Falls Prevention and Management In The Hospital Setting

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FALLS LEAD
UPDATED JANUARY 2024

What is a fall?

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

(World Health Organisation Jan 2018)

A fall is not:

-Lowering or supporting a patient to the floor

-Intentionally sitting down

- A deterioration in health, causing collapse

The Implications Of Falls

280,000 falls a year are reported to the National Patient Safety Agency

An inpatient fall is the most common Patient Safety Incident *National Patient Safety Agency (2007)*

One in every 3 people aged 65 and over fall at least once per year *NHS Choices 2015*

Financially the cost of inpatient falls is around £2.3 billion annually. This is due to:

-Prolonged inpatient stay

-Additional investigations

-Chronic and long-term support

-Staff injury and sickness

-Litigation

What Causes Falls?

There are lots of reasons people fall

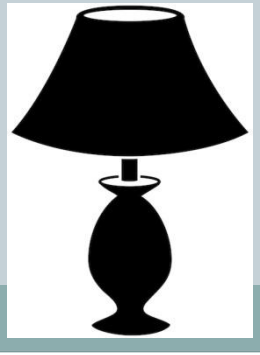
They include:

Intrinsic (factors specific to the individual)

- Balance and gait
- Reaction times
- Medications
- Sensory impairment
- Cognitive impairment
- Cardiovascular causes

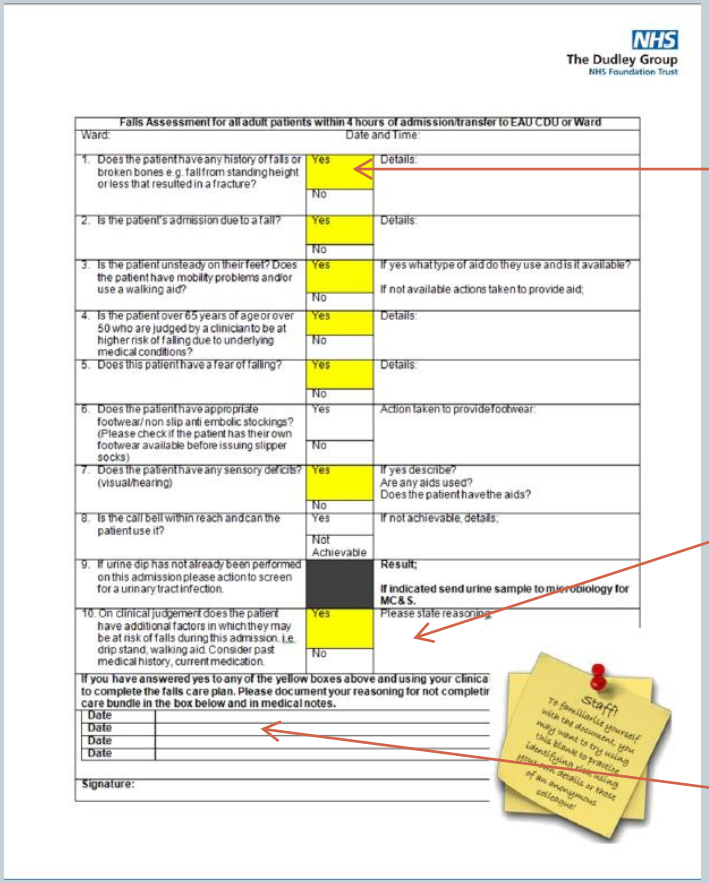
Extrinsic (factors that we may impose on the individual)

- Poor lighting
- Regular bed or ward moves
- Obstacles
- Lack of walking aids
- Unfamiliar surroundings
- Lack of suitable footwear



Inpatient Falls Risk Assessment
(Outdated document see the digital version in further slides)

Every adult patient should have a Falls Risk Assessment completed or reviewed within 4 hours of admission to a new area and then at least weekly



NHS
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Falls Assessment for all adult patients within 4 hours of admission/transfer to EAU CDU or Ward

Ward: Date and Time:

1. Does the patient have any history of falls or broken bones e.g. fall from standing height or less that resulted in a fracture?	Yes / No	Details:
2. Is the patient's admission due to a fall?	Yes / No	Details:
3. Is the patient unsteady on their feet? Does the patient have mobility problems and/or use a walking aid?	Yes / No	If yes what type of aid do they use and is it available? If not available actions taken to provide aid:
4. Is the patient over 65 years of age or over 50 who are judged by a clinician to be at higher risk of falling due to underlying medical conditions?	Yes / No	Details:
5. Does this patient have a fear of falling?	Yes / No	Details:
6. Does the patient have appropriate footwear/ non slip anti embolic stockings? (Please check if the patient has their own footwear available before issuing slipper socks)	Yes / No	Action taken to provide footwear:
7. Does the patient have any sensory deficits? (visual/hearing)	Yes / No	If yes describe? Are any aids used? Does the patient have the aids?
8. Is the call bell within reach and can the patient use it?	Yes / Not Achievable	If not achievable, details;
9. If urine dip has not already been performed on this admission please action to screen for a urinary tract infection.		**Result; If indicated send urine sample to microbiology for MC&S.**
10. On clinical judgement does the patient have additional factors in which they may be at risk of falls during this admission. i.e. drip stand, walking aid. Consider past medical history, current medication.	Yes / No	Please state reasoning:

If you have answered yes to any of the yellow boxes above and using your clinica to complete the falls care plan. Please document your reasoning for not completir care bundle in the box below and in medical notes.

Date	
Date	
Date	
Date	

Signature:

Each question should be answered. If the answer to any of the questions is yes (yellow boxes), the Patient Fall Prevention and Management Document (Hospital) should be commenced. This document incorporates the Falls Bundle

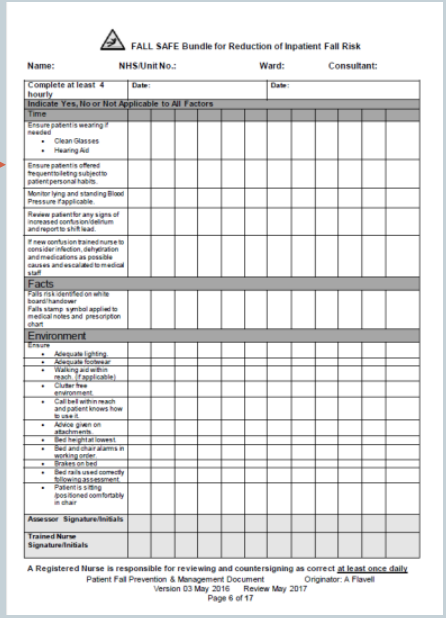
If none of the above question apply, but on making a clinical judgement you still feel the patient is at risk of falls, then your reasoning for doing this should be documented here

The person completing the assessment must sign and date at point of completion. This assessment should be reviewed upon admission, upon moving to a new area, following any change in the patient's condition and also post fall

Inpatient Fall Prevention And Management Document

(see digital the updated document in further slides)

This is the falls bundle



FALL SAFE Bundle for Reduction of Inpatient Fall Risk

Name: NHS/Unit No.: Ward: Consultant:

Complete at least 4 hourly	Date:												Date:											
Indicate Yes, No or Not Applicable to All Factors																								
Time																								
Ensure patient is wearing if needed • Clean Glasses • Hearing Aid																								
Ensure patient is offered frequent toileting subject to patient personal habits.																								
Monitor lying and standing Blood Pressure if applicable.																								
Review patient for any signs of increased confusion/delirium and report to shift lead.																								
If new confusion trained nurse to consider infection, dehydration and medications as possible causes and escalated to medical staff																								
Facts																								
Falls risk identified on white board/handover Falls stamp symbol applied to medical notes and prescription chart																								
Environment																								
Ensure • Adequate lighting • Adequate footwear • Walking aid within reach (if applicable) • Clutter free environment • Call bell within reach and patient knows how to use it. • Advice given on attachments • Bed height at lowest. • Bed and chair alarms in working order • Brakes on bed • Bed rails used correctly following assessment • Patient is sitting positioned comfortably in chair																								
Assessor Signature/Initials																								
Trained Nurse Signature/Initials																								

A Registered Nurse is responsible for reviewing and countersigning as correct at least once daily

