

<p>Reference Number: UHB 045 Version Number: 4</p>	<p>Date of Next Review: 15.06.2024 Previous Trust/LHB Reference Number: T 395</p>
<p>Falls: Policy and Procedure for the Prevention and Management of Adult In-patient Falls</p>	
<p>Policy Statement</p> <p>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.</p>	
<p>Policy Commitment</p> <p>We are committed to ensuring that 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.</p>	
<p>Supporting Procedures and Written Control Documents</p> <p>The supporting procedure describes the following with regard to falls prevention and management -</p> <ul style="list-style-type: none"> • 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 <p>Other supporting documents are:</p> <p>Mental Capacity Act 2005 Code of Practice Assessing and Prescribing Levels of Special Nursing Observations Restraint in the Care Management of Adults with Impaired Mental Capacity policy Bedrails Procedure Incident, Hazard and Near Miss Reporting Policy NICE CG 161 Welsh Health Circular (2016) 002</p>	
<p>Scope</p> <p>This procedure applies to all healthcare professionals employed by the UHB, including those on honorary contracts, who are involved in the care of in-patients. It also applies to academics, healthcare support workers, students and locums.</p>	
<p>Distribution</p>	

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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 falls steering group every three years or sooner if appropriate.

Equality Impact Assessment

An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact.

Note: if an EqIA has not been completed indicate why

Health Impact Assessment	
Policy Approved by	Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Falls Delivery 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 either by contacting the document author or the [Governance Directorate](#).

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Summary of reviews/amendments			
Version Number	Date Review Approved	Date Published	Summary of Amendments
1	10/05/2011	13/06/2011	New Document
UHB 2	Jan 2012	09/03/2012 15/08/2012 26/09/2012 30/11/2012	Updated Appendices Appendix 23 added 15/08/12 Appendix 11 updated to UHB policy Appendix 9 updated to v 5.1
UHB 2.1	Aug 2014	19/08/2014	Updated Appendices: Appendices 1,2, 3, 4, 7, 8, 15a, 15b, 21, 22, & 23 New Appendices: Appendix 24 - Familiarisation with flat-lifting and use of Hoverjack
UHB 2.2	Jan 2015	23/01/2015	Update Appendix 5
UHB 3	13/09/2016	26/10/2016	New policy and procedure- This is a New Policy which has been added to the existing Procedure using the same UHB Number New appendices Appendix 16 Amended Frop-Com Form 2.doc Appendix 17 L&S BP Procedure Poster Appendix 18 L&S Procedure Reference Cards Appendix 19 Basic Bedside Vision Assessment Appendix 20 Delirium Screen the 4A's
UHB4			Appendix 5 Immediate actions following adult inpatient fall – revised to clarify risks of anticoagulation and circumstances in which CT scanning is indicated. Revised information on use of hip protectors. Minor typographical and layout changes made to improve clarity.
UHB4a			Amended post falls section and Appendix 5 to specify that neurological observations must be completed by a registrant as per historic Regulation 28

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1 Introduction

Health care professionals have a duty of care to minimise risks to their patients. Cardiff and Vale University Health Board (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.

In-patient falls are the most frequently reported incident for the UHB (and this is true throughout the UK). 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. A previous or recent fall is an indicator of the risk of a future fall.

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 Responsibilities

All healthcare staff who are involved with the care of in-patients 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.

Clinical Board 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 in-patient falls improvement plans as part of the Health and Care Standards
- the incident reporting policy is adhered to

Directorate/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 procedure and present and act on their findings

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Lead Nurses / Senior Nurses 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 falls compliance tools audit is completed on a regular basis determined by Clinical Board Quality Safety and Experience meetings and reported to the Falls Delivery Group

Consultants /Ward Sisters/Charge Nurses/Allied Health Professional Team Managers are responsible for ensuring that:

- The clinical environments are safe and environmental risk assessments are undertaken on an annual basis
- All frontline care staff are trained in falls Multi Factorial Assessment (MFA) and Multi Factorial Interventions (MFI) to an appropriate level for the services they provide
- Information including the leaflet in Appendix 3 is available for staff to provide to patients, attorneys, deputies, relatives and carers, as appropriate
- A post falls debriefing is held and a multidisciplinary post falls discussion takes place following any fall

