid to ask for help.

Glasses and hearing aids
If needed, do you have these?

Footwear
Well-fitting slippers or shoes.

Keep yourself moving
Change your position in bed, leg exercises, sit in your chair.

move

Safe mobilisation
Walking aids, bring them with you, do you have other equipment at home? The nurses and physiotherapist will help to make sure you are safe. Don't take risks.

Clothing
Get up and get dressed every day in comfortable clothing.

dress

Keep Tidy
Keep your bed area clear of clutter and obstacles

Bathroom
Take care in the bathroom in case the floor gets wet, call for assistance.

Eating and Drinking
Have a little and often, tell us what you like.

eat, drink

Who to contact if you are worried:
- Your GP
- In an emergency 111

Time to go home
Ask questions, about medication, help at home, appointments, dressings. Eat and drink well. Stay active.

Helping you Stay Safe at Home

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Walsall Healthcare NHS Trust

Care Colleagues Collaboration Communities

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The Royal Wolverhampton NHS Trust

POST FALL PROTOCOL – ACUTE SETTING

Immediate Action

- Check for on-going danger. Call for assistance.
- Do not move patient until assessed.
- Provide reassurance to the .
- 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.
- Record baseline vital signs.
- Give analgesia as appropriate.

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

Medical review must occur within 30mins if patient has:

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

Actual / Suspected Head injury - If patient has or suspected to have hit head undertake Neurological Observations as per NICE guidance CG176 and trust policy 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 to ½ Hourly observations and request urgent medical review.

Safe Retrieval from Floor

- Assess the environment for confined space, spillages, and equipment.
- Registered healthcare professional to coordinate the plan to move the patient to safety following assessment for any obvious signs of injury.
- Use appropriate moving and handling techniques for the situation.
- If a spinal injury is suspected, equipment such as a spinal board / scoop board must be used . Air mattresses should be replaced for a foam mattress before returning patient to bed.
- If a fractured hip /femur is suspected, then a Hover jack should be used to move the patient. A hoist must not be used to lift the patient from the floor if fractures are suspected.
- 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 / compassionate engagement)
- Repeat Falls Risk Assessment, update falls care plan, reassess enhanced supervision/care score and bedrail risk assessment.

Ongoing care

- Implement falls prevention strategies e.g. move patient to higher visibility area of the ward, enhanced supervision, revisit patient advice and education, call bell, safe footwear, safety briefings and handover.
- Follow agreed clinical management plan (e.g. X-rays, CT scan, immobilisation, analgesia, clean / dress wounds, fluid balance, sepsis screen if indicated)
- Continue to observe vital signs / Neuro observations as indicated.
- Referral to community falls prevention services if appropriate and patient agrees.
- Conduct falls debrief with the team and identify any learning that can be used to prevent further falls.

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Post fall protocol for patient falls in community settings /patients own home.

Guidance to be followed for witnessed falls or patient found on floor at point of care.

1) INITIAL CHECKS

- Check for on-going danger.
- Call for assistance.
- Check ABCDE
- Provide reassurance.
- Do not move patient until fully assessed for signs of injury.
- Registered practitioner to assess patient immediately. HCA's will need to contact a registered nurse in their team for advice.
- Check "top to toe" for injury, assessing for pain in neck or spine , limb deformity or head injury.
- Contact the GP, Community Urgent Care Team, or Ambulance Service (999) for further assessment if the patient has hit their head.
- **If patient has had any loss of consciousness or has an obvious injury call 999 immediately.**

2) SECOND CHECKS

- Baseline vital signs
- Neurological observations - Vital signs and 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 techniques appropriate for the patient.

4) CLINICAL MANAGEMENT PLAN

- Monitor and remain with patient until the Ambulance crew arrives where required or when deemed 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 sequence of events 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**

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Post Falls: Key Messages

Do not move the patient!

Ensure the immediate area is safe.

Talk to the patient, give reassurance, determine level of cognition, site of any pain.

Examine the patient for signs of injury:

- Head
- Neck or back.
- Limb deformity
- Pain
- Bleeding

Medical Review

Routine

or

If urgent, within 30 mins

Record observations, including neurological observations as per NICE guidelines for actual and suspected head injury.

Transfer the patient back on to a bed using appropriate equipment and M&H techniques (Hover jack, scoop) as per the senior decision maker advice.

Dress any wounds and photograph.

Provide analgesia as required.

Reassess falls risk, moving and handling and bedrails requirements.

Review falls prevention care plan.

Reassess for enhanced supervision and appropriate position on the ward.

Apply falls alerts and slipper socks.

Document sequence of events and actions

Record incident in Datix including any injuries or wounds

Relatives or Carer contacted Duty of Candour enacted, documented in patient record and Datix.

Medical Interventions Imaging, medication review, ECG, IV fluids etc. undertaken.

Undertake a post fall debrief with team

For all falls consider safeguarding issues and seek advice from the Adult Lead for Safeguarding