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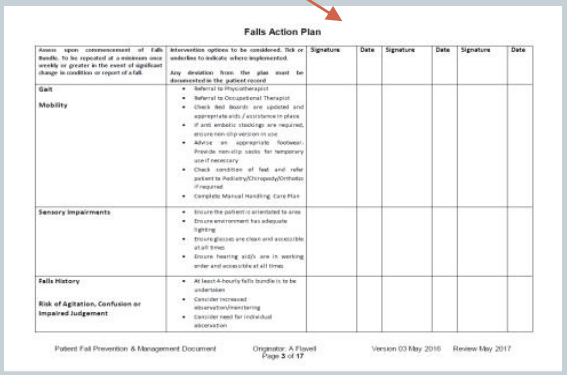
The risk assessment/action plan below should be completed for every patient commenced on the falls bundle



Falls Action Plan

Assess upon commencement of Falls Bundle, to be repeated at a minimum once weekly or greater in the event of significant change in condition or report of a fall.	Intervention options to be considered. Tick or underline to indicate where implemented. Any deviation from the plan must be documented in the patient record	Signature	Date	Signature	Date	Signature	Date
Gait **Mobility**	• Referral to Physiotherapist • Referral to Occupational Therapist • Check Bed Boards are updated and appropriate aids / assistance in place. • If anti embolic stockings are required, ensure non-slip version in use • Advise on appropriate footwear. Provide non-slip socks for temporary use if necessary • Check condition of feet and refer patient to Podiatry/Chiropody/Orthotics if required • Complete Manual Handling Care Plan						
Sensory Impairments	• Ensure the patient is orientated to area • Ensure environment has adequate lighting • Ensure glasses are clean and accessible at all times • Ensure hearing aid/s are in working order and accessible at all times						
Falls History **Risk of Agitation, Confusion or Impaired Judgement**	• At least 4-hourly falls bundle is to be undertaken • Consider increased observation/monitoring • Consider need for individual observation						

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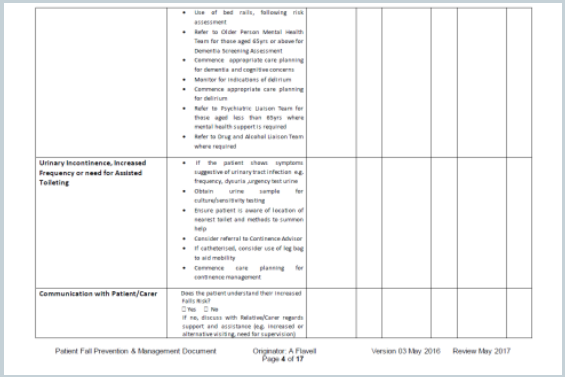

	• Use of bed rails, following risk assessment • Refer to Older Person Mental Health Team for those aged 65yrs or above for Dementia Screening Assessment • Commence appropriate care planning for dementia and cognitive concerns • Monitor for indications of delirium • Commence appropriate care planning for delirium • Refer to Psychiatric Liaison Team for those aged 16yrs then 65yrs where mental health support is required • Refer to Drug and Alcohol Liaison Team where required
Urinary Incontinence, Increased Frequency or need for Assisted Toileting	• If the patient shows symptoms suggestive of urinary tract infection eg. frequency, dysuria ,urgency test urine • Obtain urine sample for culture/sensitivity testing • Ensure patient is aware of location of nearest toilet and methods to summon help • Consider referral to Continence Advisor • If catheterised, consider use of leg bag to aid mobility • Commence care planning for continence management
Communication with Patient/Carer	Does the patient understand their increased falls risk? ☐ Yes ☐ No If no, discuss with Relative/Carer regards support and assistance (e.g. increased or alternative visiting, need for supervision)

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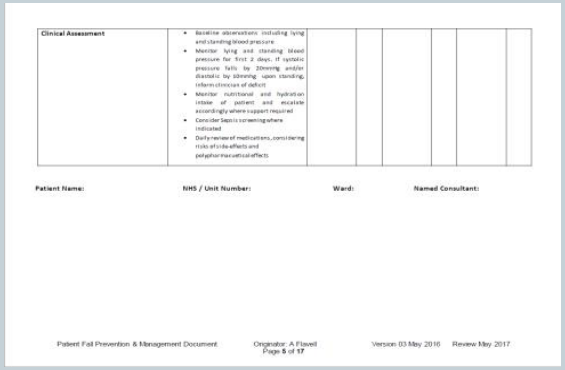

Clinical Assessment	• Baseline observations including lying and standing blood pressure. • Monitor lying and standing blood pressure for first 2 days. If systolic pressure falls by 20mmHg and/or diastolic by 10mmHg upon standing, inform clinician of deficit • Monitor nutritional and hydration intake of patient and escalate accordingly where support required • Consider Sepsis screening where indicated • Daily review of medications, considering risks of side effects and polypharmaceutical effects		
Patient Name:	**NHS / Unit Number:**	**Ward:**	**Named Consultant:**

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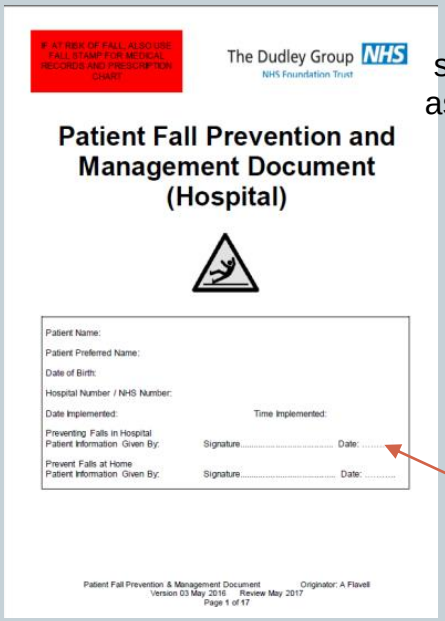

IF AT RISK OF FALL ALSO USE FALL STAMP FOR MEDICAL RECORDS AND PRESCRIPTION CHART

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Patient Fall Prevention and Management Document (Hospital)

Patient Name:

Patient Preferred Name:

Date of Birth:

Hospital Number / NHS Number:

Date Implemented: Time Implemented:

Preventing Falls in Hospital
Patient Information Given By: Signature..... Date:.....

Prevent Falls at Home
Patient Information Given By: Signature..... Date:.....

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The front section should be completed as soon as the bundle is instigated

At the back of the bundle are tear out information pages to be given to the patient for advice on falls prevention in hospital **please sign at the front of the bundle to say you have given this to the patient**

Digital update

All falls prevention and management documents have been moved to a **digital platform** and can be found on **Sunrise**. This includes the falls risk assessment, falls bundles, bedrail risk assessment, post-fall documentation, and patient advice leaflet.

Falls Prevention Aids

FALLS BUNDLE – This should be completed for every patient identified as at risk of falls at a minimum of 4 hourly (at least once every 24 hours by a qualified nurse). This can be increased if necessary

BED/TROLLEY RAILS – These should NOT be used with patients who are agitated or confused as there is a high risk of entrapment or fall from a greater height

ENHANCED OBSERVATION - Assessing for additional staffing support may be necessary if the patient is showing high levels of confusion or lacks the mental capacity to understand/make rational decisions which is likely to affect their safety. Different levels of observation can be considered, however, please ensure least restrictive options are always considered

FALLS LOGO – All patients on a Falls Prevention Bundle should have a falls symbol displayed on ward/area patient whiteboards/tracking board

FALLS RISK ALERT - This must be manually added to Sunrise once your patient has been identified as a risk of falls. This can be done by clicking on the 'Falls Risk Status' dropdown option under the comments section in the patient info tab. Once chosen, this will then display a falls risk icon on the patient alert column on the tracking board

LYING/STANDING BLOOD PRESSURE – Needs recording on Sunrise for every patient over 65 years and above, and/or all patients who have a history of falling or complain of dizziness on standing/walking.