The multidisciplinary team and/or 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 an attorney (LPA) or Court appointed deputy with the appropriate authority, decide which Multi-Factorial interventions are in the patient's best interests

Workforce and Organisational Development Directorate is:

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

Estates is:

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

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Directorates and Clinical Boards are responsible for:

- Ensuring that adherence to this policy and procedure is monitored by a variety of processes, including structured and ad-hoc case note review.
- Adult in-patient 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 Safety and Experience Committee is responsible for

- Monitoring, reviewing and, where necessary, approving amendments to this policy and procedure.

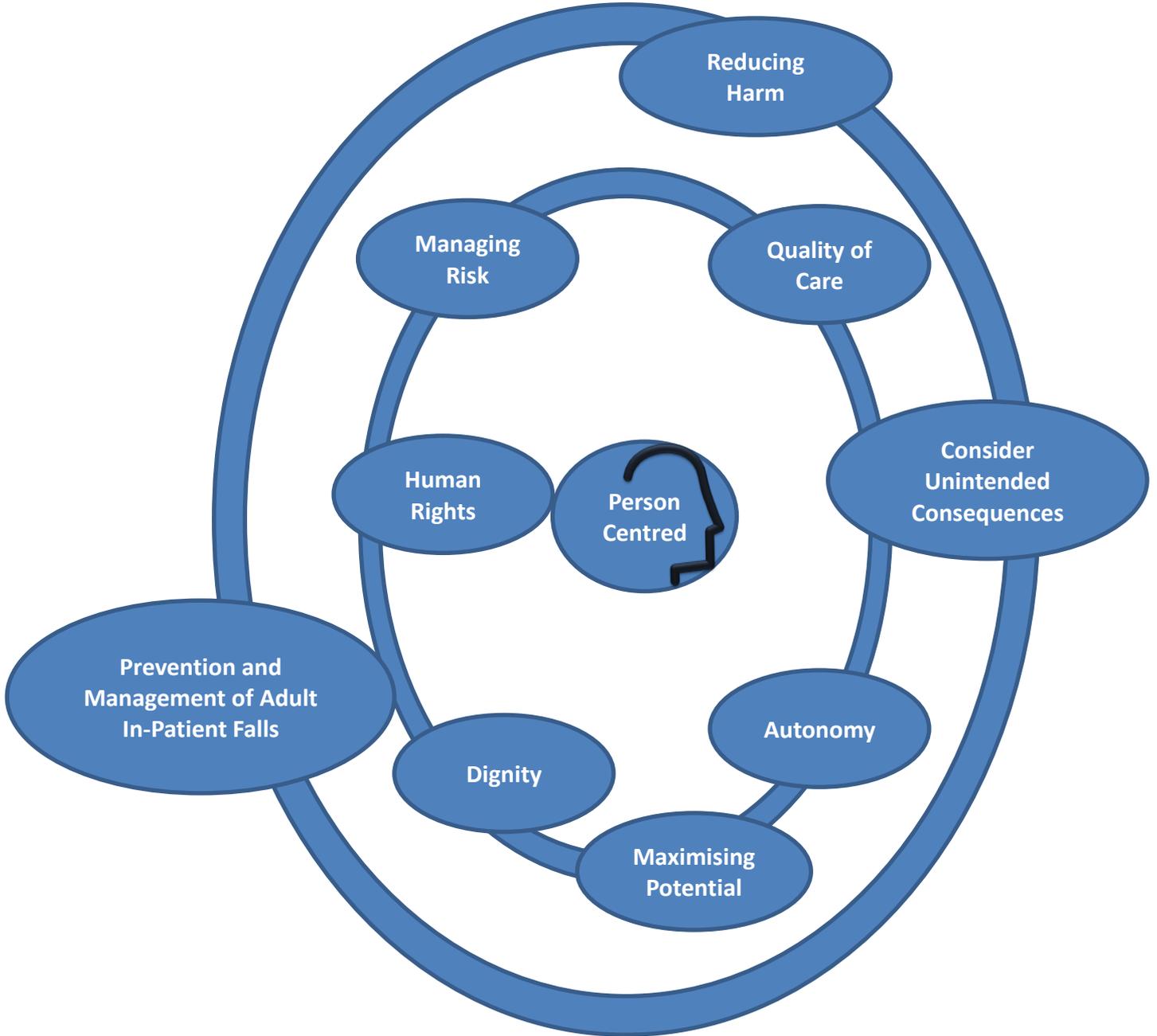
3 Abbreviations

MDT	Multi-Disciplinary Team
MFA	Multi-Factorial Assessment
MFI	Multi-Factorial Interventions
H@N	Hospital at Night

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4 Underpinning Key Principles

The underpinning key principles are illustrated below:



Risks are to be modified where possible, promoting safety and quality and complying with national requirements. The procedure accompanies the flow-chart at Appendix 1.

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The MFA must be completed in conjunction with the MFI care plan. This documentation forms parts of the Patient Risk Assessment booklet.

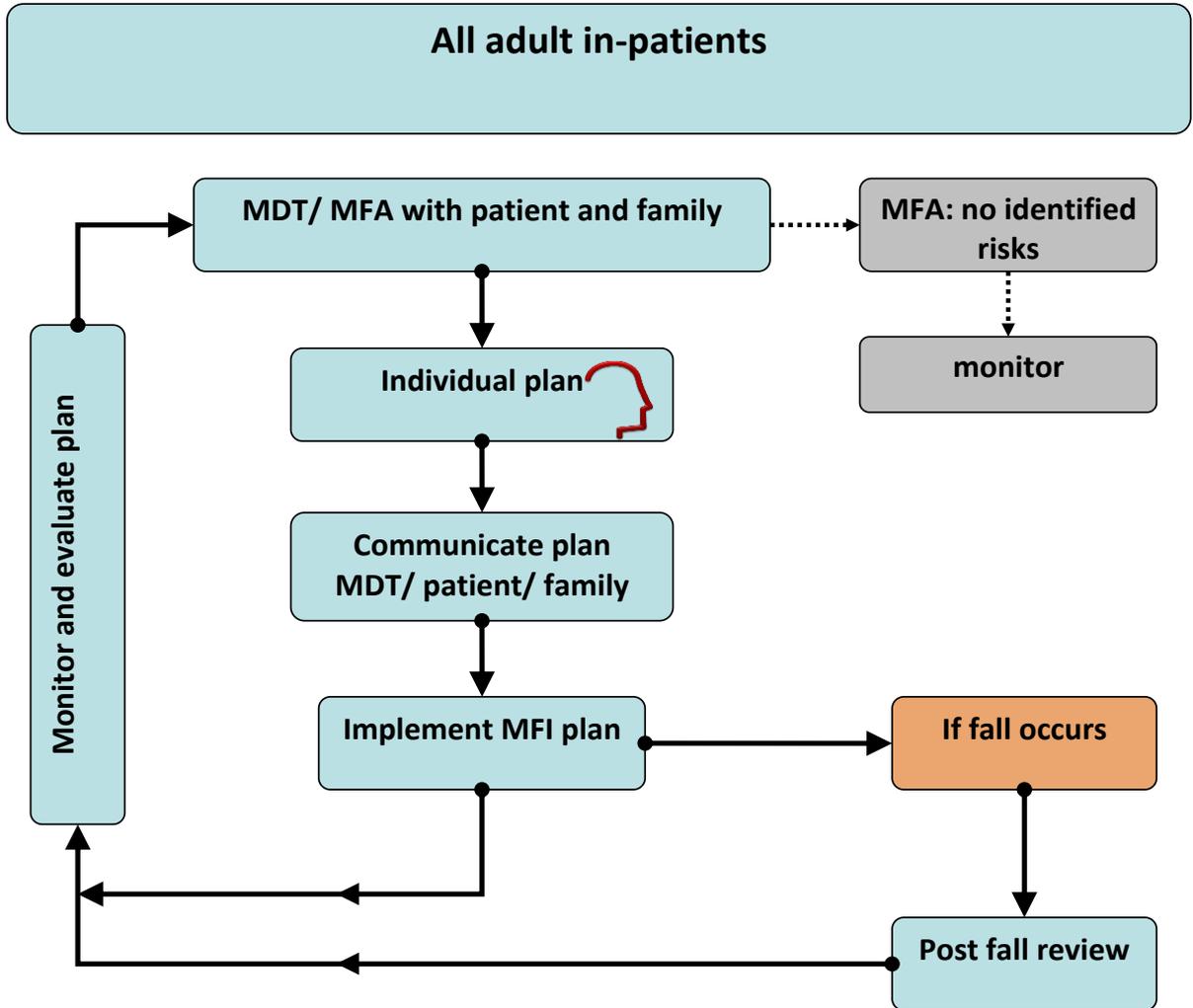
Evidence and best practice guidance for reducing the risk of falling sets out the following approach, with regular review and monitoring:

- Implementation of standard falls prevention strategies for all adult in-patients
- Patient information leaflet (Appendix 3) (available in English and Welsh) should be available to all adult in-patients, family, carers, etc
- Undertake MFA of the potential factors that could cause a fall
- Implement an MFI care plan to mitigate the risks identified
- Undertake a post-falls assessment for all patients who fall on the ward

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5 Framework for assessment

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



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6 Standard Guidance for Falls Prevention Actions and Interventions for All Adult In-patients

The NICE Clinical Guideline “Falls in Older People: assessing risk and prevention (2013) provided recommendations for falls prevention and includes standard guidance to be given to all adult in-patients. These are incorporated into the MFA as mandatory actions.

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

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 needs to be in place.

Advise on safe transfer/mobility

- Promote consistent messages.

Advice 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 Falls Prevention in Hospital leaflet (Appendix 3) available to the patient and their family.

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

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- 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 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 people 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. Falls history may be available from a variety of sources including but not exclusive to, the patient, relatives, carers, GP, Welsh Clinical Portal, PARIS, case notes.

Trolley/ Bedrail Assessment

Must be completed for all patients and re-assessed:

- With a change in condition
- with change in model of trolley/ bed
- On transfer to a different clinical area
- At least weekly in acute care

7 Multi-Factorial Assessment and Multi-Factorial Actions and Intervention

The MFA/MFI is contained in the Patient Risk Assessment Booklet (Appendix 2) and is required to be completed for all adult in-patients. Additional elements of the MFA to reduce harm from adult in-patient falls:

History of Falls

- Falls 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

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- Physical/ physiological review (including Lying /Standing BP which should be completed for all patients who can stand and recorded on the NEWS chart)
- Prescribed medication

Cognitive/ mental state

- Delirium screen \geq 65 years old (e.g. 4AT – see Appendix 16)
- Cognitive assessment – (e.g. Abbreviated Mental Test)

Mobility needs

- Gait & balance
- Mobility aids
- Footwear and foot health

Sensory impairment

- Vision and or hearing (use an assessment tool, e.g. Appendix 15, rather than just enquiring whether patient wear glasses or uses hearing aid)
- Numbness, weakness or spatial or perceptual problems

Essential care issues

- Continence
- Nutrition, hydration
- Communication

Promote MDT falls review

8 Additional Targeted Interventions

These interventions may constitute restraint and if patients lack capacity to agree, [the restraint in the care management of adults with impaired mental capacity policy and procedure](#) must be followed.

Chairs

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

Ultra-Low 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 an ultra-low bed is considered necessary, in the first instance assess availability of ultra-low beds within the ward

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- If there is no available ultra-low bed available on the ward, order from the bed supplier (Medstrom 0844 811 3676)
 - If none are available, discuss with the Senior Nurse or, if Out of Hours, the Site Practitioner
 - Document in clinical notes
 - Report unavailability of bed on the Datix incident reporting system

Safe Use of Bedrails

Undertake assessment of use as per [UHB bedrails procedure](#) and document decisions using the Bed Rails Decision making aid which is contained within the Patient Risk Assessment Booklet (Appendix 2).

