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Abertawe Bro Morgannwg
University Health Board

Policy and Procedure for the Prevention and Management of Adult Inpatient Falls

This document can be made available in alternative formats or other languages,
on request, as is reasonably practicable to do so.

Policy Owner:

Approved by:

Issue Date:

Review Date:

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will by the issue of this policy and procedure, work to ensure that the risk of harm to adult patients caused by falls is minimised.

Policy Commitment

We are committed to ensuring this policy and procedure regarding the prevention and management of falls is followed by our staff when they are caring for adult patients who may be at risk of falls.

Supporting Procedures and Written Control Documents

The supporting procedure describes the following with regard to falls prevention and management:

- The identification of those adult patients who may be at risk of falls
- Actions to be taken to prevent falls where possible
- Actions to be taken if a patient falls

Scope

This procedure applies to all healthcare professionals employed by the UHB, including those on honorary contracts, who are involved in the care of inpatients. It also applies to academics, healthcare support workers, students and locums.

Distribution

This policy and procedure will be made available on the UHB intranet, clinical portal and internet sites.

Review

This policy and procedure will be reviewed by the ABMU Falls Prevention and Management Group annually or sooner if appropriate.

Health Impact Assessment

This was not considered necessary at the time of writing, but will be completed when the policy is reviewed as part of the new UHB process that combines the Equality and Health Impact Assessments

Policy Approved by

The Group with authority to approve procedures written to explain how this policy will be implemented:

ABMU HB Falls Prevention and Management Group

Accountable Executive or Clinical Board Director

Executive Director for Therapies and Health Science

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date by contacting the document author.

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1. Introduction

Health care professionals have a duty of care to minimise risks to their patients. Abertawe Bro Morgannwg University Health Board (ABM UHB) aims to take all reasonable steps to ensure the safety and independence of its patients, and respects the rights of patients to make their own decisions about their care.

Inpatient falls are the most frequently reported incident for the UHB (and this is true throughout the UK). Falls can be both a cause and a consequence of delayed transfer of care. With the UHB's patient population increasing in age and complex multi-morbidity, the challenge to reduce the number of falls and injuries from falls is significant.

Adult patients in hospital may be at risk of falling for many reasons including a history of falls, medically unwell, dementia or delirium, the effects of their treatment or medication, poor mobility, visual and other sensory impairments along with their general wellbeing. Although most falls result in no physical harm or minor physical injuries like scrapes and bruises, falls do sometimes result in catastrophic injury, including death. Fear of falling is a common presentation but is outside of the scope of these procedures.

2. Policy Statement

ABMU Health Board will ensure appropriate care and management is provided for individuals at risk of falling. The management of falls will be implemented across ABMU Health Board that are consistent with best practice and research evidence (National Institute of Clinical Excellence (NICE) CG 161. The Organisation is aware of its responsibilities under the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999, the Workplace (Health, Safety and Welfare)

Regulations 1992 to provide a safe environment to prevent slips, trips and falls to its patients, so far as is reasonably practicable.

The Health and Safety at Work Act 1974 requires that the employer, managers and staff take reasonable care of themselves and any others that may be affected by their work activities, acts or omissions, and to ensure there are appropriate systems in place to manage these risks appropriately.

This policy will replace the existing ABMU HB policy for the Prevention & Management of Inpatient Falls (CID167).

3. Purpose & Scope

The purpose of this policy is to ensure best practice following national guidance and to minimise the potential for inconsistency in care through standardising approaches to the prevention and management of falls.

This document is relevant to all clinical staff employed or contracted within ABMU Health Board including medical staff, nurses and allied health professionals and is designed to:

- inform staff of their roles and responsibilities in relation to falls
- provide direction regarding risk assessment and mitigation of risk
- act as a resource for staff caring for individuals at risk or with a history of falling
- ensure effective monitoring, reporting and investigation of falls

4. Responsibilities

All healthcare staff who are involved with the care of inpatients have a responsibility to familiarise themselves with and follow the content of this policy and procedure.

Where staff are unsure about the reduction of risk strategies, they must seek advice from a senior colleague.