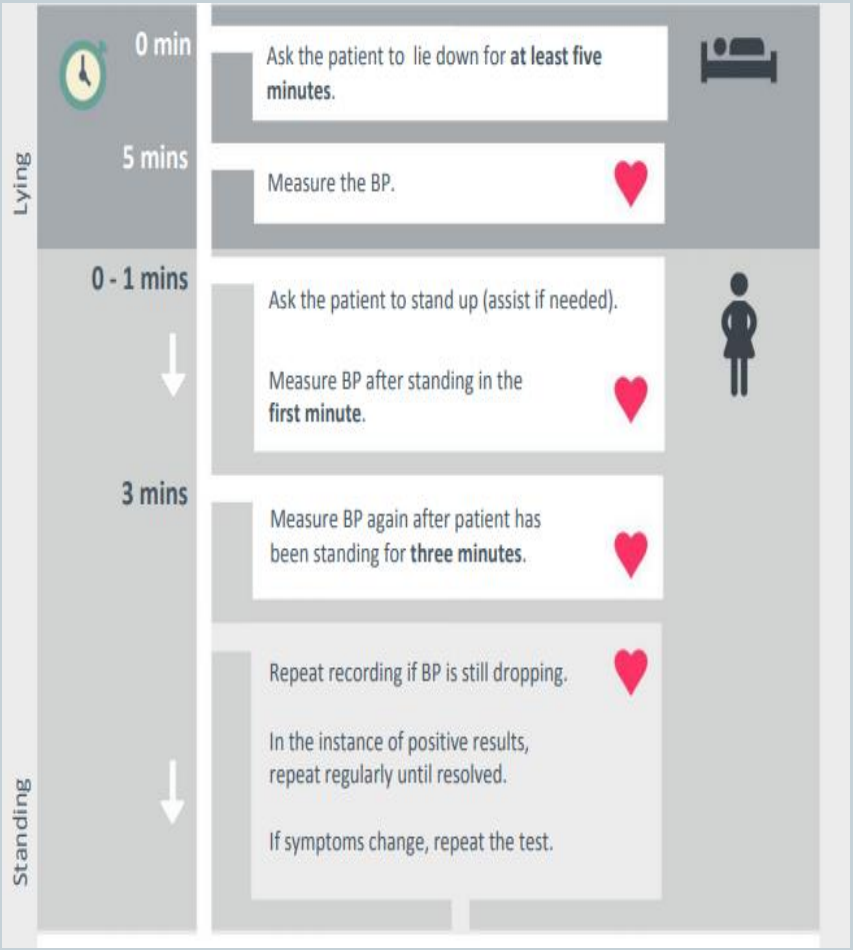
Lying and Standing Blood Pressure

In line with NICE Guidelines all patients aged 65 and over, and patients aged 50 to 64 years who are considered to be at higher risk of falling because of an underlying condition should have their lying and standing blood pressure on admission. This is because postural (orthostatic) hypotension, a drop in BP on standing, is a contributing high risk factor to falls.

Postural hypotension

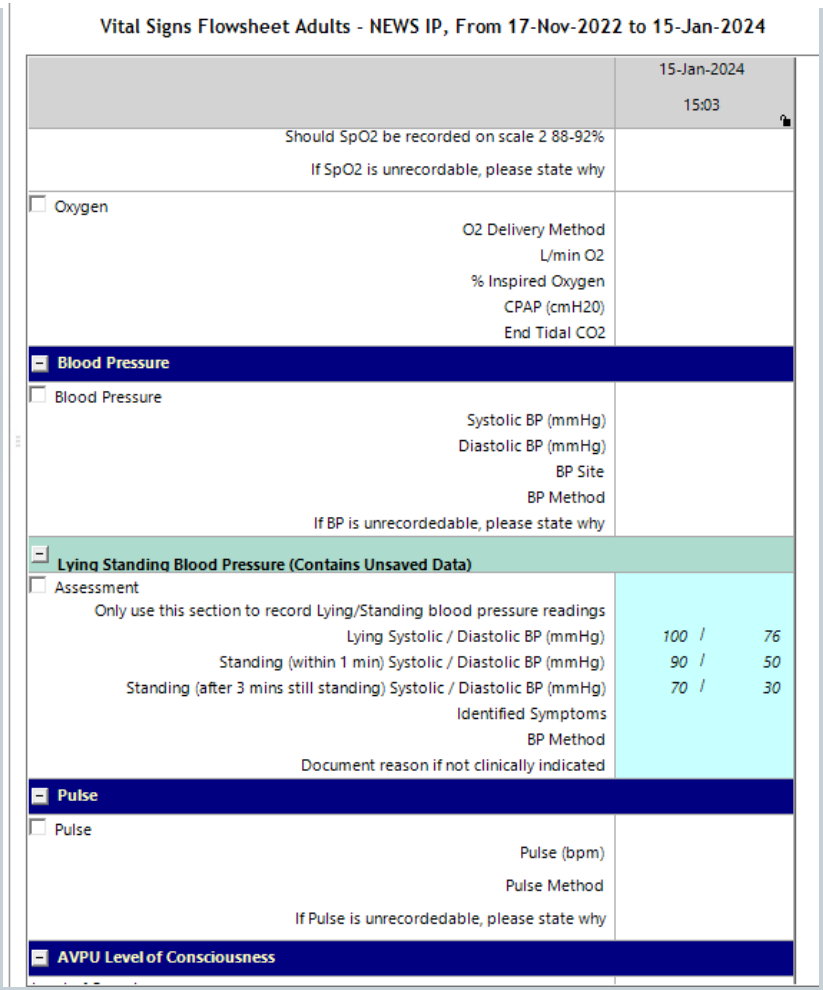
A positive result is:
-A drop in systolic BP of 20mmHg or more (with or without symptoms)
-A drop to below 90mmHg on standing even if the drop is less than 20mmHg (with or without symptoms)
-A drop in diastolic BP of 10mmHg with symptoms (although clinically less significant than a drop in systolic BP)

What to do:
-Notice and document symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations
-Advise the patient of results and if the result is positive
-Inform the Medical and Nursing team
-Take immediate actions to prevent falls and/or unsteadiness



Sunrise Lying and standing blood pressure

- Lying and standing pressure can be recorded as a stand-alone reading without triggering the other mandatory fields by following the following steps -
- Sunrise>Flowsheets>Lying standing blood pressure.
- Please be mindful to record the correct readings under the correct category.

