University Hospitals of Leicester NHS
NHS Trust

Adult Inpatient Falls Safety and Management Policy

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CONTENTS

REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

February 2024	Additional information added to section 6 highlighting the use of bed rails and the identification of patients with atypical anatomy. Bed rail care plan added via hyperlink to document. Definition added to section 7. Additional policy link added in section 13.0
September 2024	Changes to definition of falls and Harm, role and responsibilities. Additional information added to section 10 highlighting CT & X-ray requests, new appendix 7 Safe use of sensor devices, Remove appendix drugs and falls

KEY WORDS

Falls, falls risk assessment, falls screening, falls care planning, lying and standing blood pressure, Standard Falls Reduction Measures, Enhanced Falls Reduction Measures, Falls Care Review and Learning, Safe retrieval of patients, atypical anatomy, Sensor devices

1. INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy to identify adult in-patients who are at risk of falling, the interventions required to reduce the risk and potential harm to each individual.

1.2 This document provides information on actions to be taken in the event of a patient falling in UHL, (including patients admitted through Emergency Department.).

2. POLICY AIMS

2.1 The purpose of this policy is to provide managers and staff with advice and guidance to minimise falls and consequential injuries and optimise falls management and safety.

2.2 The Trust aims to optimise patient safety, quality and best practice, and further minimise harm from in-patient falls whilst safeguarding patients' dignity, rights, freedom and ability to mobilise.

3. POLICY SCOPE

3.1 This policy applies to all clinical staff including temporary and agency staff. It sets out the roles and responsibilities of staff within the Trust for the prevention, reduction and management of falls.

3.2 This policy applies to all adult in-patients aged 18 years and over

3.3 This policy provides essential information required for staff in clinical areas to screen, plan care, and manage patients following an in-patient fall. Further supporting information can be found in the appendices.

4. DEFINITIONS

4.1 A *fall* is defined as:

a. " an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Falls, trips and slips can occur on one level or from height" (World Guidance for falls prevention and management for older people 2022).

4.2 *Harm* is defined as:

a. Physical injury categorised using the Learning from Patient Safety Events LFPSE) used in DATIX - minor, moderate, major and death.

4.3 A person is said to have atypical anatomy is they have any one or more of these three characteristics:

a. Physical size less than 145 cm

b. Mass less than 40kg

c. Body mass index of less than 17

5. ROLES AND RESPONSIBILITIES

5.1 The **Chief Nurse** is the Executive lead for this policy.

5.2 The **Assistant Chief Nurse (Harm Free Care and LEAF)** has responsibility to ensure

that adequate arrangements are in place to:

a. Ensure the Trust is compliant with national and local targets.

b. Support the implementation of the Trust Adult Inpatients Falls Management and Safety Policy.

5.3 **Heads/ Deputy Heads of Nursing** are responsible for:

a. Ensuring that falls are reviewed in line with Patient Safety Incident Response framework

5.4 **Patient Safety Leads** are responsible for:

a. Overseeing that falls are reviewed in line with the Patient Safety Incident Response Framework (PSIRF), focusing on the learning for improvement.

b. Ensuring statutory Duty of Candour requirements are met as per national guidance.

5.5 **Matrons/ CMG Harm Free Care Matron & Service Leads** must:

a. Ensure inpatient falls are reviewed in line with Patient safety incident response framework PSIRF

b. At Glenfield Hospital **(DAY**), the Matron will attend inpatient falls on the clinical ward with the Flat-lifting equipment when the reported patient has a suspected hip injury and or fracture. The flat-lifting may also be considered the safest method of retrieving the patient from the floor even in the absence of an injury. They will coordinate the clinical staff in the safe retrieval of the patient from the floor.

c. Cleaning and returning the Flat lifting equipment to the agreed storage area.

d. Notifying the Manual Handling Team to restock the disposable Air Transfer mattress and if there are any issues with the flat lifting equipment.

e. Ensure the patients and/or the patient's family/carer are engaged and involved in the learning response to the fall, also meeting Duty of Candour where required in adherence to the UHL Duty of Candour (Being Open) Policy (Trust Reference B42/2010).

f. Ensure that the outcome of the learning response is shared with the patient and/or the patients family/ carer.

g. Matrons based at the Glenfield Site, to ensure they maintained clinical competence on Falls Recovery training and safe use of equipment to support clinical staff.

5.6 **Duty Managers** are responsible for**:**

a. Attending inpatient falls on the clinical ward with the Flat lifting equipment when the reported patient has a suspected hip injury and or fracture. They will coordinate the clinical staff in the safe retrieval of the patient from the floor.

b. The flat-lifting may also be considered the safest method of retrieving the patient from the floor even in the absence of an injury. They will coordinate the clinical staff in the safe retrieval of the patient from the floor.

c. Cleaning and returning the Flat lifting equipment to the agreed storage area

d. Notifying the Manual Handling Team to restock the disposable Air transfer mattress and if there are any issues with the flat lifting equipment.

e. **Leicester Royal Infirmary -** The Duty Manager will be available (via

switchboard) 24hours/7 days a week. They will attend inpatient falls on the clinical ward with the Flat lifting equipment when the reported patient has a suspected hip injury and or fracture. They will coordinate the clinical staff in the safe retrieval of the patient from the floor.

f. **Leicester General Hospital and Glenfield Hospital -** The Duty Manager will be available (via switchboard), from 19.00-07.30, 7 days a week. They will attend inpatient falls on the clinical ward with the Flat lifting equipment when the reported patient has a suspected hip injury and or fracture. They will coordinate the clinical staff in the safe retrieval of the patient from the floor.

g. Ensure they maintained clinical competence on Falls Recovery training and safe use of equipment to support clinical staff.