Quality and Safety Leads are responsible for ensuring:

- That staff are aware of this policy and procedure, how to access it and what to do if they have related queries about it
- Falls incidents are reviewed on a regular basis at quality and safety meetings
- The development and completion of annual departmental inpatient falls improvement plans as part of the Health and Care Standards
- The incident reporting policy is adhered to

Delivery Units/Service Groups/Locality Management Teams are responsible for:

- Ensuring that an assessment of staff training needs in relation to this policy and procedure is carried out and, where appropriate, staff are required to undertake relevant training, including refresher training
- Monitoring implementation of this policy and procedure, and present and act on their findings

Matrons/Senior Matrons are responsible for:

- Ensuring that the policy and procedure is monitored and that any associated governance issues are highlighted through an appropriate route and corrective actions taken
- Ensuring the falls compliant tools audit is completed on a regular basis determined by Clinical Board Quality and Safety and experience meetings and reported to the Delivery Unit Falls Scrutiny Panel.

Consultants/Matrons/Ward Managers/Allied Health Professional Team Managers are responsible for:

- The clinical environments are safe and environmental risk assessments are undertaken on an annual basis
- All frontline care staff are trained in Falls Multifactorial Assessment (MFA) and Multifactorial Interventions (MFI) to an appropriate level for the service they provide
- Information including a leaflet is available for staff to provide to patients, relatives, carers, attorneys and deputies as appropriate
- A post-falls debriefing is held and a multidisciplinary post-falls discussion takes place following any fall

The multidisciplinary team and individual registered healthcare professionals must:

- Take decisions about reducing harm from falls in the same way as decisions about other aspects of treatment and care, as outlined in the UHB Consent to Examination or Treatment Policy 2016

- Where the patient lacks mental capacity to make the decision and in the absence of any attorney (LPA) or Court appointed deputy with the appropriate authority, decide which Multifactorial interventions are in the patient's best interests

Workforce and Organisational Development are:

- Responsible for ensuring training is developed or commissioned to meet the needs of the clinical teams in falls Multifactorial Assessment and Multifactorial Interventions, falls awareness and for complex manual handling risk assessments

Estates are:

- To consider fall prevention when designing new areas and to respond in a timely manner to environmental risk factors identified by ward staff.

All Delivery Units are responsible for:

- Adhering to this policy and procedure which will be monitored by a variety of processes, including structured and ad-hoc case note review.
- Adult inpatient falls procedures will be considered as part of the UHB and Clinical Board/Directorate Clinical Audit plan.
- The UHB has a commitment to the national audit programme

The Nursing and Midwifery Board and the Health and Care Professions Council forum is responsible for ensuring that this policy and procedure is updated as necessary; that relevant training is available; and to provide information, support and training to UHB staff as required.

The Quality and Safety Committee is responsible for monitoring, reviewing and, where necessary, approving amendments to this policy and procedure.