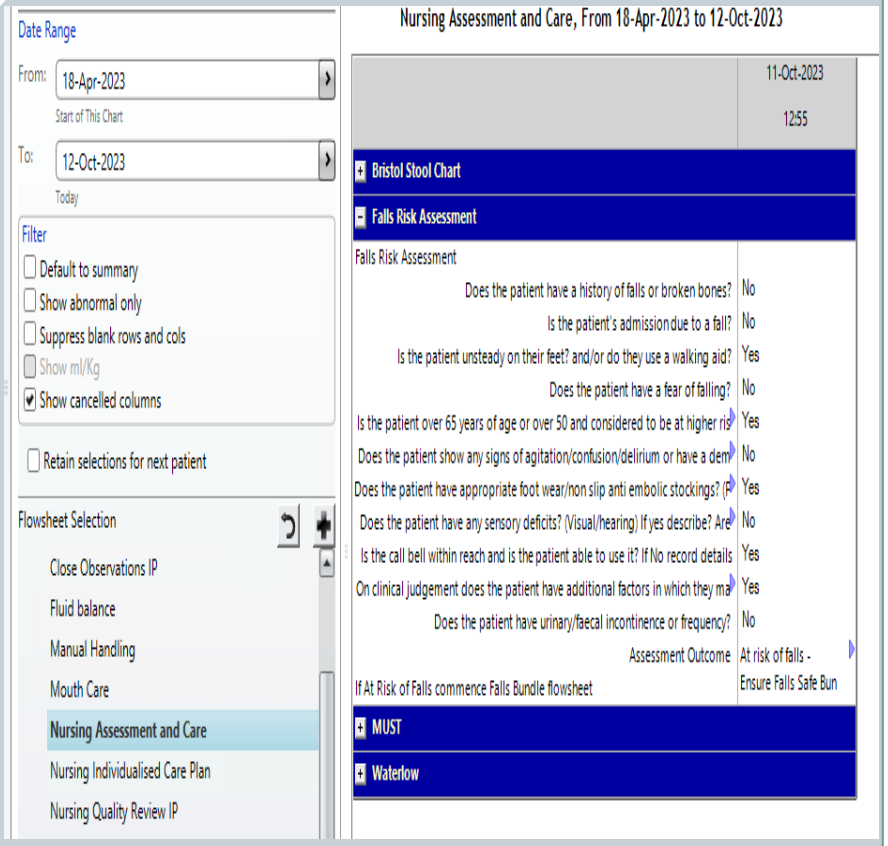


Vital Signs Flowsheet Adults - NEWS IP, From 17-Nov-2022 to 15-Jan-2024

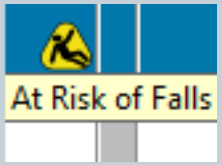
	15-Jan-2024 15:03
Should SpO2 be recorded on scale 2 88-92%	
If SpO2 is unrecordable, please state why	
Oxygen	
O2 Delivery Method	
L/min O2	
% Inspired Oxygen	
CPAP (cmH20)	
End Tidal CO2	
Blood Pressure	
Blood Pressure	
Systolic BP (mmHg)	
Diastolic BP (mmHg)	
BP Site	
BP Method	
If BP is unrecordedable, please state why	
Lying Standing Blood Pressure (Contains Unsaved Data)	
Assessment	
Only use this section to record Lying/Standing blood pressure readings	
Lying Systolic / Diastolic BP (mmHg)	100 / 76
Standing (within 1 min) Systolic / Diastolic BP (mmHg)	90 / 50
Standing (after 3 mins still standing) Systolic / Diastolic BP (mmHg)	70 / 30
Identified Symptoms	
BP Method	
Document reason if not clinically indicated	
Pulse	
Pulse	
Pulse (bpm)	
Pulse Method	
If Pulse is unrecordedable, please state why	
AVPU Level of Consciousness	

Inpatient Falls Digital Risk Assessment

- All adult patients who are admitted to the Department must have a falls assessment completed within 1 hour of arrival to the Department. This can be found as an electronic assessment on Sunrise > Flowsheets > Nursing Assessment and care > Falls risk assessment
- If the patient is assessed as being at risk of falls (answer yes to any **one** or more of the falls risk assessment), implementation of measures to reduce immediate falls risk (risk factors are listed below the initial falls assessment) is required. This includes a link to the trolley rails assessment



The falls risk icon will automatically be created.

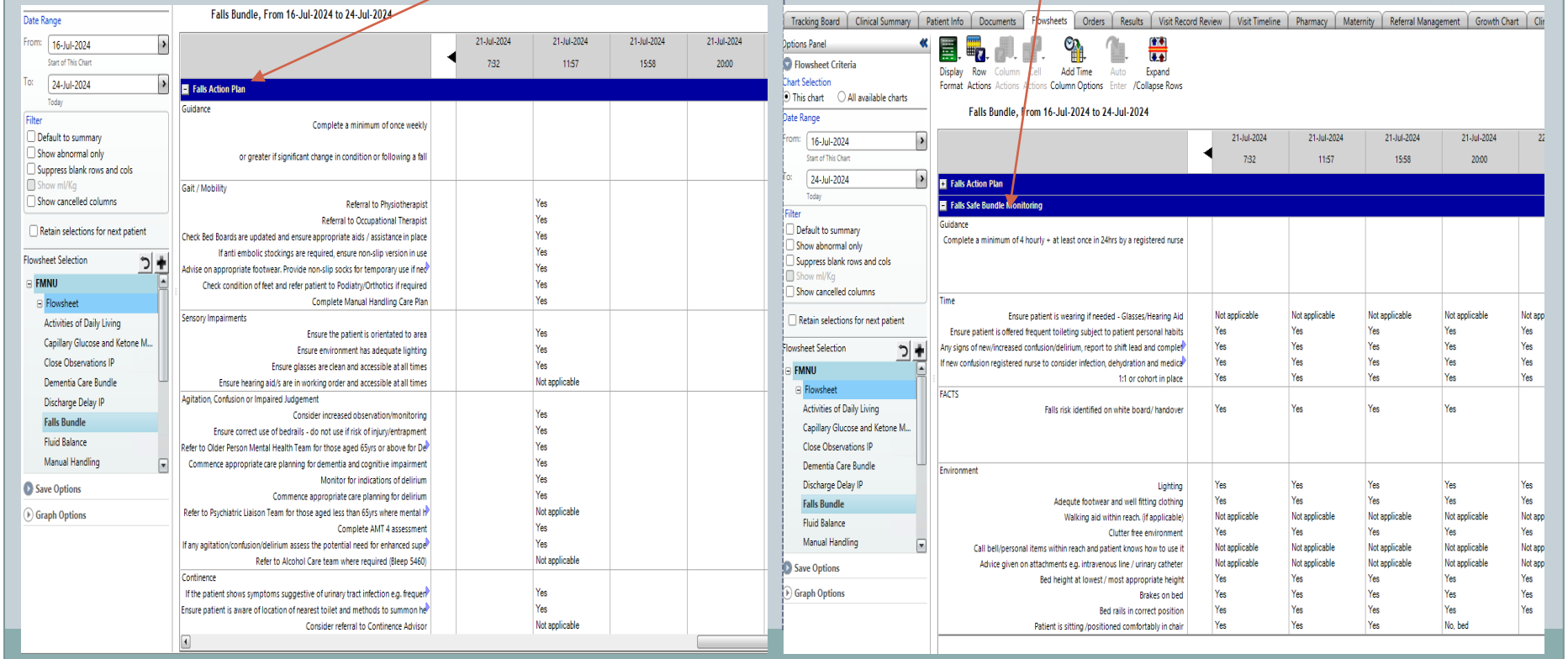


Inpatient Falls Digital Falls Bundle

All adult patients who are identified as high risk of falls. Follow the prompt to commence the Falls Bundle for completion of the risk assessment. Select from the Flowsheets>Falls bundle> Falls action plan and then Falls Safe Bundle Monitoring.

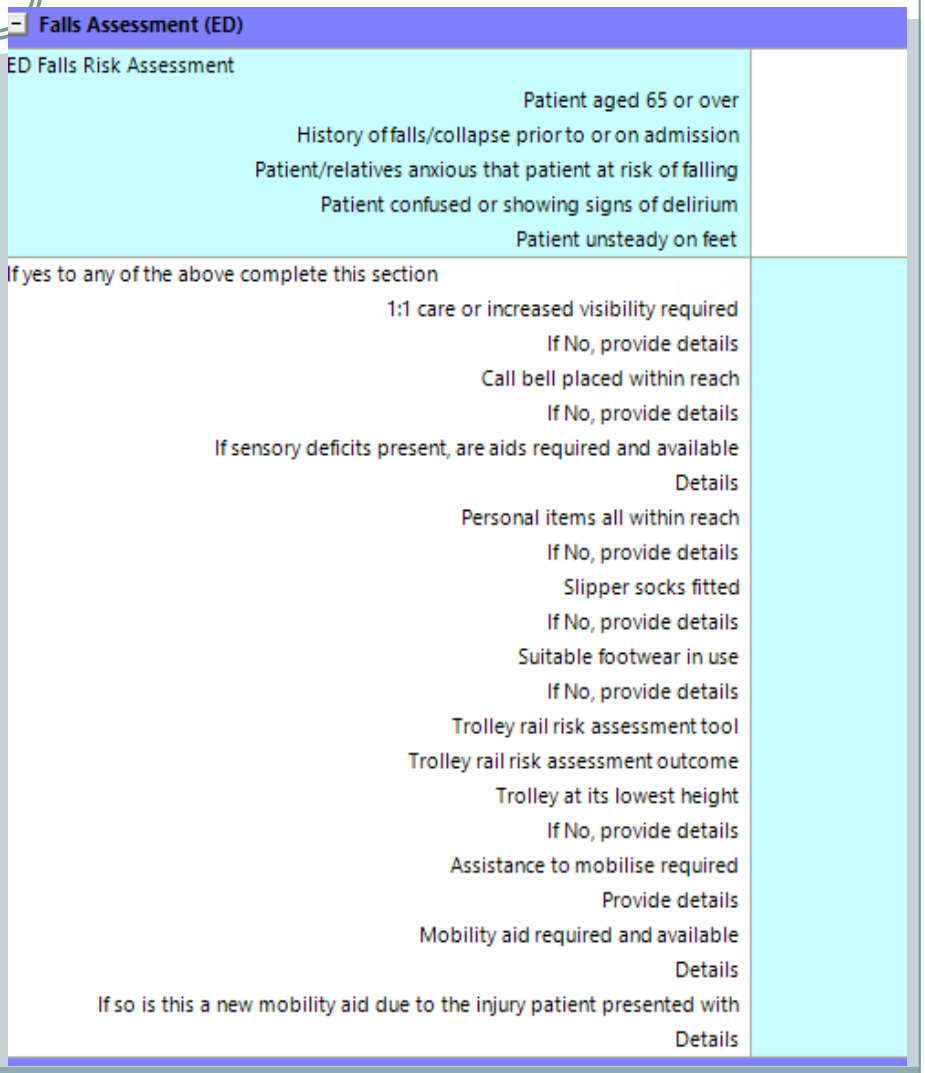
As illustrated below Falls bundle has 2 elements **Falls Action Plan** and **Falls Safe Bundle Monitoring. Both elements must be completed otherwise the risk assessment is incomplete.**