5.7 **Falls Safety Team are** responsible for:

a. Supporting the Trust to implement strategies to reduce the number of in-patient falls

b. Ensure inpatient falls are reviewed in the with Patient Safety Incident Response Framework (PSIRF) and by involving the patient and/or family/carer that maximum learning is gained by supporting facilitation of the learning responses for falls.

c. Ensuring a consistent approach to falls safety and management by sharing good practice to promote harm free care.

5.8 **Ward Sisters/Charge Nurses/Department Managers/Team Leaders** are responsible for**:**

a. Ensuring that all staff receive information, instruction and training on the key aspects of falls safety, management and care within this policy. This training should be a relevant to their working areas or duties.

b. Ensure inpatient falls are reviewed in line with Patient Safety Incident Response Plan, using proportionate response.

c. Ensure all staff are aware that patients with a suspected fractured neck of femur or fractured femur need to be lifted from the floor using the Flat lifting equipment available and who to contact to co-ordinate the safe retrieval of patients from the floor

d. Ensure the patient and/or the patients family/carer are engaged and involved in the learning response to the fall, also meeting Duty of Candour where required in adherence to the UHL Duty of Candour Policy (Trust Reference B42/2010.

e. Ensure that the outcome of the learning response is shared with the patient and/or the patients family/ carer.

f. Ensuring falls screening and falls care plans are completed in accordance to procedures (section 7and 8)

g. Ensuring post fall protocol is followed in accordance to this policy (appendix 2)

h. Identify a key member of staff to support falls link role (if necessary)

5.9 **Registered Nurses on Ward 14 LGH** are responsible for:

a. Attend inpatient falls at the Leicester General Hospital during the day on the clinical ward with the Flat lifting equipment when the reported patient has a suspected hip injury and or fracture. They will coordinate the clinical staff in the

safe retrieval of the patient from the floor (the ward where the falls has occurred will need to send an RN to Ward 14 to enable the Ward 14 RN to attend).

b. Cleaning and returning the Flat lifting equipment to the agreed storage area

c. Notifying the Manual Handling Team to restock the disposable Air Transfer mattress and if there are any issues with the Flat lifting equipment.

d. Registered Nurses on Ward 14 LGH will be required to maintained competence and complete annual mandatory training on fall recovery.

e. All falls are reviewed and managed in a timely manner in line with the PSIRF

5.10 **Nominated Falls Link** is responsible for:

a. Acting as a role model and visible advocate for falls management

Enabling individuals and their teams to learn and develop their falls safety and management practice

b. Communicating and networking around falls safety and management practice

c. Supporting individuals and teams in local audit/surveillance.

d. To attend a minimum of 2 link nurse meetings a year to remain updated on Falls Safety practices.

5.11 **All clinical (nursing) staff** are responsible for:

a. Following the procedure for falls safety and management as outlined in this policy and Care following an inpatient fall and safe retrieval of patient- Flow Chart.

b. Reviewing the patient following a fall and completing the (orange sticker). Inpatient fall- Nurse Review sticker

c. Contacting the appropriate staff for their hospital site to attend the fall with Flat lifting equipment and coordinate the use of the equipment to safely retrieve the patient with a suspected fractured neck of femur or fractured femur safely from the floor

d. Ensuring the patient and/or the patient's next of kin/relative/carer is informed in the event of an in-patient falls in line with the Duty of Candour (Being Open) Policy (Trust Reference B42/2010)

e. Ensuring Nerve Centre is updated and communicating details of any patients who have fallen and identified patients at risk of falls to staff on duty and those attending for the shift

f. Ensuring they comply with the current manual handling practices and up to date manual handling training

g. Ensuring engagement in patient safety huddles with the wider team

5.12 **All clinical (non-nursing) staff** are responsible for:

a. Contributing to the implementation of actions to support falls safety for individual patients as identified on the falls risk care plan as appropriate to their professional intervention

b. Reporting patient falls via the Datix incident reporting system in accordance with Incident and Accident reporting UHL policy (Trust reference B30/2024) Ensuring they comply with the current manual handling practices and up to date with manual handling training.

5.13 **Occupational Therapists and Physiotherapists are responsible for:**

a. Ensuring falls that occur during Therapy treatment sessions are reviewed in line with Patient safety Incident Response framework (PSIRF).
b. If required engaging in patient safety huddles with the wider Therapy team.

5.13 **Medical Staff** are responsible for:

a. Reviewing the patient following a fall and completing the Medical Review following a Fall Checklist (yellow sticker) as per (appendix 2) and the Head injury following a fall guidance and the process outlined in the UHL Falls Pathway (appendix 3).

b. Considering the effects the drug burden can have on the falls risk whilst undertaking a medication review (appendix 6).

c. Carrying out a thorough clinical assessment for patients admitted with or identified as being at risk of falls and document in the multidisciplinary notes

d. For patients requiring imaging following an inpatient fall to contact the relevant imaging team (CT or X-ray) and inform them about the urgent imaging request. (section 10.4)

e. Ensuring that the discharge summary to the General Practitioner includes details of patient fall, history, and management for their episode of care.

5.14 **Manual Handling team** will be responsible for:

a. Maintaining the Flat lifting equipment in working order.

b. Providing update training on the use of Flat lifting equipment to the agreed groups of staff

c. Ordering and replenishing the disposable Air Transfer Mattress for the Flat lifting equipment on all three sites

5.15 **Clinical Lead for Falls** will:

a. Keep up-to-date with national and local developments in the management of in-patient falls.

b. Will chair the Falls Steering Group, unless agreed by the Clinical Lead and Assistant Chief Nurse (Harm Free Care and LEAF) to delegate the chairmanship to another member of the FSG.

c. Provide information on performance management to relevant Trust Committees and Consultant forums.