5. Abbreviations

ABMU HB Abertawe Bro Morgannwg University Health Board

MDT Multi-Disciplinary Team

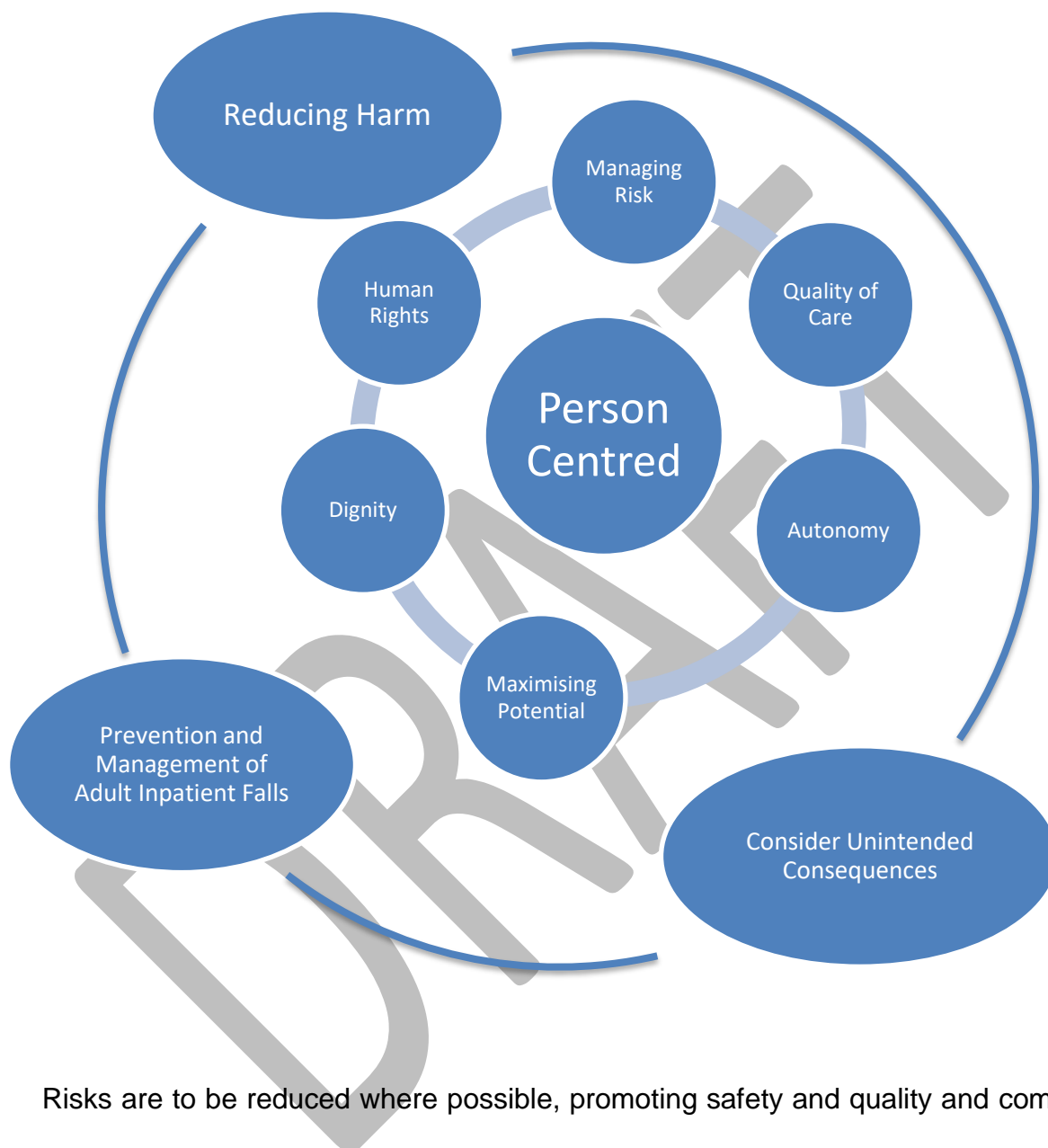
MFA Multifactorial Assessment

MFI Multifactorial Interventions

NICE National Institute for Clinical Excellence

6. Underpinning key principles

The underpinning key principles are illustrated below:



Risks are to be reduced where possible, promoting safety and quality and complying with national requirements. The procedure accompanies the flowchart 'Immediate actions following adult inpatient fall: Prevention and Management of falls flowchart' **see appendix 4 for Acute Sites or Appendix 4a for Primary & Community Hospitals.**

The MFA must be completed in conjunction with the MFA care plan see **appendix 1.**

Evidence and best practice guidance for reducing the risk of falling sets out the following approach, with regular review and monitoring:

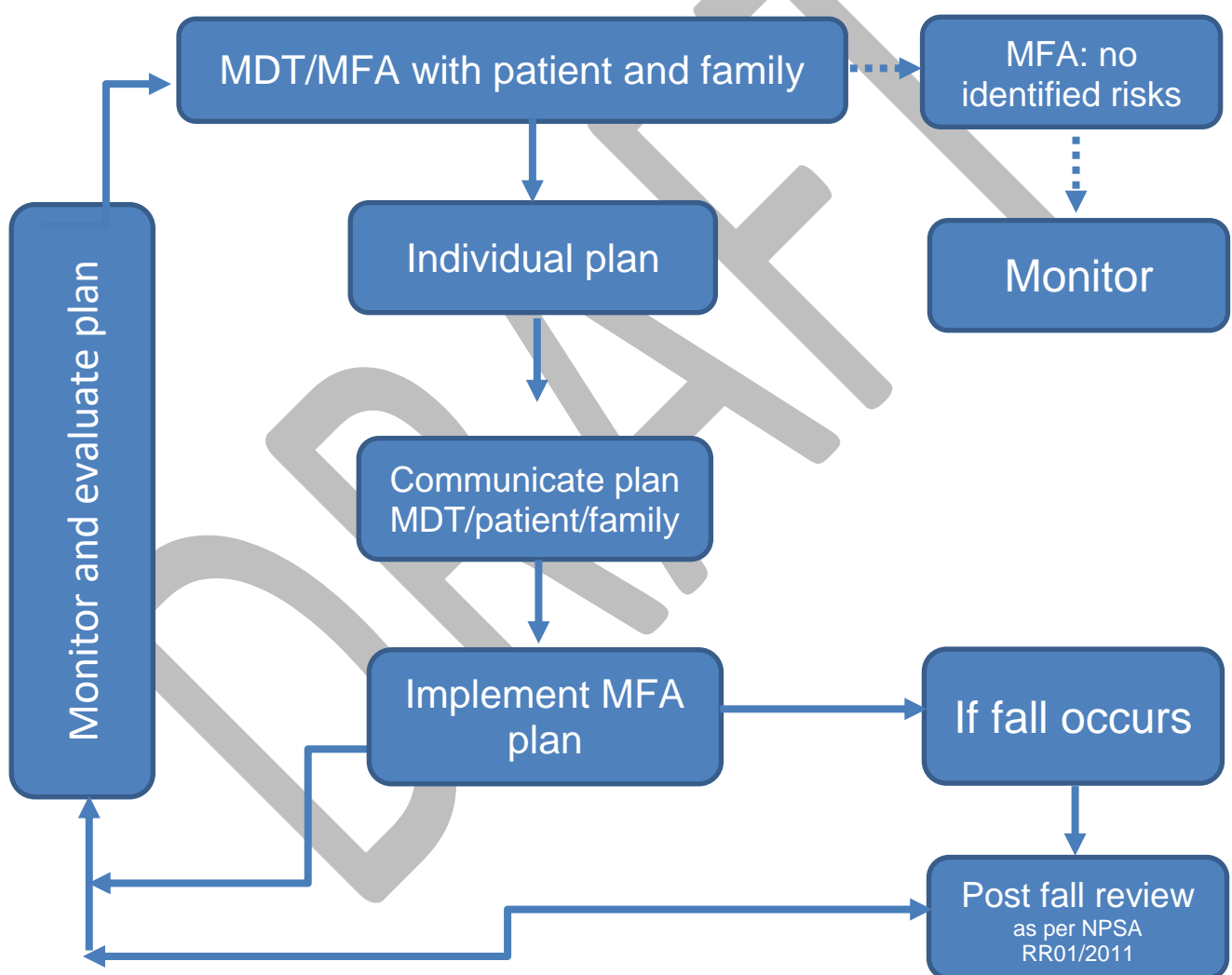
- Implementation of standard falls prevention strategies for all adult inpatients
- Patient information 'Reducing Patient Falls' should be available to all adult inpatients, family, carers, etc. see **appendices 3, 3a & 3b.**
- Undertake MFA of the potential factors that could cause a fall. See **appendix 1**
- Undertake a bed rails assessment see **appendix 2**; If bedrails not identified as required please ensure **appendix 7** is displayed
- Implement an MFA care plan. See **appendix 1**
- Undertake a post-falls assessment for all patients who fall on the ward see **Appendices 6 (Acute sites), 6a (Gorseinon) or 6b (Maesteg)**
- Complete Falls Diary (**appendix 5**)

