

## PREVENTION AND MANGEMENT OF IN-PATIENT FALLS POLICY

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<b>Author &amp; Title</b>	Liz Jagelman, Patient Safety Improvement Lead		
<b>Staff/Groups Consulted and agreed</b>	Associate Directors of Nursing Matrons Emergency Consultant Physician Eldery Care Physician (FOPAS) Nurse Consultant for Dementia Dementia Co-ordinator Associate Director of Patient Safety and Quality Falls Prevention Group		
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<b>Related procedural documents</b>	See section 8		

### 1. Introduction

- 1.1** In keeping with the Trust's Health and Safety Policy and the general procedure for preventing and managing slips, trips and falls, Yeovil District Hospital NHS Foundation Trust recognises and is committed to its duty of care to patients in reducing the risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained.
- 1.2** Yeovil District Hospital NHS Foundation Trust works in partnership with local authorities, Somerset Partnership NHS Foundation Trust and Voluntary agencies to take actions to prevent falls and to ensure effective treatment and rehabilitation to those that have fallen.
- 1.3** This Policy will provide a framework to assist staff in achieving a reduction in patient falls through awareness, multifactorial risk assessment and recommendation intervention to reduce risk, since statistics show that:-
- 30% people aged 65 years living independently will fall in any one year
  - Approximately 50% of those aged over 80 years living alone will fall in any one year
  - Falls are estimated to cost the NHS more than £2.3 billion per year
- 1.4** Falls are a major cause of death and disability including loss of independence and depression, the following groups of inpatients should be regarded as being at risk of falling in hospital (NICE, 2013);
- patients aged 65 and over
  - patients who are aged 50 to 64 years and who are judged by a clinician to be at higher risk of falling because of an underlying condition.
- 1.5** The NICE (2013) Guidelines on Falls Management, Falls: assessment and prevention of falls in older people who present for medical attention because of a fall, including falling from any height or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multi-factorial falls assessment and multi-factorial intervention.

- 1.6** A single fall is not always a sign of a major problem and an increased risk for subsequent falls as it may simply be an isolated event. A single fall may have multiple causes and repeated falls may each have a different aetiology, so it is important to evaluate each separately.
- 1.7** Although most falls do not result in serious injury, consequences for an individual falling may include:
- Infection;
  - Loss of mobility leading to social isolation and depression;
  - Increase in dependency and disability;
  - Psychological problems such as fear of falling and loss of confidence in being able to move about safely.
  - Fractures – primarily hip, wrist and humerus
- 1.8** However, when a serious injury occurs as a result of an in-patient falling, prompt assessment and treatment which include safer patient handling and positioning is crucial to the chances of the person making a full recovery. This policy details a risk management strategy to ensure that staff are advised of safer protocols for them to consistently achieve this so far as is reasonably practicable
- 1.9** This policy should be read in conjunction with the Health Records Management Policy, the Health and Safety Policy including the [‘Slips, Trips and Falls Procedure](#) at and the [Moving and Handling Policy](#).

## **2. Purpose**

- 2.1** The purpose of this policy is to work in conjunction with the general health and safety procedure for slips, trips and falls in the workplace by focusing on the associated clinical risks involved by providing advice, guidance and protocols to prevent, manage and reduce the incidents of in-patient related falls. Key objectives are to:
- Reduce the incidence of in-patient falls and fall related injuries.
  - Promote early recognition of high risk patients
  - Ensure robust appropriate assessment, intervention, documentation and information for reducing the risks of falls (Multi-factorial), to include:
    - Cognitive impairment
    - Continence problems
    - Falls history, including causes and consequences (such as injury and fear of falling)
    - Footwear that is unsuitable or missing
    - Health problems that may increase their risk of falling
    - Medication
    - Postural instability, mobility problems and/or balance problems
    - Syncope syndrome
    - Visual impairment
  - Ensure safer and appropriate protocols are in place to prevent and manage inpatient falls before, during and post incident
  - Target interventions for high risk patients to minimise the risk of falling
  - Ensure reporting of patient falls is carried out correctly and appropriately
  - Enhance staff and patient awareness of environmental hazards
  - Develop the skills and competence of practitioners with regard to falls assessment via a training and education strategy
  - Ensure the appropriate information / education and intervention is delivered to service users and carers

