Falls Management and Prevention Policy

Author (name):	Matthew Emerson
Author (designation):	Head of Quality Assurance and Improvement
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Introduction

1. This policy sets out Bolton Council's approach to managing and preventing falls in Adult Social Care Services.

2. Falls are a major cause of harm and can have devastating effects for people often leading to hospitalisation, disability, loss of independence, long-term deterioration in health and wellbeing and sometimes death.

3. It is important that staff know how to manage the risk of falling in Bolton Council services, how to deal with a fall when it happens and the methods by which falls can be prevented.

Purpose

4. This policy sets out a consistent approach to risk assessment and risk management, the protocol to follow when a fall occurs, measures for prevention and the means by which compliance with this policy will be measured.

Guiding Principles

5. To develop a culture dedicated to learning and improvement that continually strives to reduce avoidable harm and increases confidence and accountability across all areas of service.

6. It is accepted that due to an ageing population living at home with increasing complexity of needs falls are increasingly likely to occur. Our aim is to minimise the likelihood and the impact of falls as much as possible reducing harm to an absolute minimum whilst in our care.

7. All of our customers are treated equally. We do not discriminate against people because of their age, gender, race or religion. Everybody who uses our services deserves the kind of care we would expect for our own family.

8. Delivering outstanding quality is everybody's responsibility. Every employee is responsible for performing their own role to the highest possible standards. This includes continuously seeking out ways to improve and enhance the experience of our customers.

9. Bolton Council promotes a no-blame culture which means that whilst staff are accountable for their actions, assuring quality is not about finding fault and apportioning blame but identifying practice which has or could lead to harm or a poor customer experience.

10. The safety and experience of customers depends on all staff putting the quality of the service they deliver at the heart of their work.

11. How you can do it:

    1. **LEARN** from experience and from others so that we know what works and what doesn't
    2. **IMPROVE** something in your service so that we avoid making the same mistake twice or we make the most of when something is working well
    3. **SHARE** what you have done so that your colleagues and our partners can improve what they do too
    4. **REPEAT** points 1-3 because improving quality is what we do

Definitions

12. Fall – the generic term used to describe an untoward event which results in the service user coming to rest unintentionally on the ground or other lower surface.

13. Found on floor – the term used to describe the discovery of an individual on the floor the cause of which may have been a fall.

14. Notifiable safety incident - any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

    (a) appears to have resulted in—

        (i.) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

        (ii.) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

        (iii.) changes to the structure of the service user's body,

        (iv.) the service user experiencing prolonged pain or prolonged psychological harm, or

        (v.) the shortening of the life expectancy of the service user; or

    (b) requires treatment by a health care professional in order to prevent—

        (i.) the death of the service user, or

        (ii.) any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

References to Legislation and Standards

15. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

16. There are general duties placed upon employers to safeguard the health and safety of employees and others (including residents, the public and contractors) by Sections 2 and 3 of the *Health and Safety at Work etc. Act 1974.*

17. The *Management of Health and Safety at Work Regulations 1999,* Regulations 3 and 5 and the associated Approved Code of Practice, require employers to assess risks to the health and safety of both employees and residents and to put into effect appropriate arrangements for health and safety planning, organisation, control and review.

18. *The Workplace (Health, Safety and Welfare) Regulations 1992,* Regulation 12, and the associated Approved Code of Practice establish an absolute duty for floors to be suitable for their purpose (this includes adequate slip resistance, evenness and slope). Floors must be kept free of obstructions and any article or substance that may cause any person to slip, trip or fall. Regulation 13 requires measures to be taken to prevent any person falling a distance likely to cause personal injury.

19. Many Regulations have an associated Approved Code of Practice (ACOP). An ACOP has a special legal status in that if you do not follow the ACOP you must be able to show that you have complied with the law in some other way or a court will find you at fault

20. National standards and guidance relating to falls prevention and patient care is recommended within the NICE CG161 Falls (June 2013) and Pathway. The guidance published in June 2013 enhances the 2004 guidelines to include recommendations about patients within inpatient settings.

21. NICE161 Clinical Guideline *Falls: The Assessment and Prevention of Falls in Older People*

    - Older people in contact with health care professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall.
    - Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.
    - Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/balance should be offered a multifactorial falls risk assessment.

Assessing and Managing the Risk

22. A fall is nearly always due to the presence of one or more risk factors. Recognising and reducing an individual's risk factors by altering the service user's environment, for example, can often prevent a fall.

23. The risk of falling can never be completely removed but by carrying out a falls risk assessment risk factors can be identified and action taken to remove or alter risk where possible.

Falls Screening Tool

24. Before admission to a Bolton Council service, service users should be screened to identify if there is any risk of falling using the **Falls Screening Tool (Appendix 1).** The screening tool will identify whether the service user presents certain 'triggers' that suggest a fall is more likely.

25. The Falls Screening Tool should be completed as soon as possible but no later than 24 hours after admission to the service.

Falls Management Plan

26. For all service users where a risk has been identified with the Falls Screening Tool the **Falls Management Plan (Appendix 1)** must be completed. The assessment will examine the risk in more detail and identify the specific interventions that need to be in place to reduce the likelihood and impact of a fall.

27. The Falls Management Plan must be completed as soon as possible but no later than 48 hours after admission to the service (within 12 hours if admitted following a fall).

28. In the Falls Management Plan, the service should identify the actions that will be taken to mitigate the risk presented. A non-exhaustive list of potential interventions is available in the **Falls Management Plan (Appendix 1)** and the **Falls Harm Reduction and Prevention Catalogue (Appendix 3).**

29. The Falls Management Plan is designed to be a multi-disciplinary assessment allowing all disciplines active in a person's care to contribute where required.

30. Following completion of the Falls Management Plan all service users and their informal carers/family (with consent) should be informed of the risk and the measures identified to reduce the risk. They should also be given advice on the prevention of falls and supplement this with written information.

Review

31. The Falls Management Plan must be reviewed and updated regularly or when there are any changes in condition or circumstance for the service user. A change in condition or circumstance might include, for example, a deterioration in health, a change to their medication, a fall or an environmental change such as a change in setting.