Floor safety mat

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

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

9 Ongoing Multi-Factorial Assessment, Actions and Interventions

- Proportionate and timely multidisciplinary assessment
- Appropriate review using the MFA/MFI.
 - Re-assess after a fall or any change in condition; this could be an indication of becoming increasingly unwell or re-enabled with new component risks
 - In Acute Care: reassess at least weekly
 - In Long stay: if fallen since last assessment and known to be at risk, reassess in one week; if has not fallen since last review, re-assess in one month
 - Involve the patient and family in the assessment. Information may be obtained from the patient's health professionals in the community and/or the care setting

Occasional additional equipment use

- Hip protectors: Do not use hip protectors in the in-patient setting.

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- Head protection: particularly for those with a history of falling forward and or head/facial injury. The recommended product is Aremco 'Scrum type helmet' or 'skullguard helmet' available via Oracle

Patient and family perspective

- With patient consent, involve family 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, etc.

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

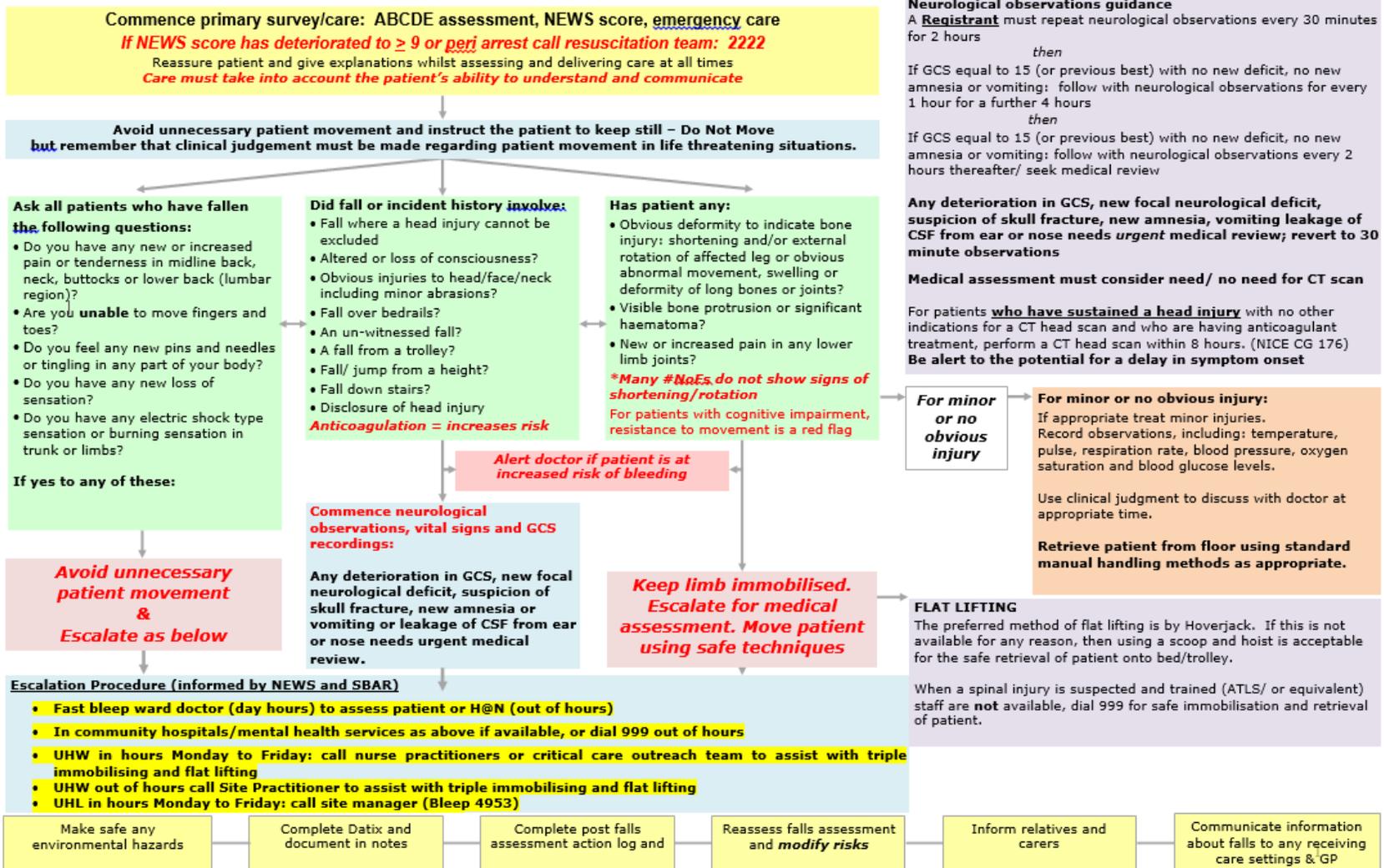
10 Consider Unintended Consequences

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, i.e., a “tipping point” from which some may not fully recover (*English & Paddon-Jones, 2010*). 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.

11 Immediate Actions following an Adult In-patient Fall

Immediate actions following adult in-patient fall:



This procedure is to be adhered to following an adult in-patient fall, ensuring that safe and quality care is given to a patient and to comply with national requirements. The flow chart for immediate actions post fall (Appendix 5) gives a sequential approach to the screening and assessment for suspected:

- Spinal injury
- Head injury
- Fractured femur including fractured neck of femur

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 in-patient 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.

Assess the scene (make safe if necessary) and mechanisms of injury; quickly establish what happened if possible.

The patient's ability to understand and communicate must be considered

For patients with cognitive impairment, it is recommended that a member of staff/carer who knows the patient assesses them for injury.

For patients who are unable to answer questions due to cognitive impairment, observation for spontaneous limb/ torso movement, gripping ability following physical prompt, facial grimacing, vocal noise, response to physical stimulus to arms and legs and moving a hand in front of face should all inform clinical judgement about moving the patient to assess or treat.