- Reduce the risk of patient falls-related litigation by ensuring compliance with MHRA and National Patient Safety Agency (NPSA), National Institute for Clinical Excellence(NICE) guidance and all relevant and associated
- If a patient does fall, there is additional guidance on how to deal with the patient, which looks at checking for injury, how to move the patient and any additional care that might need to be given (Falls Care Bundle)
- All cases of in-patient falls should be recorded as an incident through the Safeguarding Incident reporting database

### **3. Applicability**

**3.1** This policy applies to all staff employed by the Trust whether on a temporary or permanent basis.

### **4. Definitions**

**4.1** A **Fall**: can be defined as “a sudden unintentional change in position causing a person to land at a lower level, on an object, the floor or the ground, other than as a consequence of sudden paralysis, epileptic seizure or overwhelming external force.”(NICE, 2004 & 2013).

### **5. Risk Management Strategy for Preventing and Managing In-Patient Falls**

If deemed at risk of falls then staff will complete a thorough risk assessment and put in place any controls to reduce the risk of the patient falling. These controls include completion of a bedrails risk assessment and patient moving, handling and positioning assessment as laid out in **Annex A**.

In the event of a patient fall staff will assess and manage the patient as per the guidance flowchart laid out in **Annex B**.

#### **5.2 Reporting Incidents and Near Misses**

Inpatient related falls are to be reported using the Trust incident reporting procedure and staff must ensure these are logged onto the Safeguard incident reporting database..

#### **5.3 Safer Use of Bed Rails Guidance**

The Trust acknowledges that bedrails should only be used to prevent or help reduce the risk of a patient from falling out of bed and when a suitability risk assessment has been completed and deemed appropriate for the patient concerned.

Most decisions about the use of bedrails are a balance between competing risks and can be complex for individual patients relating to their physical and mental health needs, the environment, their treatment, their personality and their usual lifestyle. Therefore, all clinical staff should read and familiarise themselves with the full and detailed Guidelines for the Safer Use of Bedrails which can be found on the Policy Database on the Trust Intranet.

#### **5.4 Training**

Elements of falls awareness and risk assessment is covered in moving handling and ergonomics awareness training sessions included in the Training Needs Analysis which is maintained and co-ordinated by the Yeovil Academy as detailed in the Risk Management (Mandatory) Training Policy.

General slips, trips and falls awareness is included in the Trust Induction training programme. Management of the falling and fallen patient is covered in clinical patient handling and positioning training at induction and forms part of the patient handling and positioning mandatory update training.

Health and safety risk assessment training includes slips, trips and falls (and working at height for specific staff) as part of the overall approach to assessing safe workplaces under the Trust's Health and Safety policy and procedure.

Staff training on falls awareness aims to increase knowledge with regard to the medical cause of falls, managing a safe environment, safety care practices, risk assessment, risk reduction including falls from any heights, communication, and patient/carer education.

The Trust has identified that all clinical staff working within inpatient and pre-assessment areas (excluding paediatrics) must undertake initial falls training and update every three years. This is classed as essential training for those identified staff groups on the Trust's electronic Training Needs Analysis.

## **5.5 Raising Awareness of Patient Falls**

Patient falls reported through the incident reporting process are broken down by ward area and presented to directorate rolling governance meetings for review and trend analysis. Falls data is presented to wards managers and staff for peer review to highlight and raise awareness about preventing falls. Falls by department are displayed on ward status boards to raise the profile of real time falls incidents to staff and the public. Any fall which is reported as an incident, graded as 3 and above must be reported as a Serious Incident Requiring Investigation (SIRI) onto the Strategic Executive Information System (STEIS).