Please note the appendices will be hyperlinked in the final document

7. Framework for assessment

An MFA will be undertaken on admission/transfer in conjunction with an MFA care plan:

- i. **All adult inpatients** who, on admission, are judged by a clinician to be at higher risk of falling because of an underlying condition



8. Standard Guidance for falls prevention actions and Interventions for all adult inpatients

Standard Guidance

The [NICE \(2013\) Clinical Guideline 161](#) provided new recommendations for falls prevention and includes standard guidance to be given to all adult inpatients. These are incorporated into the MFA as mandatory actions.

These 'mandatory actions' must be carried out for all adult patients regardless of age as they are routine measures.

Standard guidance: applicable to all adult inpatients

Call bell

- Must be working and in reach (where appropriate)
- Where the patient is unable to use the call bell a specific plan must be made appropriate to the patient's needs. This must be recorded within the clinical notes.
- If a call bell is unavailable in particular areas, an appropriate alternative must be put in place.

Advise on safe transfer/mobility

- Promote consistent messages

Advise on safe footwear

- Footwear should be well fitting, supportive and non-slip.
- Anti-embolic stockings should not be worn on their own, as they are a slip hazard.
- Bare feet are not encouraged.

Information leaflet

- Make the 'pre-fall leaflet to the nearest relative / most significant other' information leaflet (**appendix 3a/will be hyperlinked**) available to the patient and their family/carer.

Patient is anticoagulated or at risk of bleeding

- Be aware
- Incorporate this information into ward safety briefings (if patient falls and is at risk of bleeding the ward doctor must be informed immediately)

Environment and/or equipment

- Ensure the patient is orientated to the ward environment
- Advise on risks from drips/tubing/aids as unfamiliar equipment might be a trip/balance hazard
 - Promote use of dimmed lighting during the hours of darkness and ensure there is adequate lighting during the day
 - Avoid bright glaring light
 - Ensure bed brakes are locked and the bed is in an appropriate low position (except when giving care/transferring or to enable independent transfers)
 - Ensure that the chair is in an appropriate design and at the appropriate height for the patient
 - Ensure spillages are reported and cleared

Post anaesthetic/procedure

- Advise about transfer/mobilising following anaesthetic or other procedure as the patient may feel dizzy and should request assistance mobilising. This advice is applicable to all patients of all ages

Falls History

- Identify how many falls the patient has had in the last 12 months. Each fall increases risk and is a trigger for reassessment

Bedrail Assessment

Must be completed for all patients and re-assessed daily:

- With a change in condition
- With change in model of trolley/bed
- On transfer to a different clinical area

[NICE \(2013\) Clinical Guideline 161](#)

9. Multifactorial Assessment and Multifactorial actions and Intervention

A MFA and MFI care plan is required for all inpatients and patients who are judged to at be higher risk of falling because of an underlying condition.

Additional elements of the Multifactorial Assessment to reduce harm from adult inpatient falls

Recent falls history

- Fall in hospital
- Fallen since last assessment

If **yes and** on anticoagulants liaise with doctor

Bone health/fracture history

- Low trauma/fragility fracture
- Osteoporosis
- Lives in care home

Underlying medical conditions

- Physical/physiological review (including lying/standing BP)

<ul style="list-style-type: none"> • Prescribed medication
Cognitive/mental state <ul style="list-style-type: none"> • Delirium screen \geq 65 years old (e.g. 4-AT) • Cognitive assessment – (e.g. Abbreviated Mental Test)
Mobility Needs <ul style="list-style-type: none"> • Gait & balance • Mobility aids • Footwear and foot health
Sensory Impairment <ul style="list-style-type: none"> • Vision and/or hearing • Numbness, weakness or spatial or perceptual problems
Essential care issues <ul style="list-style-type: none"> • Continence • Nutrition, hydration • Communication
Promote MDT falls review

[NICE \(2013\) Clinical Guideline 161](#)