For patients who are unable to answer questions but can follow simple instructions a grip/squeeze test is a first option for assessment and if patient is unable to complete this, or if not moving limbs spontaneously, treat with caution and escalate for further assessment.

Neurological Observations

- A Registrant must commence neurological observations and a full set of vital signs and record on appropriate chart (Appendix 6)
- Repeat neurological observations every 30 minutes for 2 hours

then

- If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or vomiting: follow with neurological observations for every 1 hour for a further 4 hours

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then

- If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or vomiting: follow with neurological observations every 2 hours thereafter/ seek medical review

Any deterioration in GCS, new focal neurological deficit, suspicion of skull fracture, new amnesia, vomiting, leakage of CSF from ear or nose needs *urgent* medical review; revert to 30 minute observations

Medical assessment must consider need/ no need for CT scan

NICE Clinical Guideline Head Injury: assessment and early management (2019) states:

“For patients who *have sustained a head injury* with no other indications for a CT head scan and who are prescribed anti-thrombotics or anticoagulants, perform a CT head scan within 8 hours” (NICE CG 176) N.B. If in doubt, discuss with ward doctor.

Remember! Be alert to the potential for a delay in symptom onset (in older patients this can be >72 hours)

Escalation procedures

The escalation procedure is informed by NEWS and SBAR

- Fast bleep ward doctor (day hours) to assess patient or H@N (out of hours)
- In community hospitals/mental health services as above if available, or dial 999 out of hours
- UHW in hours Monday to Friday: call nurse practitioners or critical care outreach team to assist with triple immobilising and flat lifting
- UHW out of hours call Site Practitioner to assist with triple immobilising and flat lifting
- UHL in hours Monday to Friday: call site manager (Bleep 4953)
- UHL out of hours call the Site Practitioner (Bleep 4980)

12 Triple Immobilisation

Triple immobilising and log-rolling are specialised procedures that require knowledge and expertise and **must** only be undertaken by trained and competent staff, for example with Advanced Trauma Life Support or who have received specific training. Log-rolling requires 4 people minimum plus 1 to manage the scoop.

During the log-rolling procedure, further examination of the patient can take place.

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Information to familiarise and raise awareness for ward staff of safe retrieval procedures is found in the appendices 7 to 10.