The Falls Prevention Group will raise awareness through the monthly Patient Safety Steering Group. Falls prevention is part of the South West Quality Improvement Programme. Other awareness initiatives include the use of team briefings, toolbox talks and monthly poster campaigns etc will be carried out by the risk management team organised through the Health and Safety Committee.

## **6. Implementation, Monitoring and Evaluation**

Monitoring of patient falls and root causes will be reviewed through reported incidents and ad hoc spot checks and audit.

Reviews of all reported inpatient falls incidents and advises staff on appropriate action in terms of patient handling and positioning including advice about retrieval from the floor to be implemented to prevent recurrence. Inpatient falls will be monitored, reviewed at both clinical divisional and local ward/dept peer review.

A Clinical Governance report which includes patient falls is provided monthly to the Patient Safety Steering Group (PSSG) for review. This report is provided to the monthly Patient Safety Steering Group by the Associate Director of Patient Safety and Quality. A Dashboard including the number of falls is provided to the PSSG and an overall dashboard is presented to the monthly Board of Directors meeting.

The Associate Director of Patient Safety and Quality presents an annual report to the Board of Directors including patient falls data for review.

## **7. Specific Responsibilities**

### **7.1 Falls Prevention Group**

- To ensure consistent local Falls policies, procedures and guidance are effectively implemented/reviewed and audited within Yeovil District Hospital.
- To develop and agree a multidisciplinary corporate action plan to support improvement and achieve a measurable reduction in inpatient falls.
- To seek assurance that best practice guidance is effectively implemented across the Trust.

- To monitor and review clinical risk management programmes in place for falls prevention and post falls management.
- To monitor the reporting of all falls and those resulting in harm through incident reporting and the Strategic Executive Information System (STEIS).
- To review professional documents and facilitate/implement the key learning identified via Root Cause Analysis/adverse event investigations.
- To provide a forum and facilitate a multidisciplinary approach to falls prevention.
- To provide professional development and support to all healthcare staff

## **7.2 Chief Executive and Board of Directors**

The Chief Executive is the overall accountable officer for all aspects of patient safety including health and safety standards, within the Trust. Trust Directors are responsible for the implementation of all relevant policies and arrangements within their areas of control and to lead their managers and staff in proactive and effective risk management.

## **7.3 Director of Nursing and Clinical Governance**

Director of Nursing and Clinical Governance is responsible for ensuring there are appropriate systems and processes in place for the safe management of patients at risk of falling and for liaising with the Director of HR and Head of Estates and Facilities Management (EFM) to ensure consistent approaches to staff training and management of the environment.

## **7.4 Director of Human Resources**

The Director of Human Resources is responsible for ensuring that there are robust arrangements for the training and education of staff in respect of preventing falls and for additional Health and Safety risks in relation to general slips trips and falls are brought to the attention of all workforce and that appropriate steps are taken to raise staff awareness.

## **7.5 Head of Estates and Facilities Management (EFM)**

The Director of Facilities is responsible for ensuring that adequate resources are available for the maintenance and upkeep of Trust premises including all external common and internal communal areas.

## **7.6 Clinical staff including medical staff**

All staff are responsible for:

### **Risk Assessment and Prevention**

- Ensuring that all patients admitted to YDH are screened for risk of falls within 12 hours of admission
- Completing and recording a full and thorough falls risk assessment on all patients identified at risk of falling within 12 hours of admission
- Reviewing the Inpatient falls risk assessment form and care action plan for patients when there is a change in patient's condition and/or internal or external transfer of patient and/or following a fall
- Implementing recommended interventions to prevent patient falls, in accordance with the multi-factorial risk assessment and reporting unavailability of resources