Following the initial falls risk assessment, further reassessment is required at hour 5 and every 4 hours thereafter that the patient remains in the Department. Reassessment is also required if the patient sustains a fall in the Department. A prompt for completion of the falls risk assessment is included in the quality round checklist on Sunrise



Emergency Department Falls Assessment

- All adult patients who are admitted to the Emergency Department must have an Emergency Department specific falls assessment completed within 1 hour of arrival to the Department. This can be found as an electronic assessment on Sunrise > Flowsheets > Assessment and care > ED falls assessment
- If the patient is assessed as being at risk of falls (answer yes to any **one** or more of the falls risk assessment), implementation of measures to reduce immediate falls risk (risk factors are listed below the initial falls assessment) is required. This includes a link to the trolley rails assessment
- Following the initial falls risk assessment, further reassessment is required at hour 5 and every 4 hours thereafter that the patient remains in the Emergency Department. Reassessment is also required if the patient sustains a fall in the Department. A prompt for completion of the falls risk assessment is included in the quality round checklist on Sunrise



Bed Rail Assessment

Every adult inpatient should have a Bed Rail Assessment completed or reviewed within 4 hours of admission to a new area and then at least weekly

		Mobility		
		Patient is very immobile (bedfast- or hoist dependent)	Needs Assistance to Mobilise	Patient can mobilise without help from staff
Mental state	Patient is confused and disorientated	Use bedrails with care	Bedrails **not** recommended	Bedrails **not** recommended
	Patient is drowsy	Bedrails recommended	Use bedrails with care	Bedrails **not** recommended
	Patient is orientated and alert	Bedrails recommended	Bedrails recommended	Bedrails **not** recommended
	Patient is unconscious	Bedrails recommended	N/A	N/A

Bed rails should be thought of as an intervention that requires serious consideration prior to use

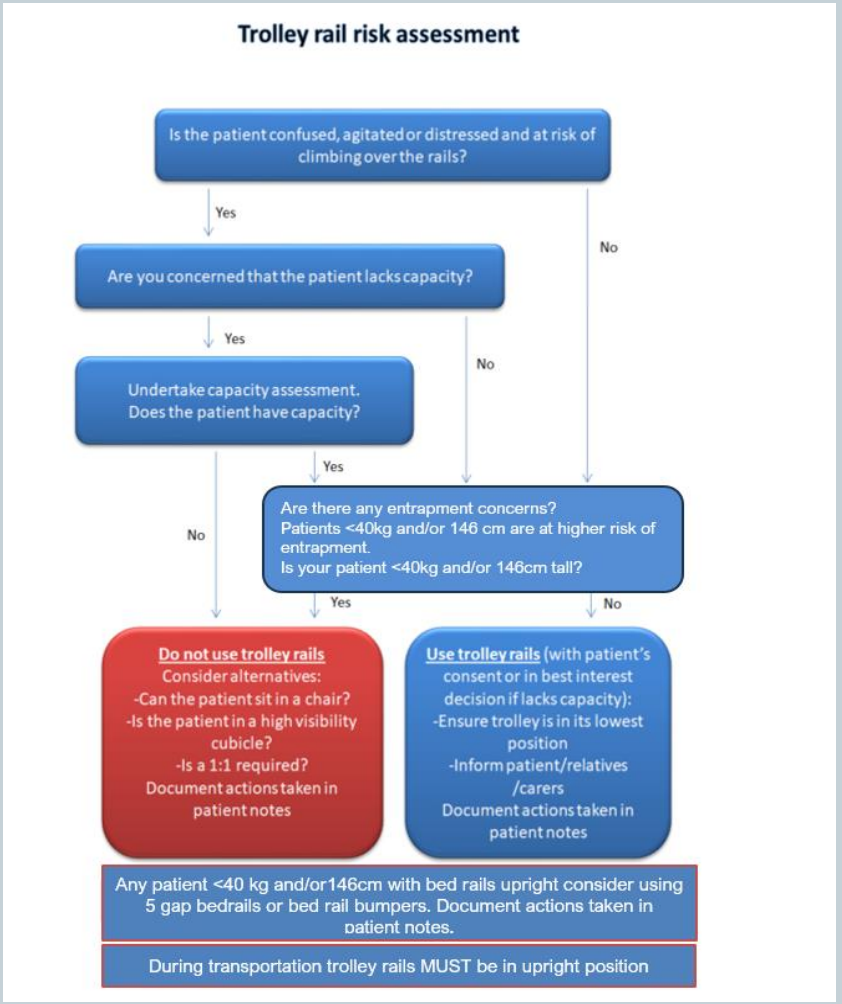
When completing the assessment remember:

- Patients with capacity can make their own decisions about bedrail use.
- Patients with visual impairment may be more vulnerable to falling from bed.
- Patients with involuntary movements (e.g., spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers.
- Patients <40kg and/or 146cm are at higher risk of entrapment, assess risk, document, and consider alternative measures.

- Bed rails should **not** be used as a form of restraint

Adult Bed/Trolley risk assessment

Follow this chart to help you risk assessment to avoid the risk of harm .



Risk Management

Our adverse incident investigations have shown that the physical or clinical condition of bed occupants means that some are at greater risk of entrapment in bed rails. Those at greater risk could include older people, adults or children with:

- communication problems
- confusion, agitation or delirium
- learning disabilities
- dementia
- repetitive or involuntary movements
- high or low body mass (which may change entrapment risks)
- impaired or restricted mobility
- Variable levels of consciousness, or those under sedation.

Risk assessments should account for any characteristics which might put the bed user at greater risk from use of bed rails. The decision to use bed rails should be made with the consent of the bed user whenever possible. The reasoning for the decision to issue bed rails should be effectively communicated and recorded, including to the carers or family members when this is appropriate.

CASE STUDY 1 – Inappropriate prescription leading to fall A bed occupant died after climbing over the bed rails and falling.

The user touched the bed position control and raised the bed to its maximum height. They then tried to get out of the bed by climbing over the rail, only to fall and suffer a broken neck. The additional height of the bed rail likely increased the severity of the injury.

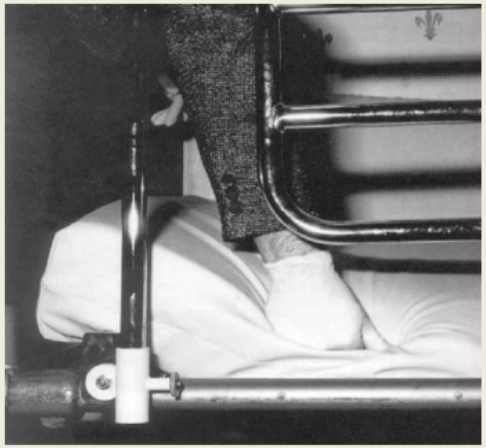
Advice – If bed users are known to be in a confused state, then bed rails may serve to increase the overall risk of injury. A risk assessment should have identified the hazard of leaving bed controls accessible and the potential for an increased fall height.