5.16 The **UHL Falls Steering Group** will:

a. Carry out the duties laid down in the terms of reference of the UHL Falls Steering Group

b. Develop and report on Key Performance Indicators (KPIs) to deliver improvements in the management of adult in-patients falls within the Trust

6. FALLS SAFETY

6.1 This policy is underpinned by the five key principles of falls safety:

a. Screening patients
b. Identifying Falls Risks
c. Reducing / Managing Falls risks
d. Care Planning
e. Communication

6.2 Additional falls safety management initiatives supporting the UHL Falls Care Plan,

management and treatment of falls are detailed in appendices 1 to 7.

7. FALLS SCREENING OF ADULT IN-PATIENTS

7.1 All patients are at risk of falling in hospital should be considered for a multifactorial assessment. Clinical team to identify the patient's individual risk factors for falling in hospital that can be treated improved and or managed during their inpatient stay.

7.2 All adult patients (including those in ED Majors and Emergency Room) must be assessed using the Screening for Falls Risk on Nervecentre within 6 hours of arrival. The assessment tool identifies patients who require **STANDARD** or **ENHANCED** Falls Reduction Measures to be put in place.

7.3 All adult patients should be offered education about falls prevention and exercise for general health to reduce the effect of deconditioning.

7.4 **STANDARD Falls Reduction Measures** will be in place for:

a. All patients aged 65 or over
b. All patients aged under 65 assessed as at risk of falls using clinical judgement because of an underlying condition.

7.5 In addition to Standard Falls Reduction Measures,

ENHANCED Fall Reduction Measures will be commenced for all patients who:

a. Has been admitted following a fall
b. Has had 2 or more falls on the last 12 months
c. Has had a fall whilst in hospital (UHL)

7.6 Enhanced Falls Reduction Measures to be considered can be found on the Trusts' **STANDUP** posters. Other measures may be implemented and ensure individualised tailored to patient care intervention, these should be recorded on Nervecentre and nursing evaluations.

7.7 The Falls risk screening on Nervecentre and Falls Care plan must be reviewed

a. Following a fall – within 4 hours
b. On transfer to another clinical area – within 6 hours
c. If the patient's condition changes
d. A minimum of weekly

7.8 Additional patient's risk factors to enhance a **Multifactorial risk assessment** (MFRA) should occur for all patients 65 and over to ensure a high-quality assessment as recommended by National Audit of inpatient fall (NAIF) should be implemented to further identify patient's risk and reduce inpatient falls whilst in hospital.

a. Lying and Standing blood pressure
b. Medication
c. Delirium
d. Vision
e. Continence
f. Elimination

7.9 Assessment currently in place and completed on Nervecentre are :

a. Core Nursing Assessment Mobility
b. Core Nursing Assessment Elimination
c. Adult bedrail risk assessment

8. All patients should be advised on fall prevention, physical activity and implement a personalised care plan to reduce risk.

9. A **Falls Care Plan** must be completed, within 6 hours of admission for any patient identified as requiring **STANDARD or ENHANCED** Falls Reduction Measures

9.1 Appropriate actions should be taken to commence Nursing Core care plans and make additional referrals in line with recommendations from Nervecentre Core nursing assessments.

9.2 A Lying and Standing Blood Pressure should be completed and recorded on Nervecentre for:

a. All patient at risk of falls in Standard and Enhanced fall reduction measures
b. On admission within 6 hours

c. Repeated when there is a positive result

d. Positive results should be escalated immediately to medical team.

e. Following a fall within 4 hours, (except in patient with a suspected hip injury or fracture).

f. The Royal College of Physician guidance to recording a lying and standing blood pressures can be found in (appendix 5).

g. A small proportion of patients who are unlikely to call for assistance and / or remember to use the call bell. These patients who may mobilise without supervision / support and or use appropriate mobility aid are at an increased risk of falling and sustaining harm. May benefit from the use of falls prevention sensor devices to further reduce inpatient falls (Assisted Technology) (appendix 6).

10. CARE PLANNING FOR PATIENTS IDENTIFIED AT RISK OF FALLING

10.1 Falls Screening and Care Planning

a. Falls Screening and Care Planning process is summarised in Section 7

b. An individualised care plan detailing the interventions to address each patient's identified risk factors should be implemented and documented using the Falls Care Plan for Adult Inpatients at Risk

c. The falls care plan is not standardised for all patients and each section must be reviewed by the Registered Nurse RN and each intervention activated **only** if it supports that patients falls management plan. NB - Some patients may require a continuous/tailored review of their care plan i.e. each shift.

d. Do not bracket and sign all section of the fall care plan if not applicable to the patient care interventions.

e. To review every 7 days, on transfer to clinical area, following a fall and if patient's condition changes.

f. All patients and their family/carer should be advised of patient's falls risk and associated care plan. To improve family/carers awareness of patient's fall risks and support with the reduction of falls whilst in hospital.

10.2 **Bed rails and the risk of entrapment** - Bed rails, also known as side rails or cot sides, are widely used to reduce the risk of falls. Bed rails may also be used as an aide by patients and / or staff to help patients reposition in bed or be requested by patients who experience severe anxiety who require bed rails to make them feel safe. Although not suitable for everyone, they can be very effective when used with the right bed, in the right way, for the right person. Before using bed rails the following actions **must** happen:

a. Nervecentre bed rail risk assessment completed within 6 hours of arrival or transfer to a clinical area.

b. Assesses for risk of entrapment, highlighting patients with atypical anatomy (see definition in section 7.3)

c. Commence appropriate bed rail care plan in line with outcome of

Nervecentre bed rail risk assessment

10.3 **What to do if a Patient Falls** - If a patient falls they must be cared for in line with:

a. Care following an inpatient fall and safe retrieval of patient-Flow chart.

b. Check patient for any injury before moving

c. If injury suspected do not move patient and request urgent medical review within 30 minutes).

d. Ensure patient is made safe and comfortable preferably still on the floor until medical review has been achieved.

e. Assess for pain, if present to administer pain relief immediately if prescribed before retrieval.

f. A medical review should take place when patient's falls took place and agree and communicate the patient is safe to be moved when injury suspected.

g. Assess for safe manual handling method to retrieve the patient from the floor in the event of an injury as per Flow chart (appendix 1).

h. In the event of fall being unwitnessed and suspected head injury, if unable to clearly confirm whether they have hit their head, to proceed as if head injury has been sustained. To commence Neurological observation in line with Head injury following and inpatient fall guidance (Trust Reference B8/2010).