Protocol for when a fall occurs

32. Even with robust risk assessment and management processes in place, falls may still occur. When a fall does occur it is important to follow the guidance set out in this policy to avoid further harm to the service user or to staff members.

33. All staff must follow the **Post-Fall Protocol (Appendix 4).**

Record Keeping

34. The Falls Management Plan must be reviewed and updated following a fall as the risks may have changed and changes to the plan required. The Plan should be updated as soon as possible or within 24 hours following a fall.

35. In addition, the Falls Record and Intervention Checklist (found towards the end of the Falls Management Plan) must be completed for each fall that occurs.

Falls diary

36. A **Falls Diary** must be kept and updated after a fall. The Falls Diary forms part of the Falls Management Plan and should be used to record the history of falls whilst in the care of Bolton Council. The Falls Diary can be found at the end of the Falls Management Plan **(Appendix 1).**

Reporting and investigating a fall

37. All falls should be reported as an incident as soon as is practicable. Our *Accident/Incident Management Policy* describes the actions that should be taken on discovery of an incident. A report must be made via the Ulysses system and for anything with harm graded 3, 4 or 5 a High-Level Investigation (HLI) implemented.

38. Where a HLI is required a root cause analysis (RCA) should be carried out. RCAs are essential so that we learn where things went wrong and improve practice as a result. To assist with this, staff should use the **RCA Falls Data Gathering Tool (Appendix 7).**

39. Where a fall is of a serious nature it may come within the definition of a Notifiable Safety Incident and should be reported to CQC. In these circumstances there will also be a requirement under our duty of candour to inform carers/family. Our *Being Open and Honest When Things Go Wrong Policy (Duty of Candour)* describes the actions that should be taken in these circumstances.

Environmental factors in care settings and the home

40. There are environmental factors that can increase the risk of falls, such as, poor lighting, slippery or uneven surfaces, clutter or poorly maintained equipment. It is important that services maintain settings so that fall hazards are removed/reduced.

41. It is equally important for services to provide education and advise service users and their family of falls hazards in the home (this is particularly important in domiciliary care settings eg Reablement or Extra Care and when service users are being discharged to their home).

42. To ensure that Bolton Council care settings are kept to the highest standards of safety, all services must carry out the **Environmental Risk Assessment (Appendix 8)** on a monthly basis.

43. For services that support people with dementia, a further specialist assessment should be undertaken **(see Appendix 2)**

44. For services where care is delivered in the person's own home or when someone is being discharged to their home a home risk assessment should be carried out (an example is Home Fast **(see Appendix 2)**.

45. Written information must be given to the service user and/or their family/informal carers that advises on reducing the risk of falls in homes.

Falls Champion

46. Each service must appoint a Falls Champion. The role of the Falls Champion is to promote falls prevention, provide expert advice to staff on managing and preventing falls, support falls audits and self-assessments, keep abreast of best practice and learning throughout the country and share with colleagues.

Falls audit

47. The **Falls Management Audit (Appendix 9)** must be carried out quarterly on a sample of service users. The Falls Management Audit is for Managers to provide assurance that this policy is being implemented and assurance that falls are being managed appropriately.

48. The outcome and the learning from the Falls Audit should be shared at team meetings and must be sent to quality@bolton.gov.uk.

Learning and Improvement

49. Gathering and analysing falls information helps to anticipate and prevent falls rather than just manage problems once they have occurred.

50. Falls must be monitored by services for trends, frequency, recurring factors eg time or location so that long term strategies/improvements can be put in place to reduce the likelihood or risk.

51. Learning should be shared within services and across the organisation so improvements can be realised. More information about learning can be found in the Accident and Incident Management Policy or on the Quality Assurance Intranet Site http://portal.bolton.gov.uk/ChildrensServices/PlanningPerformanceandresources/QualityAssuranceandImprovement/Pages/default.aspx .

Roles and responsibilities

52. All staff - All staff have a duty to ensure service users are safe and that risks are removed or reduced. Staff must report all falls in line with the Accident and Incident Management Policy. In the event of a fall, all staff must follow the Post-Fall Protocol and complete any necessary paperwork required of them.

53. Registered Managers – Registered Managers must foster a culture of safety and do everything possible to ensure the safety of service users and staff. Registered Managers must ensure that the tools outlined in this policy are implemented effectively. Registered Managers must ensure that all incidents are reported accurately on the Ulysses system and High level Investigations implemented where required. Registered Managers must analyse incidents in their service and ensure the service learns and improves practice.

What competences will staff who are implementing this policy need?

54. Following training all staff should be able to:

- Locate the policy and describe the correct procedure when dealing with someone who is at risk of falls / post-falls within their service
- Recognise when to escalate concerns and refer on to other services if required
- Carry out safe manual handling as demonstrated in manual handling training
- Use equipment safely as per training and manufacturers guidance
- List their duties under this policy

55. Following training all managers will be able to :

- Describe the correct procedure when dealing with someone who has had a fall / post-fall within their service
- Describe and demonstrate their duties under this policy
- Carry out direct observations in practice on staff / documentation to demonstrate quality assurance
- Check that all incidents are reported accurately on the Ulysses system and High level Investigations implemented where required.
- Identify incidents within their service and ensure the service learns and improves practice.
- Identify and explain future changes to the policy to their staff accordingly

Staff training

56. Staff who are involved in the care of a service user or with supporting them to mobilise and/or transfer will be required to attend the following training:

    - One hour training session for Managers and Falls Champions and cascade to staff
    - Moving and Handling Level 2 incorporating policy and falls prevention (for new starters)

- Mandatory Update Training – moving and handling refresher incorporating policy and falls prevention (for existing staff)

Implementation and review

57. The policy and guidance will be available on the intranet site.

58. All staff and managers will initially receive a one hour training session delivered at various venues across Bolton which will include familiarisation to falls prevention policy, documentation, procedure and roles and responsibilities.

59. Once initial training has been received staff to attend mandatory update training to receive refresher training.

60. All New starters will receive training relevant to their role which will be included in the mandatory moving and handling training Level 2 as from ratification of this policy.