10. Additional Targeted Interventions

<p style="text-align: center;">Targeted interventions</p> <p>These interventions may constitute restraint and if patients lack capacity to agree, the care management of adults with impaired mental capacity policy and procedure in line with Mental Capacity Act Code of Practice 2005 must be followed</p>
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Chairs

- As chairs provided are different styles and heights, each patient will require an individual assessment to ensure the chair is appropriate to meet their needs

Hi-Lo Beds

- Consider for those patients that have fallen from the bed and are at risk of further falls from the bed
- Indicated for patients who are at risk of climbing over or around bedrails
- May be required to assist with safe transfers if the patient is of a petite stature
- If a Hi-Lo bed is considered necessary, in the first instance scope availability of Hi-Lo beds within the ward
- If there is no available Hi-Lo bed in the ward or hospital site, order from the relevant bed hire company
- If none are available, discuss with the Senior matron or, if out of hours, the out of hours site practitioner
- Document in clinical notes
- Report unavailability of bed on the DATIX incident reporting system

Floor safety mat

- Risk benefit analysis required as can be trip hazard for patient and staff

Safe use of Bedrails

- Undertake assessment of use as per UHB bedrails procedure and document decisions using the bedrails record and decision aid.
- If bedrails not identified as required please ensure **appendix 7** is displayed

Assisted Technology Solutions

These do not necessarily prevent falls but may assist staff in the management of individual patient risk

- Consider assisted technology solutions e.g. sensor alarms. Any equipment should be trialled and evaluated on an individual basis considering suitability.
- Assistive technology must not compromise the individual's dignity or independence
- Assistive technology should not impact on other patients comfort e.g. repeated alarm noises

Increased Nursing Observation

Please refer to [CID2490 Nursing Observation Guidelines](#)

11. Ongoing Multifactorial Assessment, actions and Interventions

Ongoing Multifactorial assessment, actions and Interventions

- Proportionate and timely multidisciplinary assessment
- Appropriate review using the 'Falls and Bone Health Multifactorial Assessment, actions and interventions' tool see **appendix 1**
- Reassess after a fall or any changes in condition; this could be an indication of becoming increasingly unwell or re-enabled with new component risks
- Reassess at least daily
- Involve the patient and family/carers in the assessment. Information may be obtained from the patient's health professionals in the community and/or the care setting

Patient and family/carer perspective

- With patient consent involve family/carers in care planning
- Ask about other risks and other interventions
- If patient lacks capacity to make decisions about falls prevention, then follow Mental Capacity Act and if you need to make a best interests decision, consult with family/friends/carers etc.

Other interventions can be considered for an individual patient in order to mitigate modifiable risks.

12. Consider Unintended Consequences

Be aware that attempts to reduce the incidence of falls may cause unintended undesirable consequences potentially more harmful to the patient than a fall.

For example, with advancing age, it becomes increasingly likely that even a brief, clinically mandated period of rest could cause a serious decline in muscle strength and functional capacity. Therefore, maintaining a level of mobility or physical activity for people who fall or are at risk of falls is a fundamental level of care that must be actively considered by the multidisciplinary team and can be enhanced by specific physiotherapy exercises.

13. Assessment and Immediate actions following an adult inpatient fall

This procedure is to be adhered to following an adult inpatient fall, ensuring that safe and quality care is given to a patient and to comply with national requirements see **appendix 4 (Acute sites) or Appendix 4a (Primary & Community)**. The procedure accompanies the flowchart 'Immediate actions following adult inpatient fall' **Appendices: 6 (Acute sites), 6a (Gorseinon) or 6b (Maesteg)** which gives a sequential approach to the screening and assessment for suspected:

- Spinal injury
- Head injury
- Fractured neck of femur and other fractures

As assessments are undertaken concurrently, it is important to recognise and prioritise care of the most significant injuries.

The importance of recognising a possible/actual significant injury following an inpatient fall is a vital component of post-falls management. A missed significant injury followed by inappropriate patient handling can result in catastrophic life-changing injuries, including death for the patient and risks to the University Health Board (UHB).