10.4 **CT or X-ray imaging**

a. A medical team to contact the relevant imaging team (CT or X-ray and inform them about the urgent imaging request,

b. For CT scans during out of hours, contact the Registrar on extension 16969 for the request to vetted.

c. For urgent reporting (CT and X-ray) out of hours, contact the Registrar on extension 16969.

d. For only X-rays during working hours, please contact the plain contact the plain X-ray reporting hub on 17501.

e. Escalate to the imaging manager on call, can be contacted via switchboard.

10.5 **Discharge**

On discharge, the patients GP should be informed of all falls and risk factors completed by the medical team responsible for the patient's care on the discharge summary (TTO) on Nervecentre this should include recommendations
and any follow-up in the community

11. POLICY STATEMENTS AND STANDARDS

11.1 Monitoring of In-patient Falls will be completed at Ward and CMG level in line with the process outlined in the
Standard Operating Procedure: Care Review and Learning – Falls

12. EDUCATION AND TRAINING REQUIREMENTS

12.1 All clinical staff are responsible for ensuring they are up to date with knowledge of procedures of falls management and post falls care.

12.2 Falls prevention training including policy, risk assessment and post fall actions will be provided to all new starters to UHL in the form of Registered Nurse (RN) induction Healthcare Support Worker (HCSW) Induction, Preceptorship programme and International nurse's induction, and in relevant department inductions for non-nursing staff. On HELM platform the Falls Safety E-learning is essential to role requirement.

11. PROCESS FOR MONITORING COMPLIANCE

11.1 It will be the responsibility of Clinical Management Groups (CMG) and the Harm Free Care Team to monitor compliance, as described in the Policy Monitoring Table.

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Screening for falls risks and outcomes	Harm Free Care	Nervecentre reporting	Quarterly	Falls Steering Group
Staff training on falls care and Management	Harm free Care	Helm	Annually	Falls end of year report
Monitor number of falls where lapse were present	CMG Falls Lead/Harm Free Care	Falls Data from Falls Care Review and Learning	Quarterly	Falls Steering Group, Harm Free Care group and NMAHP group.

12. EQUALITY IMPACT ASSESSMENT

12.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

12.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

13. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

13.1 Related policies:

- Risk Management Policy (B12/2002)
- Bed Rail UHL Policy (E2/2015).
- Head Injury Following Inpatient Falls UHL guidance (B8/2010).
- Guideline for the Escalation of Deteriorating Glasgow Coma Score (GCS) (B15/2012)
- Incident and Accident Reporting Policy (A10/2002).
- Being Open (Duty of Candour) Policy (B42/2010)
- Orthostatic Hypotension UHL Guidelines (B45/2017)
- Standard Operating Procedure: Falls Care Review and Learning (B10/2021)
- Safer Handling Policy (B29/2023)
- NPSA Alert NatPSA/2023/010/MHRA

- Patient safety Incident Response policy (B16/2024)

13.2 References and Evidence Base

- National Institute for Health and Care Excellence. (2013) *Falls in older people: assessing risk and prevention. Nice Clinical Guideline 161.* London: NICE.
- National Institute for Health and Care Excellence. (2015) *Falls in older people. Nice Clinical Guideline qs86.* London: NICE.
- World guidelines for falls prevention and management for older adults: a Global initiative. (2022)

14. PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

14.1 This policy will be reviewed and evaluated by the UHL Falls Steering Group every three years or where there is any significant change required, driven by incidents, risk or national guidance to ensure its continued effectiveness.

14.2 This document will be uploaded onto SharePoint and available for access by Staff through UHL Connect. It will be stored and archived through this system.

Care following an inpatient fall and safe retrieval of patient Flow Chart

NHS
University Hospitals of Leicester
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- Complete set of observations
- ABCDE approach
- Check for signs and symptoms of injury

Injury suspected?

No

Administer analgesia, as required before patient is moved

Transfer patient to bed using safe manual handling method

Request medical review

Yellow Sticker in medical notes

Update Patient and / or NOK in line with Duty of Candour policy and document in medical notes

Complete DATIX incident report

Update nursing notes /NerveCentre

Yes

ANY OTHER SUSPECTED FRACTURE

Administer analgesia, as required before patient is moved

Transfer patient to bed using safe manual handling method

Request medical review

Yellow Sticker in medical notes

Update Patient and / or NOK in line with Duty of Candour policy and document in medical notes

Complete DATIX incident report

Update nursing notes /NerveCentre

SUSPECTED OR ACTUAL FRACTURE TO FEMUR

- Patient at risk of further injury, will be in distress and in pain.
- **DO NOT move the patient:** they MUST be flat lifted under the instruction of a trained member of staff.

REQUEST MEDICAL ATTENTION IMMEDIATELY

LRI

Contact the Duty Manager via Switchboard (available 24/ 7 days).
They will bring the equipment and have the expertise in flat lifting to coordinate clinical staff.

GH

DAY
Contact the Matron of the Day (available 12hrs / 7days).
NIGHT
Contact the Duty Manager via Switchboard (available 12hrs / nights / 7 days).
They will bring the equipment and have the expertise in flat lifting to coordinate clinical staff.