61. Communication regarding the policy will be made with staff via training and internal bulletins.

62. Learning and improvement activity will be published on the intranet and cascaded to staff via the internal bulletin.

63. Quality assurance of the policy will include:

    - Competencies will be assessed by managers through supervision, team meetings and PDRs. This will be written into standard agendas and audit tools.
    - Compliance and implementation of this policy will be monitored and measured by the Falls Management Audit and reported quarterly to the Quality Governance Board.
    - The policy will be reviewed annually by the Head of Quality Assurance and Improvement in collaboration with service managers and other stakeholders.

Appendix 1

Screening tool and Management Plan

Name of service user:		**DOB**	**Service**
Co-ordinator/care supervisor		**Date of assessment**	

Falls Screening tool		
1. Is there a history of any fall in the previous year?	Yes	No
Number of Falls in the last year Number =		
2. Tries to walk alone but unsteady /unsafe/dizzy?	Yes	No
3. Significant problems with sight / balance?	Yes	No
4. Is person on four or more medications / or recently prescribed sedatives / antipsychotics	Yes	No
5. Incontinent or frequency affecting safety?	Yes	No
6. Are there any concerns that the person is at risk of falls?	Yes	No
7. Is there a fear of falls?	Yes	No
8. Has information on the prevention of falls been given to SU on admission?	Yes	No

Outcome from screening: If the answer to any of the questions is 'Yes', the Falls Management Plan should be completed.

You must record that there is a falls risk within relevant section of liquid logic and make reference to this Falls Management Plan**. N/A for bed based**

For community services - consider if known to IMC at home, if yes falls assessment will have been completed if required.

Risk factor (Tick if applicable, then link with recommended actions)	**Risk factor Yes or No**	**Details/Information gained from service user/Observations**	**Signature and date completed**
History of falling: ☐ Has the service user had one or more falls in the past 12 months? Please document if unable to recall fall		Obtain details about past falls: No of falls, Perceived cause of fall, activity at time of fall, Injuries sustained, Fractures sustained and Symptoms such as dizziness, and previous treatment received.	
Balance and mobility:			
Medication:			
Nutrition:			

Risk factor (Tick if applicable, then link with recommended actions)	**Risk factor Yes or No**	**Details/Information gained from service user/Observations**	**Signature and date completed**
Cognitive impairment:			
Continence:			
Night patterns:			
Feet and footwear:			
Other Are there other factors that you consider relevant in considering this service user's falls, risk, eg alcohol intake, pain, low mood/ depression?			
Onward referrals to consider		**Actions completed**	
Bed based – Inform GP of any follow up actions i.e. refer to memory clinic. **Community** - If unexplained falls or due to medical reason consider referral to GP			
Bed Based – If ongoing rehab potential consider referral to IMC at Home **Community** - If issues with mobility, balance, home environment and activities of daily living consider referral to IMC at home and/or ILS			
Telecare			
Community - Medication identified as possible cause of falls referral to Pharmacy			

Actions required	Completion date	Outcomes

Falls Diary

Service user name:				NHS Number:		
Date	Time	Location of fall	Injury	How fall occurred and actions taken	Ulysses number	Signed

Home Support Reablement (HSR) Guidance

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
1. History of falling: Has the service user had one or more falls in the past 12 months? Obtain details about past falls: • No of falls • Perceived cause of fall • activity at time of fall • Injuries sustained • Fractures sustained • Symptoms such as dizziness, and previous treatment received.	• **Contacting GP for assessment if there have been unexplained falls; several falls in a short period of time or any of the following symptoms: dizziness, black-outs, feeling light-headed, leg weakness, blurred vision. Give details of specific concerns.** • **Contact GP to complete bone health assessment due to fracture risk.**
2. Balance and mobility: Is the service user unsteady/ unsafe walking? Does the service user have difficulty with transfers (getting on and off the toilet/ bed/ chair)?	**Referral to IMC at home for assessment due to unsteady mobility/Balance problems or potential equipment needs. Referral to telecare.**
3. Medication: Is the service user taking 4 or more medications? Is the service user taking any of the following that you are aware of: Sedatives, Anti-depressants, Anti-Parkinson's, Diuretics (water tablets), Anti-psychotics, Anti-coagulants, Anti-hypertensives Has there been a recent change in medication that may affect falls risk (eg changes involving any of the above)? Has the service user reported any side effects?	• **Referral to GP** • **Referral to Pharmacy Team to review medications with respect to falls risk**
4. Dizziness and fainting: Does the service user experience: • Dizziness on standing • A sensation of the room spinning when moving their head or body • Fainting attacks • Palpitations?	**Refer the service user to the IMC at home for a nurse review of dizziness/ fainting/ blackouts/ palpitations.** **Ensure support workers encourage fluid intake** **prompt service user to move ankles up and down before rising, then rise slowly and with care from lying to sitting, and sitting to standing.**
5. Nutrition: Has the service user lost weight unintentionally or do they have little appetite? Does the service user spend little time outside in daylight?	• **Complete nutritional screening form and refer to IMC at home for further assessment.**
6. Cognitive impairment: Is the service user confused, disorientated, restless or highly irritable or agitated?	• **If there is a new change in cognitive status monitor for pain, signs of infection or constipation and consider**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
Does the service user have reduced insight and/ or judgement and/ or are they uncooperative with staff Has there been a recent change in medication?	**referral to GP for further assessment.** • **Support workers to monitor home environment for hazards and report as necessary.**
7. Continence: Do continence issues contribute to the service user's falls risk? Does the service user have continence aids (pads): Are these privately purchased or provided by the bowel and bladder team.	• **Referral to GP for continence assessment.** • **Ensure use of continence products as appropriate.** • **Ensure support workers encourage fluid intake** • **Referral to IMC at home for equipment needs.** • **Support workers to monitor home environment for hazards and report/resolve as necessary. i.e. wet floors**
8. Sensory impairment: Does the service user have poor vision? (Remember: following a stroke someone may have restricted vision on one side, some people with dementia experience visual problems)? Does the service user have poor hearing? Does the service user feel that their sensory impairment is contributing to their falls?	• **Recommend an assessment by an optician.** • **Ensure environment is free of clutter and obstacles and bedroom lighting is adequate, consider need for night lights.** • **Ensure glasses are in good condition, clean, worn consistently, kept within reach when not worn.** • **If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist with GP.** • **Ensure hearing aid is worn, clean and batteries are working** • **Referral to ILS for sensory assessment**
9. Night patterns: Has the service user fallen at night? Does the service user often get out of bed overnight? Is the service user able to get in and out of bed safely on their own?	• **Advice on night lighting appropriate to vision.** • **Optimise environmental safety – remove clutter and hazards.** • **Check bed height is suitable for the service user.** • **Ensure spectacles and buzzers/pendants are within easy reach.** • **Referral to IMC at home for equipment.** • **Referral to ILS for telecare assessment.**
10.Feet and footwear: Does the service user have corns, ingrown toe nails, bunions, fungal infections, pain or loss of the sensation in their feet?	• **Recommend service user to request referral to podiatrist via GP** • **Advise service user and family to consider appropriate**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
Does the service user wear ill-fitting shoes, high-heel shoes, or shoes without grip?	**footwear** • **Advise service user not walk with socks only. If shoes are too tight or loose fitting, walk with bare feet.** • **Advise service user to consider double sided rubber tread socks if shoes are often removed.**