Case study 2

CASE STUDY 2 – Unsuitable combination of a bed and a bed rail

A bed rail intended for use on a domestic divan bed was used on a hospital type bed. This produced a large gap between the bottom of the bed rail and the bed when the mattress was compressed.

A child slipped feet first between the bed rail and the bed. The gap was not large enough for the child to pass completely through and the child was trapped at chest level and died from postural asphyxiation.



Advice – When supplied, the suitability of the installation should be checked including following the manufacturer's instructions for use regarding compatibility with other devices.

Case study 3

CASE STUDY 3 – User entrapment in inappropriate gaps

Entrapment can happen between the end of the bed rail and the headboard if the gap is inappropriate. Avoid gaps over 60 mm which could be enough to cause neck entrapment.

Entrapment can also occur in the space between a poorly fitting mattress and side of the bed rail or bed rail that does not fit the bed base snugly enough.

The compressible nature of the edge of most mattresses can contribute towards the entrapment risk.

Advice – Assess the possible gaps between rails and other equipment, particularly in the high-risk areas shown in Figure 5 during the rail fitting process.

Safety with children and small adults

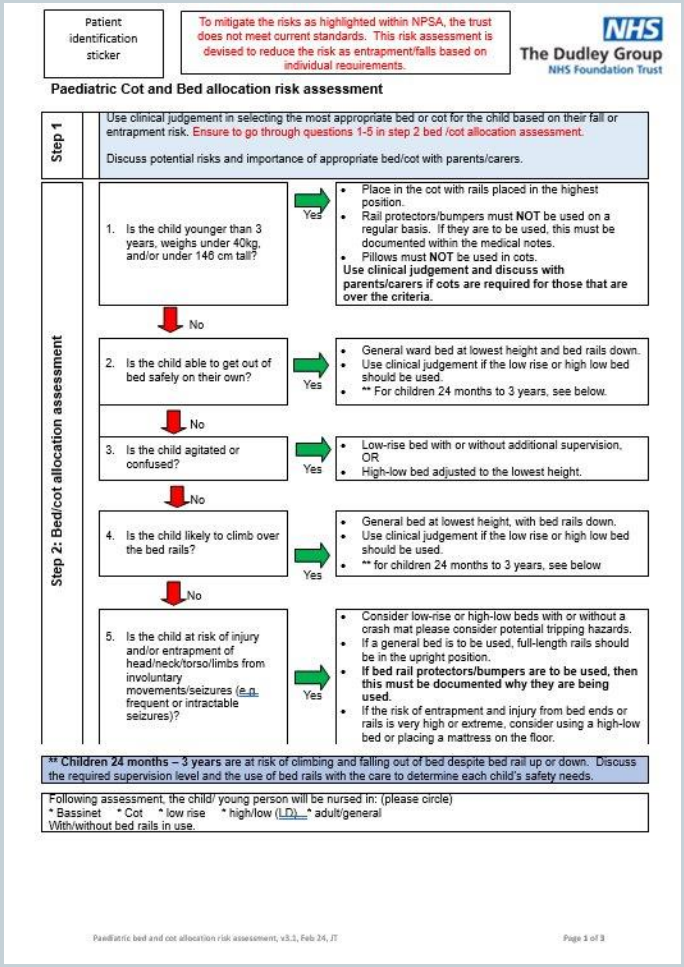
- The majority of bed rails on the market are designed to be used only with individuals over 1.46 m in height (4’ 11”), which is also the height of an average 12-year-old child. A risk assessment should always be carried out on the suitability of the bed rail for the individual child or small adult, as bar spacing and other gaps will need to be reduced.

CASE STUDY 5 – Insufficient risk assessment which failed to account for the user’s body size

A bed rail was supplied to the parents of a child being cared for in the community. No assessment of the child’s physical size was carried out to determine if an entrapment hazard existed: in this case the gap between the horizontal bars of the bed rail was too large. The child slipped between the bars and asphyxiated as a result of head entrapment.

Advice – Risk assessments should include an evaluation of the suitability of the equipment for the physical characteristics of the intended user.

Paediatric Bed/Trolley risk assessment



Patient identification sticker

To mitigate the risks as highlighted within NPSA, the trust does not meet current standards. This risk assessment is devised to reduce the risk as entrapment/falls based on individual requirements.

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Paediatric Cot and Bed allocation risk assessment

Step 1

Use clinical judgement in selecting the most appropriate bed or cot for the child based on their fall or entrapment risk. Ensure to go through questions 1-5 in step 2 bed /cot allocation assessment.

Discuss potential risks and importance of appropriate bed/cot with parents/carers.

Step 2: Bed/cot allocation assessment

1. Is the child younger than 3 years, weighs under 40kg, and/or under 146 cm tall?
   - Yes → Place in the cot with rails placed in the highest position.
     - Rail protectors/bumpers must **NOT** be used on a regular basis. If they are to be used, this must be documented within the medical notes.
     - Pillows must **NOT** be used in cots.

     Use clinical judgement and discuss with parents/carers if cots are required for those that are over the criteria.
   - No ↓
2. Is the child able to get out of bed safely on their own?
   - Yes → General ward bed at lowest height and bed rails down.
     - Use clinical judgement if the low rise or high low bed should be used.
     - ** For children 24 months to 3 years, see below.
   - No ↓
3. Is the child agitated or confused?
   - Yes → Low-rise bed with or without additional supervision, OR
     - High-low bed adjusted to the lowest height.
   - No ↓
4. Is the child likely to climb over the bed rails?
   - Yes → General bed at lowest height, with bed rails down.
     - Use clinical judgement if the low rise or high low bed should be used.
     - ** for children 24 months to 3 years, see below
   - No ↓
5. Is the child at risk of injury and/or entrapment of head/neck/torso/limbs from involuntary movements/seizures (e.g. frequent or intractable seizures)?
   - Yes → Consider low-rise or high-low beds with or without a crash mat please consider potential tripping hazards.
     - If a general bed is to be used, full-length rails should be in the upright position.
     - **If bed rail protectors/bumpers are to be used, then this must be documented why they are being used.**
     - If the risk of entrapment and injury from bed ends or rails is very high or extreme, consider using a high-low bed or placing a mattress on the floor.

**** Children 24 months – 3 years** are at risk of climbing and falling out of bed despite bed rail up or down. Discuss the required supervision level and the use of bed rails with the care to determine each child's safety needs.

Following assessment, the child/ young person will be nursed in: (please circle)
* Bassinet * Cot * low rise * high/low (LD) * adult/general
With/without bed rails in use.

Paediatric bed and cot allocation risk assessment, v3.1, Feb 24, JT Page 1 of 3

Please turn over to acknowledge that the assessment has been undertaken by staff member and discussion held with parent/carer.

Following identification that a bed is required, please identify the following:		
Is a 'special' mattress required (e.g. pressure relieving)?	YES	NO
Are the bed rails high enough to consider any increased risk of entrapment/fall due to mattress thickness?	YES	NO
Are gaps avoided that could present an entrapment risk to the young person? Is their head or body large enough not to pass: • Between the bars of the bed rails? • Through any gap between the bed rail and the side of the mattress? • Through the gap between the lower bed rail bar and the mattress, allowing for compression of the mattress at its edge?	YES	NO
Are the gaps between the bars/rails less than 100mm?	YES	NO
Is the headboard to bed rail gap less than 60mm?	YES	NO
Is the footboard to bed rail gap less than 60mm?	YES	NO
Has the bed and rail been inspected and maintained regularly?	YES	NO

Assessment and discussion with parents made by

Signature Print name

Designation Date

Parents consent / do not consent to use of bedrails

Signature Print name

Designation Date

If consent not obtained, document reason why in medical notes.

Parents must sign to accept responsibility if advised to use a cot but request a bed for their child.