LGH

DAY
Contact the Registered Nurse based on Ward 14
NIGHT (19:00-07:30)
Contact the Duty Manager via Switchboard.
They will bring the equipment and have the expertise in flat lifting to coordinate clinical staff.
N.B. RN from ward will be required to swap with RN from Ward 14

Review and update falls screening and care plan to implement Enhanced Falls Reduction Measures

SUSPECTED OR ACTUAL HEAD OR SPINAL INJURY

- Patient at risk of further injury if incorrectly moved.
- Please seek advice before the patient is moved.
- Head injuries are more likely to sustain a traumatic neck injury.
- Any new or worsening neck pain post fall, check for tingling/numbness to lower extremities.
- Need to consider possibility of spinal injury.

REQUEST MEDICAL ATTENTION IMMEDIATELY

GH/LGH

Will need to dial 999 for spinal board

LRI

IN HOURS
Contact the Spinal Specialist Nurse based on Ward 17
OUT OF HOURS
Contact the Registered Nurse who will cover and or escalate to the Duty Manager.
These patients MUST be flat lifted under instruction of trauma trained member of staff

Ensure circumstances of the fall and any new / additional care needs are verbally handed over to the team and fully documented in patient's medical notes and NerveCentre THINK physiotherapy reassessment

DO NOT move the patient until you have:

Checked for signs and symptoms of injury – top to toe review

- Are there any obvious signs of bleeding?
- Are there any deformities / bruising to limbs or body?
- Is either leg shortened and rotated? (#NOF)

While completing the physical examination, ask yourself the following questions:

- Is the patient complaining of any pain?
- Did the patient hit their head*?
- Have they collided with an object / landed on something?
- Is the patient complaining of pins and needles / tingling in lower limbs?

**If fall unwitnessed and patient is unable to confirm if they hit their head, proceed as if head injury sustained.*

MEDICAL REVIEW

- *When a injury is suspected the patient must to be reviewed within 30 minutes.*
- *If no injury is suspected the patient must to be reviewed within 12 hours*

Refer to UHL Guidelines for the Escalation of Deteriorating Glasgow Coma Score (GCS) B15/2012 and Management of Head Injury in Adults Following In-patient Falls B8/2010 on INsite

For further information see 'Fall Safety and Management for Adult Inpatients UHL Policy' on INsite

VERSION 1 – July 2021

Lorna Knight, Patient Experience Team 2021

Appendix 2

This policy seeks to support staff in responding appropriately when a patient falls in the clinical area. For quick reference there is a Care following an inpatient fall and safe retrieval of patient Flow Chart (See Appendix 1)

If a patient falls (witnessed or non-witnessed) the following actions should be taken:

- Immediately assess the patients:

  A - Airway

  B - Breathing

  C - Circulation

  D - Disability

  E - Exposure

- Carry out observations including blood pressure, pulse, respirations, oxygen saturation and capillary blood glucose. Record findings on Nervecentre
- **Before the patient is moved,** check for any signs and / or symptoms of injury. These checks are detailed in the chart below:

Checks for signs and symptoms of injury
Are there any obvious signs of bleeding
Are there any deformities / bruising to limbs and body
Are either leg shortened and rotated (#NOF)
While completing the physical assessment, ask yourself the following questions:
Is the patient complaining of any pain
Did the patient hit their head*
Have they collided with an object / landed on something
Is the patient complaining of pins and needles / tingling in lower limbs

*If fall unwitnessed and the patient is unable to confirm if hit head, proceed as if head injury sustained

- If an injury is suspected:
  - Request urgent medical review. If out of hours, this should be within 30 minutes

- A medical review after an inpatient Fall Checklist' (Yellow sticker) should be completed and put in the patient's notes
- Administer analgesia prior to moving the patient.
- If there is a suspected or actual head or spinal injury the patient is at risk of further injury if incorrectly moved, **a Trauma trained member of staff must assess the patient before they are moved**. Consider flat lifting using a spinal board. Ensure the immobilisation of suspected injury throughout.
- LRI In hours - Contact the Spinal Specialist Nurse based on Ward 17, LRI Out of hours - Contact the Registered Nurse who will cover and or escalate to the Duty manager

1. GH – May need to dial 999 for the Spinal board
2. LGH – May need to dial 999 for the Spinal board
3. Carry out observations including blood pressure, pulse, respirations, oxygen saturation and capillary blood glucose. Record findings on Nervecentre
4. Patients who have head injuries following an inpatient falls are more likely to sustain a traumatic neck injury. Any new or worsening peck pain post fall, check for tingling/numbness to lower extremities. Need to consider possibility of spinal injury. **These patients MUST be flat lifted under the instruction of a trauma trained member of staff**
5. Commence neurological observation in line with Management of Head Injury in Adults Following In-patient Fall Policy (B8/2010)
6. There is a suspected hip injury or fracture the patient is at risk of further injury if incorrectly moved. **DO NOT MOVE** the patient. Administer analgesia prior to movement of the patients (see flowchart for instruction for each site. **These patients MUST be flat lifted with Flojac under the instruction of a trained member of staff**

- If no injury suspected:

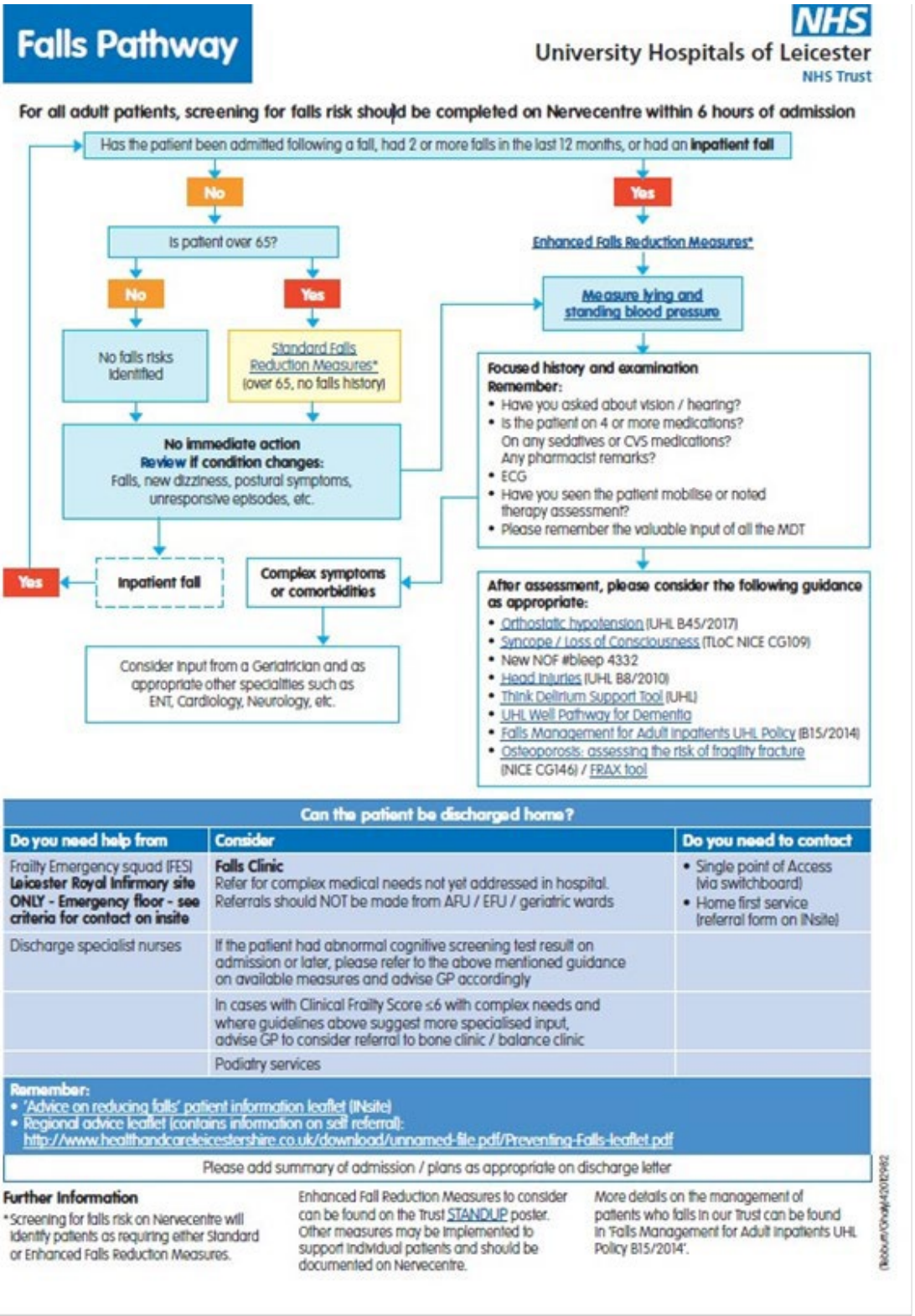
7. Request medical review and patient to be review at the point of the fall.
8. Place completed yellow 'Medical review after an inpatient fall checklist' in case notes
9. Administer analgesia as required
10. Move the patient using a suitable method of moving and handling from the floor with appropriate equipment and technique

- For all falls:

11. Request medical review and patient to be review at the point of the fall.
12. Complete/review assessment of falls risk factors and falls care plan.
13. Complete the Inpatient Fall Nurse Review (orange) sticker and place in the patient's nursing notes and update Nervecentre. Inform patient and/or next of kin of incident and actions/measures taken. If applicable meet the requirements of statutory Duty of Candour in adherence with the Duty of Candour Policy (B42/2010)

14. Complete a DATIX incident report. The chart below details the investigations that should be completed depending on the level of harm following the incident (severity and result).

Level of Harm	Action required
Level 1 – No Harm	Review at ward level. Datix coded with Ward Matron
Level 2 – Minor harm Harm requiring first aid level treatment, or Extra observation only (e.g. bruises, grazes)	Review at ward level. Datix coded with Ward Matron Discuss at monthly falls care review with HON
Level 3 – Moderate harm Harm requiring hospital treatment or a prolonged length of stay but from which a full recovery is expected (e.g. fractured clavicle, laceration requiring suturing, head injury)	Review at ward level team Datix coded with Ward Manager and Matron Respond using the appropriate patient safety incident response framework. Discuss at monthly falls care review with HON/ Harm Free Matron & Deputies Duty of Candour requirements need to be met
Level 4 – Major harm Harm causing permanent disability (e.g. brain injury, hip fractures where the patient is unlikely to regain their former level of independence)	To review t ward level Discuss with the Adult Safeguarding team Datix coded with Ward Manager and Matron Respond using the appropriate patient safety incident response framework Discuss at monthly falls care review with HON/ Harm Free Care Matron & Deputies Duty of Candour requirements need to be met
Level 5 –Death Where death is directly attributable to the fall	Investigate at ward level Discuss with the Adult Safeguarding team Datix coded with Ward Matron Respond using the appropriate patient safety incident response framework and identified learning form the incident. Discuss at monthly falls care review with HON/ Harm Free Care Matron & Deputies Duty of Candour requirements need to be met CMG to share outcome of learning and theme and any action with the team



Falls Pathway

NHS
University Hospitals of Leicester
NHS Trust

For all adult patients, screening for falls risk should be completed on Nervecentre within 6 hours of admission

Has the patient been admitted following a fall, had 2 or more falls in the last 12 months, or had an **inpatient fall**

No

Is patient over 65?