Wilfred Geere Guidance

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
11.History of falling: Has the service user had one or more falls in the past 12 months? Obtain details about past falls: • No of falls • Perceived cause of fall • activity at time of fall • Injuries sustained • Fractures sustained • Symptoms such as dizziness, and previous treatment received.	• **Contacting GP for assessment if there have been unexplained falls; several falls in a short period of time or any of the following symptoms: dizziness, black-outs, feeling light-headed, leg weakness, blurred vision. Give details of specific concerns.** • **Care supervisor to complete moving and handling assessment, SURA, skills plan and falls management plan on admission to the unit.**
12.Balance and mobility: Is the service user unsteady/ unsafe walking? Does the service user have difficulty with transfers (getting on and off the toilet/ bed/ chair)?	• **Care supervisor to assess on admission and escalate any concerns to GP.** • **Therapy to screen within 24-72hrs of admission. If discharge to assess beds**
13.Medication: Is the service user taking 4 or more medications? Is the service user taking any of the following that you are aware of: Sedatives, Anti-depressants, Anti-Parkinson's, Diuretics (water tablets), Anti-psychotics, Anti-coagulants, Anti-hypertensives Has there been a recent change in medication that may affect falls risk (eg changes involving any of the above)? Has the service user reported any side effects?	• **Referral to GP to review medications with respect to falls risk** • **Care Supervisor to obtain current list of medications from service users GP on admission to compare with admission medications.** • **Pharmacy to review current list of medications from service users GP on admission to compare with admission medications. Discharge to assess beds**
14.Dizziness and fainting: Does the service user experience: • Dizziness on standing • A sensation of the room spinning when moving their head or body • Fainting attacks • Palpitations?	• **Refer the service user to the GP for a district nurse review of dizziness/ fainting/ blackouts/ palpitations.** • **Ensure care staff encourage plenty of fluids** • **Encourage service user to move ankles up and down before rising, then rise slowly and with care from lying to sitting, and sitting to standing.**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
15.Nutrition: Has the service user lost weight unintentionally or do they have little appetite? Does the service user spend little time outside in daylight?	• **Complete nutritional screening form on admission and if risk identified dietary intake sheets to be completed** • **Care staff to record diet and fluid intake, care supervisor to monitor and refer to GP if concerns** • **Weight to be recorded weekly**
16.Cognitive impairment: Is the service user confused, disorientated, restless or highly irritable or agitated? Does the service user have reduced insight and/ or judgement and/ or are they uncooperative with staff Has there been a recent change in medication?	• **If there is a new change in cognitive status monitor for pain, signs of infection or constipation and consider referral to GP for further assessment.**
17.Continence: Do continence issues contribute to the service user's falls risk? Does the service user have continence aids (pads): Are these privately purchased or provided by the bowel and bladder team.	• **Referral to GP for continence assessment.** • **Ensure use of continence products as appropriate.** • **Ensure care staff encourage fluid intake**
18.Sensory impairment: Does the service user have poor vision? (Remember: following a stroke someone may have restricted vision on one side, some people with dementia experience visual problems)? Does the service user have poor hearing? Does the service user feel that their sensory impairment is contributing to their falls?	• **Recommend an assessment by an optician.** • **Ensure environment is free of clutter and obstacles and bedroom lighting is adequate, consider need for night lights.** • **Ensure glasses are in good condition, clean, worn consistently, kept within reach when not worn.** • **If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist with GP.** • **Ensure hearing aid is worn, clean and batteries are working** • **Referral to ILS for sensory assessment**
19.Night patterns: Has the service user fallen at night? Does the service user often get out of bed overnight? Is the service user able to get in and out of bed safely on their own?	• **Advice on night lighting appropriate to vision.** • **Optimise environmental safety – remove clutter and hazards.** • **Check bed height is suitable for the service user.** • **Ensure spectacles and buzzers/pendants are within easy**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
	reach.
20.Feet and footwear: Does the service user have corns, ingrown toe nails, bunions, fungal infections, pain or loss of the sensation in their feet? Does the service user wear ill-fitting shoes, high-heel shoes, or shoes without grip?	• **Referral to podiatrist.** • **Advise service user and family to consider appropriate footwear** • **Advise service user not walk with socks only.** • **Advise service user to consider double sided rubber tread socks if shoes are often removed.**
21. New Service users Is the service User orientated to their new environment? Does the service user have suitable clothing and footwear?	• **Care supervisor to orientate service user to the unit on admission, introduce to staff, explaine call system and encourage to use.** • **Consider PIR if service user lacks capacity to retain information and falls risk identified.**