Re-assessment record

Please record if re-assessment is required – please add narrative or example when this required for guidance

Date of re-assessment:

Reason for reassessment and changes made:

Assessed by:
Print name: Signature:

Designation:

Discussed with parent/carer:
Parent/carers name: Signature:

Designation:

What To Do When Someone Falls

Initial Assessment

- A, B, C, D, E
- Patient capabilities, obvious cause of fall?
- Observations, blood glucose level and neurological observations

Mobility

- Assess the patient for injury prior to moving
- Is patient able to get themselves up if no injury suspected?
- If injury is suspected use Scoop stretcher or hover technology (ensure all equipment is in working order)

Medical Review

- Any fall with suspected injury should have a medical review within **30 minutes**
- A red task should be requested on the nerve centre if parent team are unavailable. If necessary a MET call can be raised
- If no injury is suspected a medical review still needs to be completed within 12 hours

Once patient is safe

- Complete lying and standing blood pressure if safe to do so
- Medics to document their review by completing the post-fall document on Sunrise
- Update falls and bed/trolley rails assessments
- Consider whether the patient requires enhanced care to prevent further falls
- In line with national and hospital guidance we need to be fully transparent when someone has fallen. The patient should be kept fully up to date with changes in their condition and their next of kin should be informed where appropriate
- Complete a Datix detailing the circumstances of the fall

Neurological Observations

If a fall is **UNWITNESSED** or a **HEAD INJURY IS SUSPECTED** then neurological observations MUST be completed and inputted onto Sunrise

Glasgow Coma Scale (GCS), pupil reaction and limb powers must be completed post-fall when

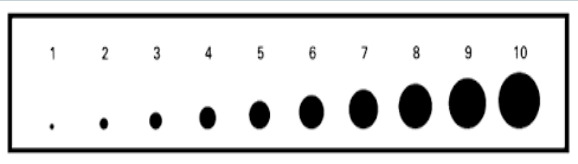
- The fall was unwitnessed
- The patient hit their head during the fall
- There is a change in GCS post-fall

Frequency of observations

Half hourly – two hours

One hourly – four hours

Two hourly – ongoing



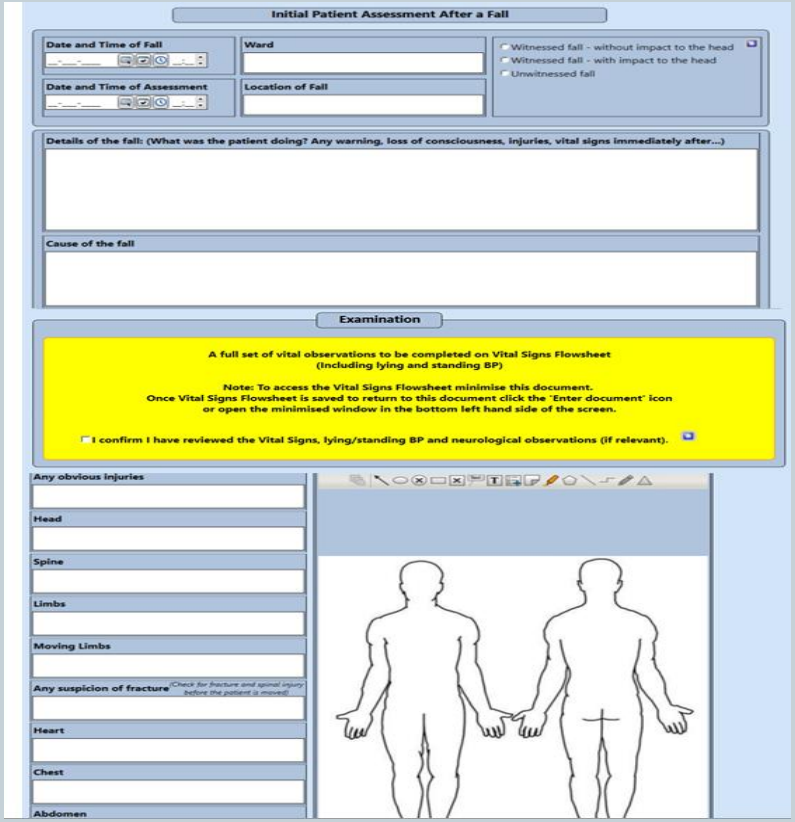
If there is **any** deterioration in GCS during the above period, escalate and continue half hourly neurological observations until advised otherwise by the medical team

The patient **MUST** be woken up for neurological observations if asleep

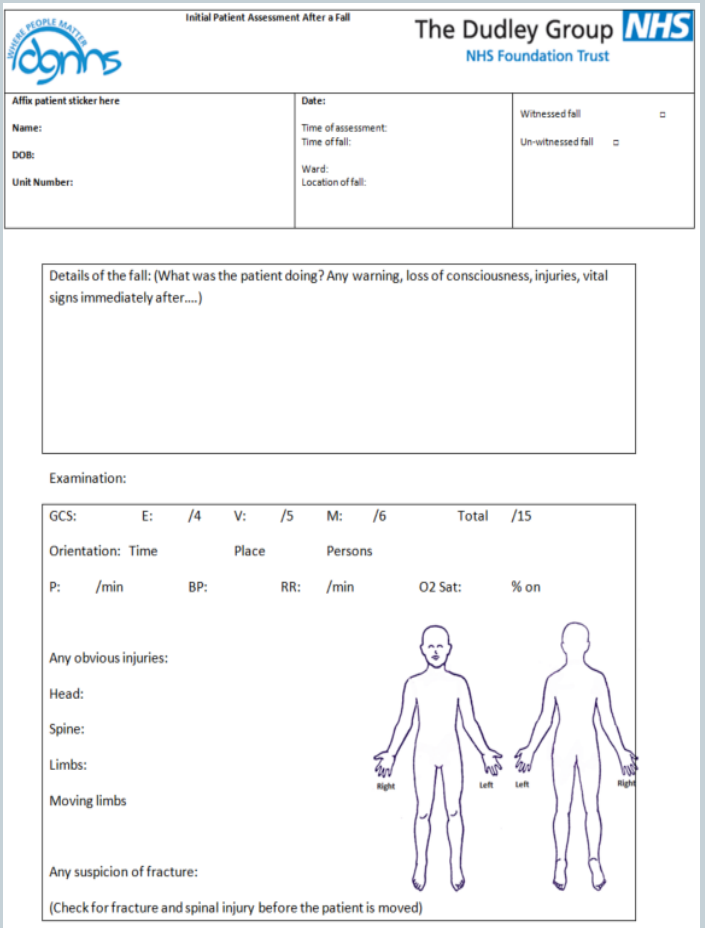
Ensure any changes in GCS, limb power, pupil reaction or size are **ESCALATED IMMEDIATELY TO A MEMBER OF THE MEDICAL TEAM**

Post Fall Document

- The Post Fall Document can be found on Sunrise (Select patient > Enter document > Search for Post Fall Document by typing into search field > Complete document and save)
- This is to be completed by the reviewing Doctor post fall