Although catastrophic injuries are rare events, screening and assessment following all adult falls will determine if a patient requires further medical assessment and specialist care.

14. Serious Incident & Datix Recording Requirement

Any incidents, accidents, or situations where an adult inpatient falls **MUST** be reported using DATIX – please see the Incident, Hazard and Near Miss Reporting policy.

Additional:

- Complete the post falls diary (**Appendix 5**)
- Document in the patients' clinical notes
- Reassess multifactorial assessment and modify (if appropriate) multifactorial interventions
- If appropriate, and with the patient's consent or in the patient's best interests, notify designated family member
- For injurious falls, commence Root Cause Analysis
- Communicate falls history at patient safety briefing/board or ward round as appropriate
- Communicate falls history to any receiving care environment including GP if returning home

15. Nurse Staffing Act

When a fall occurs causing harm on a ward that falls under the Nurse Staffing Levels (Wales) Act, it will be established via the Datix investigation as to whether the agreed Planned Roster for that area was met. If the Planned Roster was not maintained during which time a fall occurred, an investigation must be completed on the actions taken in an attempt to provide the correct number of nurses to meet the roster. This is reported to the Executive Board bi-annually and Welsh Government 3 yearly.

16. Notification of a Serious Incident

An SI will consist of a notification of the injurious fall submitted to Welsh Government (WG), a detailed investigation of the incident and a closure form will then be submitted to WG.

A Serious Incident (SI) must be submitted to WG for all individuals who have sustained an injurious fall i.e. spinal injury, head injury resulting in cranial bleed and fractured neck of femur requiring surgery intervention, and are in receipt of commissioned health care.

The SI notification should be submitted to Serious Incident team within 24 hrs of the injury.

17. Submission of a Serious Incident Closure Form

The SI closure form should include a copy of the fall investigation (from Datix) and be submitted once the investigation is complete and be within 60 days of the notification. The SI closure form must include whether the fall is determined as avoidable or unavoidable and incorporate evidence of the outcome and learning from the falls investigation and scrutiny.

18. Peer Review Scrutiny panel

The purpose of the peer review panel meetings is to drive accountability and quality improvement relating to the fall at a local level and to provide assurance to Service Delivery Unit Directors. Peer review scrutiny panel meetings will be convened to scrutinise the major & moderate fall incidents that occur in ABMU care and will form stage two of the falls investigation. The frequency of the meetings will be determined by the volume of incidents to ensure risk is managed in a timely manner.

The panel will determine if the fall was avoidable or unavoidable and identifying issues that require action. The panel will feedback and share lessons learnt relating to the fall incidents to staff in their SDU and monthly to the Health Board Prevention and management of all adult inpatient falls strategy group.

The scrutiny panel Chair will be a senior member of the nursing management team and membership will include relevant SDU nursing staff. Members of the multidisciplinary team are invited to attend meetings e.g. physiotherapy, occupational therapy, doctor and governance team member. The panel chair is responsible for ensuring the meeting proceedings and outcomes are recorded.

19. Safeguarding

The ABMU HB Safeguarding team will review all incidents in relation to falls. The review will be triggered by the incident approver/investigator by selecting YES to the box 'Is this a safeguarding Adult Incident' in the Datix incident report

This will trigger an e-mail requesting review by the Safeguarding Team (ST)

NOTE: there is no requirement to automatically generate an 'Adult at Risk' (VA1) referral at this stage – please discuss with the team as a priority if it is believed a referral is urgently required.

20. Linking Policies and Guidance

- [Mental Capacity Act 2005 Code of Practice](#)
- [CID123 Safe and Supportive Observation and Engagement of Patients at Risk Policy & Guidance \(not including Caswell Clinic\)](#)
- [Using bedrails safely and effectively](#)
- [ABM HB Incident Policy and Procedure, March 2010](#)
- [NICE \(2013\) Clinical Guideline 161](#)
- [Welsh Health Circular \(2016\) 002](#)
- [CD2490 Nursing Observation Guidelines](#)
- [NAIF Audit Report 2017/RCP London](#)
- [Putting Things Right Policy](#)