Laburnum Lodge Guidance

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
22.History of falling: Has the service user had one or more falls in the past 12 months? Obtain details about past falls: • No of falls • Perceived cause of fall • activity at time of fall • Injuries sustained • Fractures sustained • Symptoms such as dizziness, and previous treatment received.	• **Consultant review within 7days of admission** • **Nursing assessment within 24hrs of admission** • **Therapy screen within 24hrs of admission maximum of 72hrs if admitted Friday after 4pm** • **Pharmacy review within 24hrs of admission maximum of 72hrs if admitted Friday after 4pm** • **Care supervisor to complete moving and handling assessment, SURA, skills plan and falls management plan on admission to the unit.**
23.Balance and mobility: Is the service user unsteady/ unsafe walking? Does the service user have difficulty with transfers (getting on and off the toilet/ bed/ chair)?	• **Care supervisor to assess on admission and escalate any concerns to therapy team.** • **Therapy to screen within 24-72hrs of admission.**
24.Medication: Is the service user taking 4 or more medications? Is the service user taking any of the following that you are aware of: Sedatives, Anti-depressants, Anti-Parkinson's, Diuretics (water tablets), Anti-psychotics, Anti-coagulants, Anti-hypertensives Has there been a recent change in medication that may affect falls risk (eg changes involving any of the above)? Has the service user reported any side effects?	• **Pharmacy to obtain current list of medications from service users GP on admission to compare with admission medications.** • **Consultant review within 7 days of admission.** • **Contact GP if any immediate concerns**
25.Dizziness and fainting: Does the service user experience: • Dizziness on standing • A sensation of the room spinning when moving their head or body • Fainting attacks • Palpitations?	• **Nursing staff to complete lying and standing blood pressure on admission as part of nursing assessment.** • **Any deficit noted repeat for 3 days consider GP review if any immediate concerns.**
26.Nutrition: Has the service user lost weight unintentionally or do they have little appetite? Does the service user spend little time outside in daylight?	• **Nutritional screening completed within 24hrs admission as part of nursing assessment.** • **Referral to community dietician** • **Care staff to record diet and fluid intake, care supervisor**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
	and nursing staff to monitor and discuss any concerns at safety huddle.
27.Cognitive impairment: Is the service user confused, disorientated, restless or highly irritable or agitated? Does the service user have reduced insight and/ or judgement and/ or are they uncooperative with staff Has there been a recent change in medication?	• **If there is a new change in cognitive status monitor for pain, signs of infection or constipation and consider referral to GP for further assessment.** • **Dementia screening tool completed on admission.** • **OT to complete cognitive assessment.**
28.Continence: Do continence issues contribute to the service user's falls risk? Does the service user have continence aids (pads): Are these privately purchased or provided by the bowel and bladder team.	• **Nursing staff to complete continence assessment.** • **Ensure use of continence products as appropriate.** • **Ensure support workers encourage fluid intake** • **OT to assess for commode if appropriate to manage night time needs.**
29.Sensory impairment: Does the service user have poor vision? (Remember: following a stroke someone may have restricted vision on one side, some people with dementia experience visual problems)? Does the service user have poor hearing? Does the service user feel that their sensory impairment is contributing to their falls?	• **Recommend an assessment by an optician.** • **Ensure environment is free of clutter and obstacles and bedroom lighting is adequate, consider need for night lights.** • **Ensure glasses are in good condition, clean, worn consistently, kept within reach when not worn.** • **If hearing has not been assessed in last 12 months, discuss options, including referral to audiologist** • **Ensure hearing aid is worn, clean and batteries are working** • **Referral to ILS for sensory assessment on discharge**
30.Night patterns: Has the service user fallen at night? Does the service user often get out of bed overnight? Is the service user able to get in and out of bed safely on their own?	• **Advice on night lighting appropriate to vision.** • **Optimise environmental safety – remove clutter and hazards.** • **Check bed height is suitable for the service user.** • **Ensure spectacles and buzzer within reach** • **2hrly comfort checks nightly**

Falls Screening tool and Management Plan-Guidance	
Risk factor – issues to consider	**Actions to consider**
	• **OT to asses for equipment.** • **Consider PIR if service users lacks capacity to retain information**
31.Feet and footwear: Does the service user have corns, ingrown toe nails, bunions, fungal infections, pain or loss of the sensation in their feet? Does the service user wear ill-fitting shoes, high-heel shoes, or shoes without grip?	• **Referral to podiatrist/ orthotics where appropriate** • **Advise service user and family to consider appropriate footwear** • **Advise service user not walk with socks only** • **Advise service user to consider double sided rubber tread socks if shoes are often removed.**
32. New service users Is the service user orientated to their new environment? Does the service user have suitable clothing and footwear	• **Care supervisor to orientate service user to the unit on admission, introduce to staff, explaine call system and encourage to use.** • **Consider PIR if service user lacks capacity to retain information and falls risk identified.**

Appendix 2: Falls Harm Reduction and Prevention Guidance

For building-based services

Consider environmental factors

- Aspects of the environment that could impact on service user's risk of falling (such as flooring, density, sheen, colour and pattern, lighting and provision of hand holds) are systematically identified and addressed. This should be completed in the form of an environmental assessment and should consider aspects relating to the environment that has particular impact for sensory impairment e.g. patients with dementia.

- Provide a physically safe environment (i.e. eliminate spills, clutter, electrical cords, stable furniture when leaned on and unnecessary equipment).

- Make sure toilets are clearly signposted

- The service user's bed must be in the lowest position with wheels locked that is functionally able for the patient i.e. service user should be able to sit to stand without great effort.

- Lighting adequate to support independent movement. Light cord within reach, visible and service user informed of the location and use.

- Support service user to understand the use of grab bars to assist in standing up in bathroom and toilet areas.

On Admission

- Orient the service user to new surroundings and staff.

- Demonstrate the call system. Help service users to call for help before getting out of bed or up from the chair if required. Reinforce a consistent message that the service user should call for assistance and not just in an emergency.

- The call bell must be within reach, visible and the service user informed of the location and use. Personal care items placed within arm's length. e.g. reading glasses, walking aids, drink

- Service user's spectacles must be clean and well fitting. If they are in need of repair, this should be attended to, as a matter of urgency

- Service user footwear must be comfortable and well fitting.

Observations

- Older people accessing mental health services are particularly vulnerable to falls due to the potential for multiple risk factors of dementia, depression, side effects from medication, or problems with balance, strength and mobility.