- Triple immobilising, log-rolling and flat-lifting using
- Hoverjack and scoop for suspected spinal injuries
- Safe retrieval for suspected lower limb fracture using Hoverjack
- Hoverjack Quick Guide (Appendix 7)
- A PowerPoint presentation is also available that demonstrates the above procedures visually (Appendix 9)

13 Screen for a possible or actual fracture

Though a fall from a height is more likely to result in a fracture; all patients must be screened due to the risk of osteoporosis:

Identify if the patient has any:

- Obvious deformity to indicate bone injury; shortening and/or external rotation of affected leg or obvious abnormal movement, swelling or deformity or long bones or joint?
- Visible bone protrusion or significant haematoma?
- New or increased pain in any lower limb joints?

***Remember!* Shortening and rotation of an affected leg in a hip fracture does not occur in all patients**

If following careful assessment of patient, there is no obvious injury or minor injury:

- Treat minor injuries
- Record observations, including temperature, pulse, respiration rate, blood pressure, oxygen saturation and if the patient has diabetes, check blood glucose level
- Use clinical judgement as to when to discuss with doctor, for example, a minor skin tear would not require urgent medical attention

***Remember!* Retrieve patient from floor using standard manual handling methods as taught on manual handling training**

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14 Reporting and record keeping

Any incidents, accidents, or situations where an adult in patient falls **MUST** be reported using Datix – please see the Incident, Hazard and Near Miss Reporting Policy. N.B. The accepted definition of a fall is “an event which results in a person coming to rest inadvertently on the ground or floor or other lower level” (WHO 2021).

Additionally:

- Complete the post falls action log within the generic assessment booklet
- Document in the patient’s clinical notes
- Reassess multifactorial assessment and modify (if appropriate) multifactorial interventions
- If appropriate, and with the patient's consent or in patient’s best interests, notify designated family member
- For injurious falls, commence completion of the Injurious Falls Investigation (Appendix 12)
- Consideration must be given to a need for a full root cause analysis investigation
- 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 Resources

The training resource implications for the implementation of these 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 ward/department budget.

16 Training

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

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17 Implementation

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

18 Equality

Cardiff and Vale UHB is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups. We have undertaken an Equality Impact Assessment and received feedback on these procedures and the way it operates. We wanted to know of any possible or actual impact that these procedures may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics. The assessment found that there was no impact/little impact to the equality groups mentioned. Where appropriate we have taken the necessary actions required to minimise any stated impact to ensure that we meet our responsibilities under the equality and human rights legislation.

19 Audit

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

It is anticipated that the use of the "Perfect Ward" app in the clinical areas will provide falls data for incorporation into audit. Until Perfect Ward is available in all inpatient areas, the Ward Compliance Audit Tool (Appendix 17) may be used by ward managers to assess compliance with this policy.

20 Distribution

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

21 Review

This procedure will be reviewed by the Falls Delivery Group every three years or sooner if appropriate.

Document Title: Policy and Procedure for the Prevention of Adult inpatient Falls	23 of 23	Approval Date: 15.06.2021
Reference Number: UHB 045		Next Review Date: 15.06.2024
Version Number: 4		Date of Publication: 11.10.2021
Approved By: Quality, Safety and Experience Committee		

22 Appendices

Appendix 1	Flow Chart A3 Prevention
Appendix 2	Patient Risk Assessment Booklet
Appendix 3	Falls Prevention in Hospital (English) Falls prevention in Hospital (Welsh)
Appendix 4	AU Falls Assessment
Appendix 5	Flow Chart Immediate Actions
Appendix 6	Neurological Observation Chart
Appendix 7	Hoverjack Quick Guide
Appendix 8	Flat lifting procedure for suspected lower limb fracture, including fractured neck of femur.docx
Appendix 9	Familiarisation with Flat Lifting and use of Hoverjack
Appendix 10	Triple Immobilising Document
Appendix 11	Low Trauma Fractures and Osteoporosis Doc
Appendix 12	Injurious Falls Investigation Tool
Appendix 13	L&S BP Procedure Poster
Appendix 14	L&S Procedure Reference Cards
Appendix 15	Basic Bedside Vision Assessment
Appendix 16	Delirium Screen the 4A's
Appendix 17	Ward Compliance Audit Tool

23 References

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National Institute for Care and Clinical Excellence (2014) Clinical Guideline 176: *Head injury: assessment and early management*.

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