21. National Service Framework for Older People in Wales 2004

The National Service Framework (NSF) for Older People was launched in March 2006, Standard Eight has stated the aim “is to work in partnership with Local Authorities and Stakeholders, take action to prevent falls, osteoporosis, fractures, and other resulting injuries, and maintain well being in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation and with their carers, receive advice on prevention through integration of falls and fractures services”. To meet the standards set in the National Service Framework, organisations need to ensure the following key areas are identified:

1. Older people who have fallen are enabled to reach their optimum potential for independence.

2. Reduce the number of falls amongst older people.
3. Care is provided in accordance with best practice.
4. Reduce the number of osteoporotic fractures.
5. Identification of risk of falls.
6. Falls assessment must be multi-factorial.
7. Evaluation of risk factors

22. Resources

The training resource implications for the implementation of those procedures will be absorbed into existing training.

The provision for ultra low beds is partially incorporated into the Total Managed Bed Contract. Other equipment such as, floor safety mats, will be managed within the individual wards/department budget.

23. Training

Awareness is raised through eLearning and further education and training is provided through local induction and nurses foundation programme. The UHB manual handling training programme provides instruction on safe handling of the fallen patient.

24. Implementation








Directorates/Localities are responsible for implementing these procedures. The Lead Physician for adult Falls, Consultant Nurse, Older Vulnerable Adults and Mental Capacity Act Manager will provide advice and support as required.







25. Audit

The Health Board will participate in national and local audit. The findings will be reported to the Health Board on a quarterly basis.

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26. Appendices

Appendix 1	<p>Falls and Bone Health Multifactorial Assessment (MFA) and Care Plan</p>  <p>Falls and Bone Health Multifactoria</p>
Appendix 2	<p>Adult inpatient bedrail risk assessment</p>  <p>Adult inpatient bedrail risk assessm</p>
Appendix 3	<p>Pre-fall patient information leaflet</p>  <p>Pre-fall Patient information leaflet \</p>
Appendix 3a	<p>Pre-fall information leaflet for relatives/carers</p>  <p>Post Falls Information leaflet</p>
Appendix 3b	<p>Post-fall patient information leaflet</p>  <p>Post Falls Information leaflet</p>
Appendix 4	<p>Immediate actions following adult inpatient fall: Prevention and management of falls flowchart</p>  <p>Falls flowchart draft V4.1_0618.doc</p>
Appendix 4a	<p>Immediate actions following adult inpatient fall: Prevention and management of falls flowchart (<i>Gorseinon & Maesteg Hospitals only</i>)</p>  <p>Falls flowchart Primary and commur</p>

Appendix 4b	<p>Immediate actions following adult inpatient fall: Prevention and management of falls flowchart (<i>Mental Health & Learning Disabilities only</i>)</p>  <p>MH LD falls flowchart V4.1_0618</p>
Appendix 5	<p>Falls Diary</p>  <p>Falls Diary v4.1_0618.docx</p>
Appendix 6	<p>Falls Alert</p>  <p>FALL EVENT ALERT.doc</p>
Appendix 6a	<p>Falls Alert (Gorseinon Hospital only)</p>  <p>Falls Alert Gorseinon v4.1_0618</p>
Appendix 6b	<p>Falls Alert (Maesteg Hospital only)</p>  <p>Falls Alert Maesteg v4.1_0618.doc</p>
Appendix 7	<p>Bed Rails Poster</p>  <p>Bed Rails X poster.docx</p>

27. References & Bibliography

[All Wales NHS \(and Local Government\) Manual Handling Training, Passport and Information Scheme \(2003\)](#)

[National Audit of Inpatient falls; audit report 2017 – Royal College of physicians](#)

[National Institute for Clinical Excellence – Falls in older people– 2017 Quality Standard \[QS86\]](#)

[National Institute for Clinical Excellence – Falls in older people: assessing risk and prevention– 2013 \[cg161\]](#)

[National Patients Safety Agency \(National Reporting and Learning Agency\)](#)

[National Service Framework for Older People in Wales 2004](#)