- For those service users at risk of falling who are unable to use the call bell and who prefer to walk independently although unsafe to do so due to cognitive impairment, consideration should be given to a bedroom allocated closer to where the Carer's and supervisors are based.

- Situations when **enhanced observation** and engagement are indicated in relation to imminent risk situations are: when the patient's physical health affects personal care needs, mobility, balance and coordination or the patient is confused and disorientated to the extent that s/he may wander aimlessly if unsupervised.

For services delivered in a person's home

Many falls happen in a person's own home. Services should provide advice and support to service users so that risks are reduced.

Tips for preventing falls in the home include:

- Immediately mopping up spillages
- Removing clutter, trailing wires and frayed carpet
- Using non-slip mats and rugs
- Using high-wattage light bulbs in lamps and torches, so you can see clearly
- Organising your home so that climbing, stretching and bending are kept to a minimum, and to avoid bumping into things
- Getting help to do things that you're unable to do safely on your own
- Not walking on slippery floors in socks or tights
- Not wearing loose-fitting, trailing clothes that might trip you up
- Wearing well-fitting shoes that are in good condition and support the ankle
- taking care of your feet by trimming your toenails regularly and seeing a GP or chiropodist about any foot problems

- Services should carry out or support a service user and/or their family to do a home risk assessment.

- Provide some practical information for service users. SAGA's 'Get Up and Go' booklet provides a great deal of information about reducing the risk in the home and preventing falls out and about http://www.nhs.uk/Conditions/Falls/Documents/SAGA_Falls-Prevention.pdf

- The Council offers a free Home Risk Assessment and the potential for a grant for improvements to be made. Phone 01204 328 178 to make a referral.

- Services should consider referring to the NHS Falls and Community Therapy Team where there is a high risk or if the service user has suffered a fall. Contact 01204 462555

Health related guidance

Strength and balance exercises

Activities that improve muscle strength in your legs, arms, back, shoulders and chest are particularly important as you get older. They can make it easier to get up out of a chair and because they improve your posture, co-ordination and balance, they're an effective way to reduce the risk of falling. Moving about less can make you more prone to falling as your leg muscles become weaker.

(Staying steady, Keep active and reduce your risk of falling, Age UK, April 2016)

Where possible services should empower residents, services users to move about as much as possible and carry out regular strength and balance exercises.

Vitamin D and Calcium

You can help keep your bones strong by eating a diet rich in calcium and making sure that you get enough vitamin D. Calcium makes our bones strong and we need vitamin D to help our bodies absorb it. Your body makes vitamin D mainly when your skin is exposed to sunshine. For this reason, some direct exposure to the sun is necessary, although it's important not to let your skin redden or burn. From March to October, try to go out every day without sunscreen for short periods (around ten minutes) either once or twice a day depending on how dark your skin colour is. Remember to make sure that you are actually outside – your body can't make vitamin D from sunshine coming through closed windows. There are some food sources of vitamin D – salmon, sardines, other oily fish, eggs and fortified spreads – but sunshine is the main source. Good sources of calcium are dairy foods, fortified soya products and canned fish (with bones). It is also found in fortified breakfast cereals, white bread, pulses and nuts such as almonds.

The Government recommends that certain groups of the population, including people aged 65 and over, take ten micrograms (10µg) of vitamin D daily as a supplement. If you think you could be at risk of not getting enough vitamin D, particularly if you are housebound, have darker skin, or cover your skin for cultural reasons, raise this with your GP. Always speak to your GP before starting to take a vitamin D supplement or over-the-counter medicine daily.

(Staying steady, Keep active and reduce your risk of falling, Age UK, April 2016)

Where possible services should empower and motivate residents, services users to go out every day for short periods between March and October.

Services who provide meals to residents and service users, where appropriate should promote a balanced healthy meal including a calcium rich diet.

Osteoporosis

Smoking is a risk factor for osteoporosis and bone fracture, where possible services should promote and empower their service users and residents to live a healthy lifestyle. Providing opportunities to access stop smoking services and strategies to cope whilst giving up smoking.

Empowering self help

Where possible services should create an environment where residents and service users are empowered and motivated to maintain self-care, independence and healthy lifestyles.

Alcohol

Drinking alcohol can lead to loss of co-ordination and exaggerate the effects of some medicines. This can significantly increase the risk of a fall, particularly in older people.

Avoiding alcohol or reducing the amount you drink can reduce your risk of having a fall. Excessive drinking can also contribute to the development of osteoporosis.

http://www.nhs.uk/Conditions/Falls/Pages/Prevention.aspx

Alcohol guidelines

The alcohol limit for men has been lowered to be the same as for women. The UK's Chief Medical Officer (CMO) guideline for both men and women is that:

•You are safest not to drink regularly more than 14 units per week. This is to keep health risks from drinking alcohol to a low level

•If you do drink as much as 14 units a week it is best to spread this evenly across the week

One off drinking

If you have one or two heavy drinking sessions you increase the risks of death from long-term illnesses, accidents and injuries. When it comes to single drinking occasions you can keep the short term health risks at a low level by sticking to a few simple rules:

•Limiting the total amount of alcohol you drink on any occasion;

•Drinking more slowly, drinking with food, and alternating with water.

https://www.drinkaware.co.uk/alcohol-facts/alcoholic-drinks-units/latest-uk-alcohol-unit-guidance/