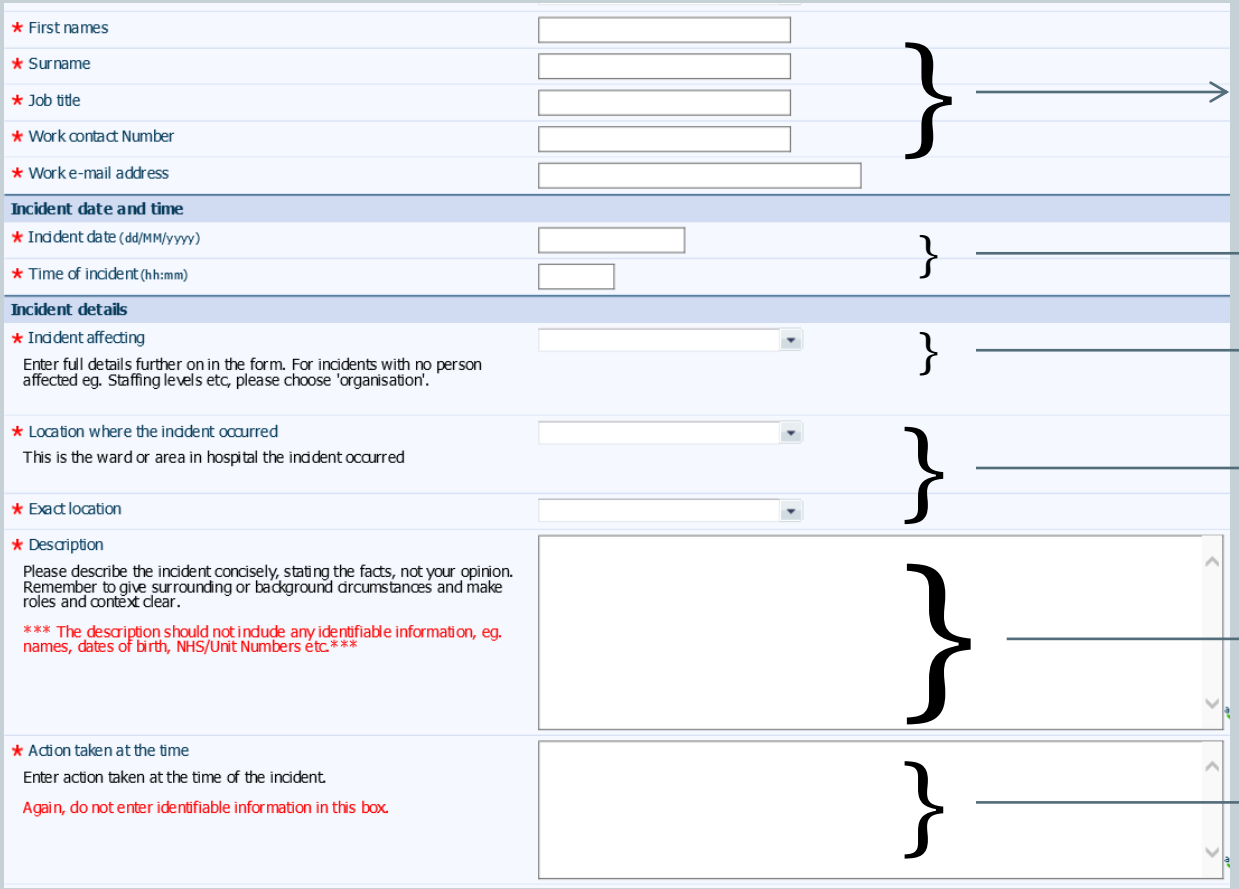


- The Post Fall Document on Sunrise (left) has replaced the paper document below which is now obsolete



Datix – What To Include

When any patient falls or a near miss occurs a Datix MUST be completed



Details of the person completing the Datix

When did the incident occur?

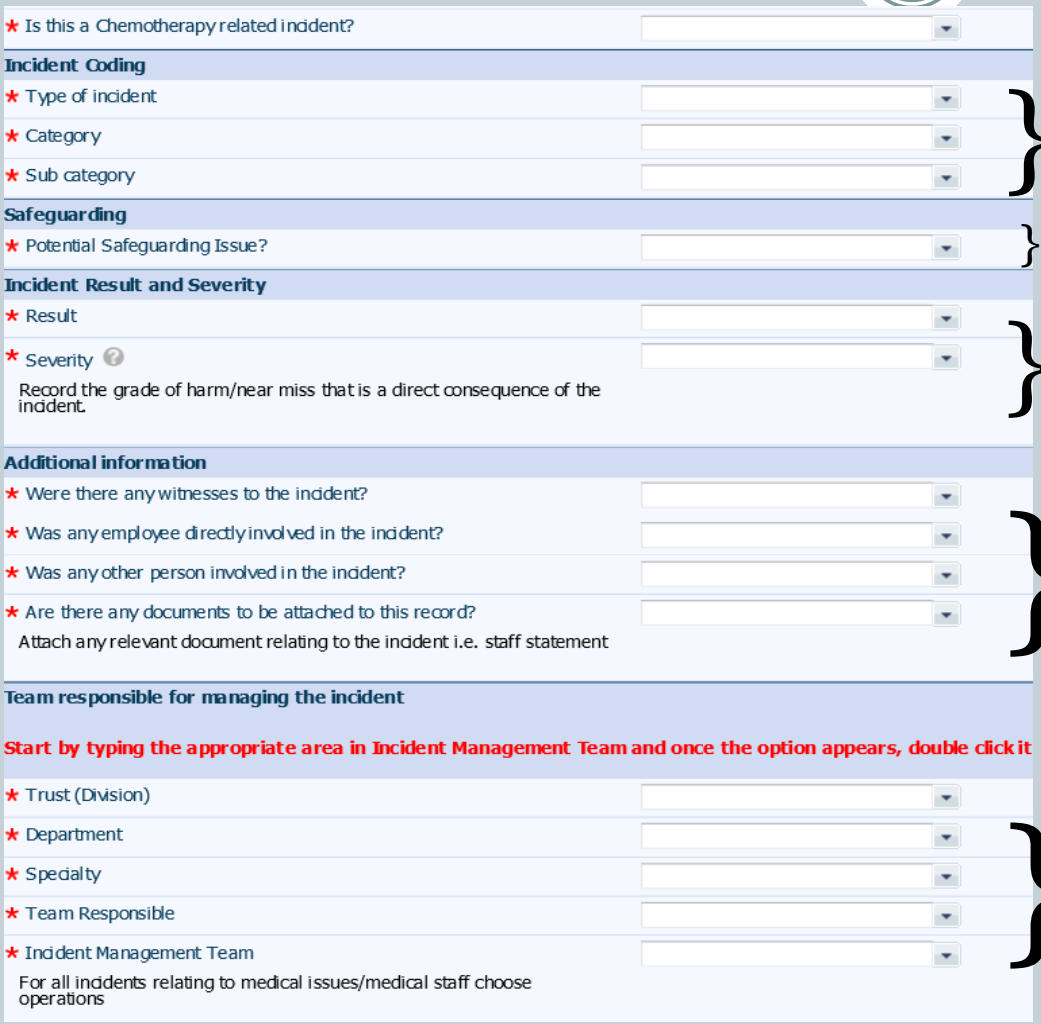
Who did the the incident affect? i.e. patient, staff, visitor

Where the incident occur?

This section is for an incident description. What occurred and what happened leading up to the incident. This should be made up of factual details and should contain no identifiable information

This section is for actions taken post fall. Please include how the patient was retrieved from the floor

Datix – What To Include



What type of incident is it? Fall whilst alone, fall with staff, near miss etc.

Potential safeguarding issue?

Level of harm caused by fall:- No harm/ low harm/severe harm. What kind of impact will this have in the long term?

Any witnesses? Anybody else involved? Any supporting documents?

Who manages the incident? This is usually the area where the fall occurred and is the nursing team NOT operations

Ongoing Care

How do we keep patients on their feet once they leave hospital?

Just like preventing a patient from falling whilst in hospital, it is very difficult to prevent all falls once a patient is discharged. What we can do is make sure that patients have access to the right support and with education we can help minimise their risk of falls once at home. As healthcare professionals, we can refer our patients to the Community Falls Team. This specialist team will visit the patient in their home, conduct a holistic assessment and identify any hazards in the home. They can also carry out a full medication review and refer on to the Consultant-led falls clinic

Community falls pathway referral

It is our responsibility to keep patients mobile wherever possible. The Therapy team in your area will be able to signpost local groups and ability-appropriate activities that could help prevent patients from deconditioning and future readmissions

We can’t (and shouldn't) keep people still, so let’s get them as safely mobile as possible

So, Remember

- Falls risk assessment carried out on admission (including to ED), after a significant even or change in condition and as a minimum every week

- Ensure falls prevention strategies are considered and implemented if identified as being appropriate for the individual

- DATIX should include as much **factual** detail as possible

- Ensure your patient is monitored correctly following a fall and any new strategies to prevent further falls are utilised

- Refer any patients you are concerned about to the community falls service

Falls Prevention and Management Training Declaration

Once you have read this training package, please ensure you send an email to Learning and Development confirming that you have completed the training. The email for Learning and Development is - dgft.learning@nhs.net

On updating of your training record the following will be accepted:

- I confirm that I have read the entire Falls Prevention and Management Training and understood its contents
- I understand that there are supporting Policies and Guidelines available on the Trust HUB
- I confirm that I have a responsibility to follow the guidance set out in this training and the associated Policies and Guidelines

If you do not email confirmation of completion, your training record will NOT be updated

Please contact Soaad Gheleh, Falls Lead , if you have any falls related queries

Email – Soaad.gheleh@nhs.net

Tel - 01384 456 111 Ext 3758

Thank you