No

No falls risks identified

Yes

Standard Falls Reduction Measures* (over 65, no falls history)

Yes

Enhanced Falls Reduction Measures*

Measure lying and standing blood pressure

Focused history and examination
Remember:
- Have you asked about vision / hearing?
- Is the patient on 4 or more medications? On any sedatives or CVS medications? Any pharmacist remarks?
- ECG
- Have you seen the patient mobilise or noted therapy assessment?
- Please remember the valuable input of all the MDT

No immediate action
Review if condition changes:
Falls, new dizziness, postural symptoms, unresponsive episodes, etc.

Yes

Inpatient fall

Complex symptoms or comorbidities

Consider input from a Geriatrician and as appropriate other specialities such as ENT, Cardiology, Neurology, etc.

After assessment, please consider the following guidance as appropriate:
- Orthostatic hypotension (UHL B45/2017)
- Syncope / Loss of Consciousness (TLoC NICE CG109)
- New NOF #bleep 4332
- Head Injuries (UHL B8/2010)
- Think Delirium Support Tool (UHL)
- UHL Well Pathway for Dementia
- Falls Management for Adult Inpatients UHL Policy (B15/2014)
- Osteoporosis: assessing the risk of fragility fracture (NICE CG146) / FRAX tool

Can the patient be discharged home?

Do you need help from	Consider	Do you need to contact
Frailty Emergency squad (FES) **Leicester Royal Infirmary site ONLY - Emergency floor - see criteria for contact on insite**	**Falls Clinic** Refer for complex medical needs not yet addressed in hospital. Referrals should NOT be made from AFU / EFU / geriatric wards	• Single point of Access (via switchboard) • Home first service (referral form on INsite)
Discharge specialist nurses	If the patient had abnormal cognitive screening test result on admission or later, please refer to the above mentioned guidance on available measures and advise GP accordingly	
	In cases with Clinical Frailty Score ≤6 with complex needs and where guidelines above suggest more specialised input, advise GP to consider referral to bone clinic / balance clinic	
	Podiatry services	

Remember:
- 'Advice on reducing falls' patient information leaflet (INsite)
- Regional advice leaflet (contains information on self referral): http://www.healthandcareleicestershire.co.uk/download/unnamed-file.pdf/Preventing-Falls-leaflet.pdf

Please add summary of admission / plans as appropriate on discharge letter

Further Information

*Screening for falls risk on Nervecentre will identify patients as requiring either Standard or Enhanced Falls Reduction Measures.

Enhanced Fall Reduction Measures to consider can be found on the Trust STANDUP poster. Other measures may be implemented to support individual patients and should be documented on Nervecentre.

More details on the management of patients who falls in our Trust can be found in 'Falls Management for Adult Inpatients UHL Policy B15/2014'.

Hyperlink to document here

Guidance on Assessing Suitable Footwear

Patients should be encouraged to bring in or have brought in, suitable footwear.

The footwear should be well fitted, low heeled, fastened to the foot and have a non-slip sole.

*Where suitable footwear is not available the ward should provide the patient with a pair of non-slip socks in the **appropriate size**.*

Consideration should be given to the patient's ability to put on/ take off and fasten their footwear.

If the patient has dressings on their feet, oedema or long-term medical foot problem that prevents them from wearing commercially available slippers / shoes, a referral should be made to the Orthotic Department. Patients with diabetes should be referred to the Diabetic Specialist Nurses.

Royal College of Physicians | Falls and Fragility Fracture Audit Programme (FFFAP)

How to measure 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 their blood pressure.
2. Use a manual sphygmomanometer if possible and definitely if the automatic machine fails to record.
3. Explain the procedure to the patient.

minutes

Lying down

0 Ask the patient to lie down for at least **5 minutes**.

5 Measure the BP.

Standing

0 Ask the patient to stand up (assist if needed).
Measure BP after standing in the **first minute**.

Measure BP again after patient has been standing for **3 minutes**.

5 **Repeat recording** if BP is still dropping.

In the instance of positive results, **repeat regularly** until resolved.

If symptoms change, **repeat the test**.

10

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

1. Introduction

A Fall Sensor device (Assisted technology) is an additional falls prevention tool for patients assessed as requiring Enhanced Falls Reduction Measures, with additional risk concerns (see section 3, criteria for patient use). The falls sensor device is a monitor that will alert staff of patients potentially at risk of falling from the bed or chair. The sensors pads are placed under the patient when they are either in bed or sat on a chair. They are activated when the patient moves, and emit a sound to alert staff that the patient has moved from the bed or the chair. The sensor device will be available for use on a small proportion of patients who are unlikely to call for assistance and / or remember to use the call bell. These patients who may mobilise without supervision / support and or use appropriate mobility aid are at an increased risk of falling and sustaining harm.

2. Scope

This guidance is to support clinical staff to identify patients who, may benefit from a Falls Prevention Sensor Device to reduce their risk of a fall while in hospital.

These devices are not intended to deter the patient from mobilising, if the patient wishes to mobilise and requires supervision this must be provided, as required, to ensure the patient's safety.

The Falls Sensor device is designed for single patient use whilst in use and has the ability to connect two sensor pads to one monitor. Providing one pad for the bed and one for the chair, this enable the patient to use in bed or when sitting out in the chair. When two patient's weight is detected on both pads a negative confirmation tone is sounded (see Audible alarm section below).

2. Recommendations

Criteria for patient use:

Patient on Enhance Falls Reduction measures **AND** *any of the criteria below*:

- Patient in a side room where visibility is reduced.
- Patient likely to fall if they attempt to get up and mobilise without requesting assistance/ unaided or without mobility aid.
- Patient requires Bay /Tag Nursing Observation -within eye sight (LEVEL 2).
- Consideration to patient with cognitive deficits that increases risk of fall if to mobilise unaided.