Appendix 3: Catalogue of Tools, Services and Information

A	• **Admission Avoidance Team** can respond to falls in order to prevent someone's admission to hospital. Referrals to this service are often via the North West Ambulance Services but services can contact directly on 01204 462188 or 462199 • **Age UK** offers further advice for older people on falls prevention in the community http://www.ageuk.org.uk/health-wellbeing/keeping-fit/falls-prevention/exercise-regularly/
B	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
C	• **Care Home Team** is an integrated team of Advanced Nurse Practitioners and Pharmacists who provide support to people who are permanently resident in residential and nursing care homes in Bolton. You can contact the team on 01204 462626
D	• **Dementia Services EHE Environmental Assessment** - Environmental assessment tool for services who support people with dementia. http://www.kingsfund.org.uk/sites/files/kf/field/field_pdf/is-your-care-home-dementia-friendly-ehe-tool-kingsfund-mar13.pdf • **Disability Facilities Grant (DFG)** – available to support eligible people to make improvements to their own home – Tel 01204 328178
E	• **Environmental Risk Assessment** tool for bed-based care services (Appendix 6 of this document) • **Exercise** to improve muscle strength and balance has been shown to reduce the risk of falls. Patients that have balance and gait impairment must have access to physiotherapy for assessment of mobility, muscle strength and balance. NHS Choices has more information on suitable exercises for older people http://www.nhs.uk/Tools/Pages/Exercises-for-older-people.aspx
F	• **Falls Screening Tool** for services assessing someone's risk (Appendix 1 of this document) • **Falls Management Plan** for services to assess the risk in more detail and identify the correct interventions (Appendix 1 of this document) • **Falls Management Audit** for managers to assess the extent to which this policy is implemented (Appendix 9 of this document) • **Falls and Community Therapy Team** is a community therapy rehabilitation service specialising in improving service users' independence, mobility and preventing falls within the home and community setting. The Team aims to prevent avoidable hospital admissions by supporting and caring for service users in their usual place of residence. Contact 01204 462555. This service is available to anyone aged 18+. • **Footwear -** Wearing safe, comfortable and appropriate footwear can ensure an individual has the most potential to walk and balance well. Unsafe footwear can contribute to falls through stumbling, affecting balance, and slipping. http://www.nhs.uk/Livewell/Staywellover50/Pages/Foot%20care.aspx • **FRAX (Fracture Risk Assessment Tool)** developed by Sheffield University

	for the World Health Organisation. Provides a simple assessment for osteoporosis https://www.shef.ac.uk/FRAX/ • **'Falls Rounding'** – an approach to reducing falls in residential care settings by making regular welfare checks of high risk service users in their rooms reducing the likelihood of risky mobilisation. Contact quality@bolton.gov.uk .
G	• **"Get up and Go!"** leaflet produced by The Chartered Society of Physiotherapists, SAGA and Public Health England provides lots of useful information and support to prevent the risk of falls in the community. Order hard copies or download from http://www.csp.org.uk/publications/get-go-guide-staying-steady
H	• **Healthy Homes Check** is a free service to assess someone's home for falls risk and an opportunity to apply for a grant to fund improvements. Phone 01204 328178 or email boltoncareandrepair@boltonathome.org.uk to book a free assessment.
I	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
J	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
K	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
L	• **Learning from incidents** – resources to help you learn and improve following a fall can be found on the Quality Assurance and Improvement Intranet site here .
M	• **Moving and Handling training** is a requirement for staff involved in providing direct care to someone. Training can be booked via Oracle or emailing trainingsharedservicecentre@bolton.gov.uk.
N	• **NICE Quality Standard** – Falls in Older People https://www.nice.org.uk/guidance/qs86. Provides recommendations for reducing falls in hospital but useful for care homes too.
O	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
P	• **Post-Fall Protocol** what to do if you see a fall or find someone who you think has fallen (Appendix 4 of this document) • **Passive Infra-Red (PIR**) is available in Laburnum Lodge and Wilfred Geere. PIR will alert staff when a service user is moving in their bedroom and is useful when a service user does not have capacity, or cannot use, the staff call button
Q	• **Quality Assurance and Improvement Team** will support services to carry out root cause analysis so that learning and improvements can be identified quality@bolton.gov,uk

R	• **Root cause analysis** data gathering tool will help you get the information you need to conduct a thorough RCA (Appendix 5 of this document). • **Root cause analysis training** is delivered by the Quality Assurance and Improvement Team and can be booked via Oracle or emailing trainingsharedservicecentre@bolton.gov.uk
S	• **Shared Lives** House Check provides a checklist specifically aimed at assessing the risk in the Shared Lives service • **Service User Risk Assessment** (SURA) (Local Authority only) • **Strength and balance training** – is an important intervention for someone who has a history of falling or they are unsteady or unsafe walking. Contact the Falls and Community Therapy Team to book 01204 462555
T	• **Telecare** is a range of devices and equipment that use technology to enable people to live independently and safely either in their own home or care environment. For service users living in their own homes referral for Telecare equipment is made through the Independent Living Service (ILS). In a residential environment this equipment may be purchased by the care home or patient/carer/family.
U	• **Ultra-Low Beds** - for service users that cannot be given bedrails as they may try to climb over them or for service users with delirium who are at risk of falling out of bed, ultra-low beds can help prevent harm from falls.
V	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
W	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.
XYZ	Help us to improve this document. Email quality@bolton.gov.uk with any suggestions you have.

Appendix 4: Post-Fall Protocol

Action to be taken following any service user fall

1. Carry out an immediate assessment of the service user. Check for any signs of injury.
    a. Check if the service user is responsive
    b. If unresponsive, check the service user's airways, breathing and circulation
    c. Check for pain, loss of sensation, loss of movement in the arms and/or legs, and observe for swelling, visible injury and deformity. Shortening and outward rotation of the leg can indicate a hip fracture.
    d. Check for nausea, confusion, drowsiness, delirium and agitation

2. Where the above is present and/or where serious injury is suspected (eg fracture, head or spinal injury) **DO NOT ATTEMPT TO MOVE THE SERVICE USER** as this could lead to further injury**.** Make the service user comfortable using pillows and blankets and stay with them. Seek medical attention (ie a Nurse or GP) or request an emergency ambulance via 999.

3. If the service user banged their head or it is suspected that they banged their head seek medical assessment from a Nurse or GP or dial 999 for an emergency ambulance.

4. Where there is no serious injury suspected, ask the service user about pain. If there is no concern and if safe to do so use an appropriate manual handling technique (get appropriate equipment if needed) to move the service user and return them to a bed or chair. If the service user can get off the floor independently allow them to do so.

5. Check their body for any cuts or bruises and provide appropriate care.

6. If a nurse is on site take and record minimum mandatory observations: blood pressure, pulse, respirations and temperature as a minimum. Where the service user's condition allows, lying and standing BP should be recorded following the NHS Trust's protocol for this measurement.