### **Following a Fall**

- Ensuring that following a fall an appropriate (medical) clinical assessment is made prior to recovering the patient from the floor by the assessed appropriate method
- Implementing all actions for the Trust Post Falls Care Bundle including:
  - timely (neurological) observations are made following the fall and appropriate action is taken when observations change

- Recording all incidents in the patient's notes in line with the record keeping policy:
  - Updating falls, patient handling and bedrails risk assessments and action plans as deemed necessary following the fall of an in-patient
- Comprehensively completing an incident report form
- Referring the patient for appropriate medical assessment/treatment/review if deemed necessary
- Helping the patient to engage in any multi-factorial intervention aimed at addressing their individual risk factors.
- Dealing with any issues identified as soon as practicable, such as removing environmental hazard, repairing damaged equipment and reviewing supervision levels in conjunction with the manager on duty
- Making a more senior member of staff/manager aware of any actions that may need to be initiated outside the member of staff's line of responsibility.
- Informing the inpatient's next of kin of the fall
- Patients who do not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the mental capacity act.

### **7.7 Heads of Departments and Ward Managers**

Heads of Department and Ward Managers are responsible for ensuring that:

- Workplaces are assessed and documented for slips and trips
- Workplaces managed by them are free of slips and trips hazards
- Appropriate resources are targeted at reducing falls in the workplace.
- Patient falls risks are identified and assessed within 12 hours of admission
- Ensure that following an inpatient falling and appropriate (medical) clinical assessment is undertaken PRIOR to recovering them from the floor and that the
- method of recovery is appropriate and safe.
- Incident forms are completed effectively with all relevant information include and learning outcomes from the incident result in changes in practice
- Appropriate/effective remedial action is taken to reduce risk of falls including referral for treatment or rehabilitation for patients when required
- Monitoring and reviewing falls reports within their area to identify trends and efficiency of remedial action taken, communicating any relevant issues to Clinical Governance office
- Appropriate information, training and supervision is provided to all staff on risks and controls identified in relation to slips, trips and falls
- Adequate patient falls prevention equipment and appropriate staffing needs have been identified for their area and, as appropriate, highlight any shortfalls via a risk assessment and documented incident reporting to their relevant divisional lead any shortcomings
- A Satellite Trainer has been nominated for patient falls in each service area and adequate support is provided to fulfil their role
- Staff are involved in falls prevention strategies within their area and discussion on falls is included on team meetings to raise awareness

### **7.8 Fire, Health & Safety Advisor**

The Trust Fire, Health and Safety Advisor fulfils the role of lead competent person in relation to the management of all health and safety in the workplace. The post holder will:

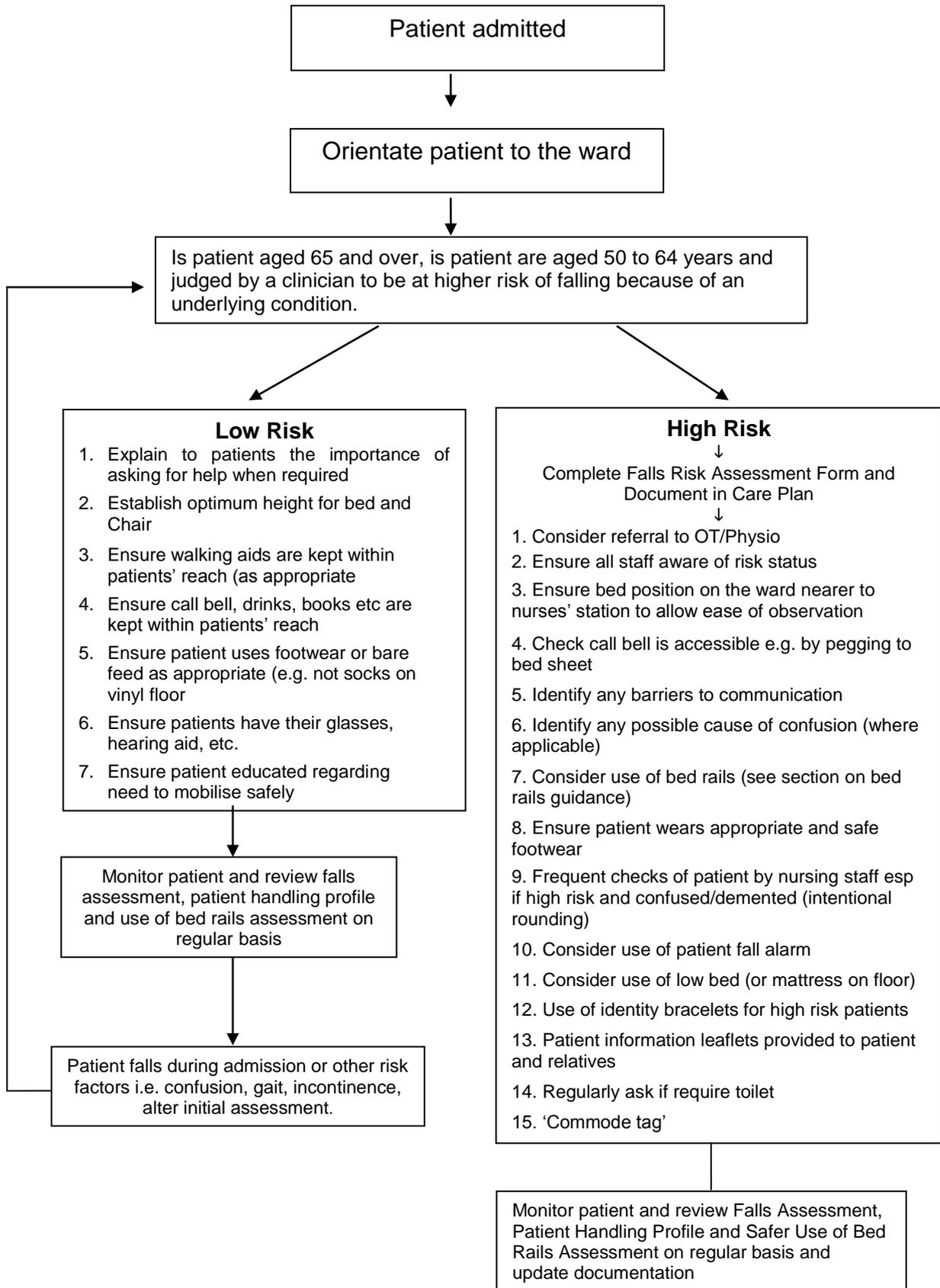
- provide support and advice to managers and employees on legal and technical compliance with H&S related responsibilities
- provide advice on training, assessment and audit as required in order to assist management in achieving the requirements of the Trust's slips trips and fall procedure

- manage the review and amendment of the general slips trips and falls procedure under the Health & Safety Policy

## **8. Sources of References and Acknowledgements**

- Department of Health National Service Framework Standard 6 for Older People (2001)
- National Institute for Health and Care Excellence – Falls: assessment and prevention of falls in older people (2013)
- National Institute of Clinical Excellence Guidance on Falls (2004), (*Slips, trips and falls in hospital* National Patient Safety Agency, 2007 [www.npsa.nhs.uk](http://www.npsa.nhs.uk))
- Management Health and Safety at Work Regulations 1999 – HSE
- Safer Use of Bed Rails Guidance – HSE
- The Guide to Handling of People 6th Edition – National Back Exchange/Backcare 2010
- Moving and Handling People – An Illustrated Guide – Clinical Skills Ltd 2010
- NPSA Rapid Response Report – Essential Care after an Inpatient Fall – NPSA/2011/RRR01

# ANNEX A: INPATIENT FALLS PREVENTION FLOW CHART



## ANNEX B: MANAGEMENT OF THE FALLEN/COLLAPSED PERSON