Exclusion criteria

- Patient who weigh less than 32kgs.
- Patient with capacity not at risk of falls or other form of patient harm.

(NB. If the patient continually attempts to get up unaided or unsupervised the use of the sensor device may not be appropriate and the level of observation for the patient must be reviewed

Clinical staff responsibility:

- Registered Nurse to complete a risk assessment form to ensure the patient meets the criteria (as above) before using the falls sensor device. **(Appendix a**)
- A fall sensor device trained member of staff to test the sensor pads and monitor before first use, each time the system is put into use and twice daily thereafter. **(Appendix a)**

- To record in use date on the sensor pads when commenced.

Testing the Sensor pads	
No.	**Action - Bed and chair**
1	If the monitor has an ON/OFF switch, ensure it is switched ON.
2	If there is an audible low battery alert, replace the batteries immediately.
3	If it is a Cordless system, ensure that transmitter in the sensor pad is switched to the ON position.
4	Check the start date on the pad, if the pad is over 12 months old, Ramblegard recommend you take it out service and seek replacement.
5	Ensure that the sensor pad is placed on a smooth flat surface and the pad is not creased of folded in any way
6	Check that you have positioned the sensor pad correctly
7	Ensure that matching monitor and sensor pad(s) are used together.
8	It is recommended that the sets are clearly numbered to avoid confusion.
9	To test, activate the sensor to confirm that it is alarming and resetting correctly.
10	When satisfied with the points above please completed the daily checks sheet provided before putting the system into use.

Sensor device General Guidance:

- **DO NOT** place the monitor within 0.3 metres (1ft.) of and facing the patient.
- Sensor pads are single patient use
- Registered Nurse to review all patients with sensor pad in place daily, or if their conditions changes to ensure continued appropriate use.
- Bed and chair pads should be cleaned and removed and stored away appropriately.
- Maximum of 4 patients per ward to use the device at any time.
- If the pads become soiled, it is recommended they are cleaned with Chlorclean or Clinelle wipes.
- Do not use on patient with poor skin integrity or patients with pressure ulcers.
- Do not use the sensor device on patients that are prone to walking with purpose due to likelihood of frequent alarm activation. This may cause distress to the patient and the neighbouring patients in the bay.
- Sensor pad may not be effective with all air type chair cushions
- Do not bend, fold, submerge in liquid, or tamper with Sensor pad. If the sensor pad is folded, it may not function properly.
- The Sensor device can be over ridden by a cognitively aware person, a patient with only a few moment of lucidity or an uncooperative patient.

If you are unsure – Test before use- see section: **‘Testing the Sensor pads’**

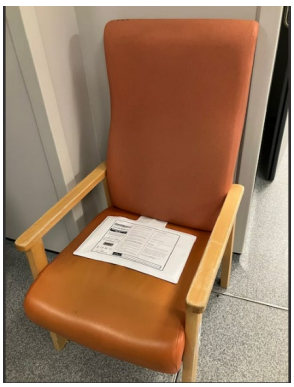
Sensor pads:

Bed Pad – Placement

Place the pad across the width of the bed, on top of the mattress, covered by top sheet. The pad is placed directly under the patient buttocks 8 to 13cm below the bend in the mattress when the head of the bed is elevated.

Chair pad- Placement

Place the pad across the width of the chair. For best sensitivity, place the sensor pad above any other pads. Adjust the position so that it fits directly under the patient buttocks. The favourable location is toward the rear of the seat, 10cm from the back of the chair.



Audible alarms

The monitor provides three types of audible alarms

Sensor pad alarm- is sounded when a patient removes their weight from the sensor pad while the monitor is armed.

Confirmation tone-(positive and negative) is sounded to verify success or failure of an operation. These tones are much quieter than the sensor pad alarm.

- Positive confirmation tone indicates successful association of monitor and sensor pad
- Negative confirmation tone indicates either when the sensor pad cable is disconnected or two sensor pad with weight applied at the same time.

Consumables

All sensor pads and transmitter (consumable parts) are replaced with new part, to ensure continued compliance, every 12 months over the contract period.

3. Supporting Documents and Key References

Adult Inpatient Falls Safety and Management policy (B15/2014)

4. Key Words

Monitors, Sensor pads, inpatient falls, Enhanced Falls Reduction Measures, Sensor device.

This line signifies the end of the document

This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

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Author / Lead Officer:	Lorna Knight	**Job Title:** Falls Safety Lead

Reviewed by:		
Approved by:	**Clinical Policy and Guideline Committee**	**Date Approved: 10.10.24 (v11)**

REVIEW RECORD

Date	Issue Number	Reviewed By	Description Of Changes (If Any)

DISTRIBUTION RECORD:

Date	Name	Dept	Received

APPENDIX A

ALL PREVENTION SENSOR DEVICE RISK ASSESSEMENT

Please complete the questions below	Yes	No
Is patient on Enhanced Falls Reduction Measures?		
Is the patient likely to fall if they attempt to get up and mobilise without requesting assistance?		
Does the patient require maximum Level 2 Bay /Tag Nursing Observation (within eye sight)?		
Does the patient weigh more than 32kg?		

If the patient requires **Level 3** Continuous Enhanced Observation (1:1), a sensor pad could be considered in the interim as a temporary measure. This must be escalated to Matron of the day.

SENSOR DEVICE MONITORING CHART

Please complete check of the Sensor pads twice a day to confirm it is functioning correctly working.
NB: The product is warrantied for up to 14 days from recorded (in-use date). If product fails to function properly at any time, stop use immediately and replace with new sensor pad.

Patient details :			**Ward:**	
Date & time	**Bed/Chair pads**	**Monitor Flashing Y/N**	**Alarm: Y/N If Yes give reason for alarm trigger**	**Comments:**