7. Continue to monitor for symptoms of nausea, atypical confusion, drowsiness, delirium, agitation and pain though a proportionate schedule of observation. This observation may require to be more intensive for those who are at higher risk of bleeding such as people taking warfarin or people with cognitive impairment or communication difficulties. Observe for changes in mobility or difficulty taking weight through the legs.

8. Make safe any obvious environmental hazards which may have contributed to the fall.

9. Inform the service user's relatives in a timely manner dependent on consequences of fall i.e. immediately in the event of serious injury or transfer to A&E, within 24 hours if service user has obvious signs of injury e.g. extensive bruising or when next visiting unit where no injury has occurred. Where possible ensure you have the consent of the service user to share this information.

10. Complete on-line incident form (Ulysses) and include any actions taken. Remember to update Manager. In the event of suspected or confirmed serious injury, the relevant manager must be informed immediately. All serious injuries and repeated falls must be subjected to a full Root Cause Analysis.

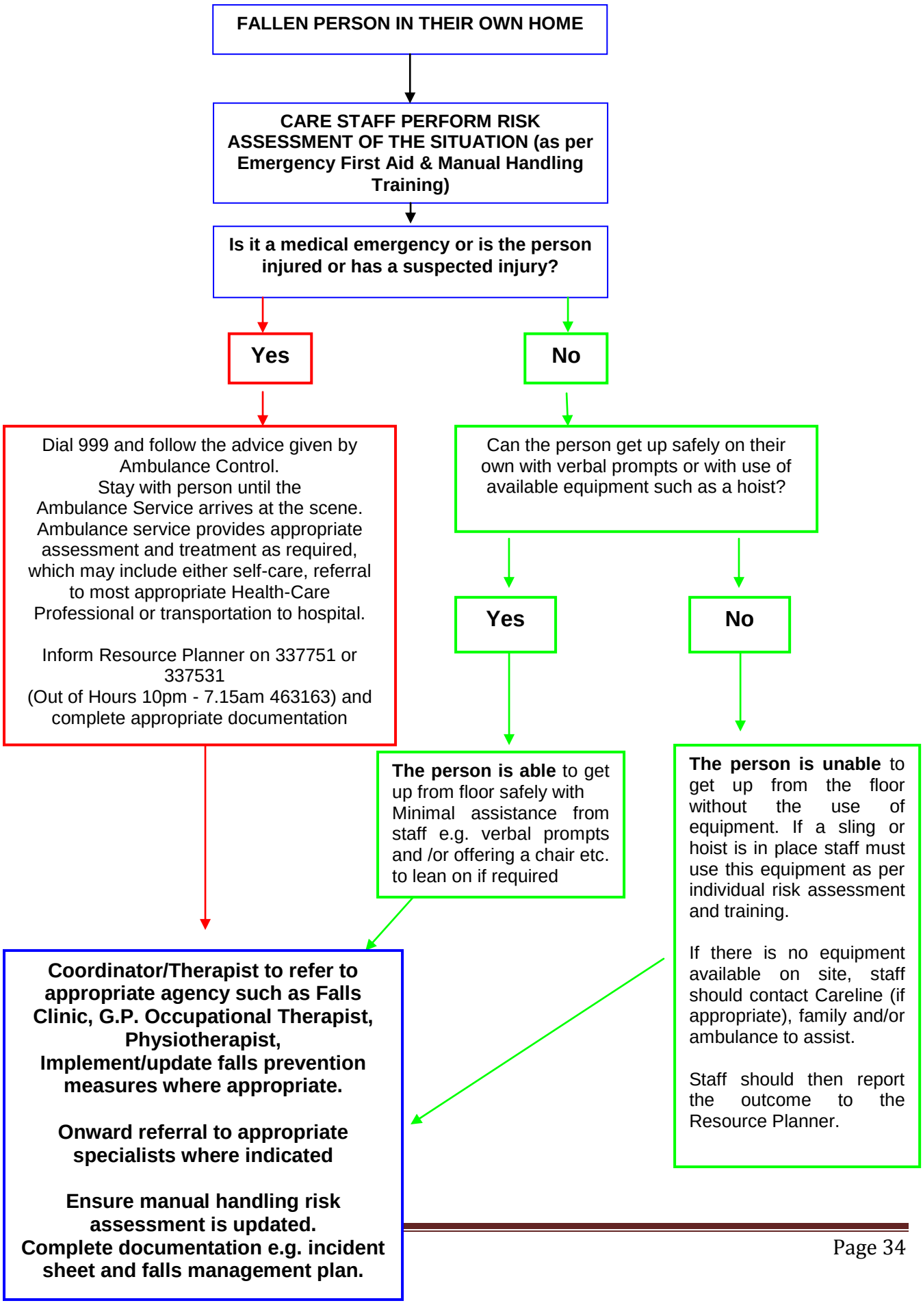
11. Update and review the Falls Management Plan including the Falls Diary to reduce risk of service user falling again.

12. Update Care plan

13. If the service user is a recurrent faller seek advice/review from a Geriatrician, or contact the Falls and Community Therapy Service on Contact 01204 462555.

Appendix 5:

Fallen Person Flowchart (Community)



Appendix 6

Fallen Person Procedure for Resource Planners / Coordinators

- If a member of staff finds a person on the floor and contacts the office the Resource Planner is to ask the staff member if they have completed an assessment of that person i.e. airway, breathing, circulation, confusion, broken bones, bleeding, pain.

- If the person has any of the above the member of staff is advised to ring 999 and ask for an ambulance.

- Staff should update the falls diary in the white file.

- If the fall occurs out of hours (between 10pm – 7.15am) staff should contact overnight Coordinator to seek advice.

- The Resource Planner / Coordinator should contact the next of kin and inform them of their relative's fall. Record this conversation on Liquid Logic.

- The member of staff to use any equipment as per training (as appropriate)

- The member of staff should report back to the Resource Planner/Coordinator once they have assisted the person safely onto a chair as per training and made them comfortable or the ambulance has attended and made their medical assessment.

- Staff to return to base to complete appropriate accident / incident documentation and staff statement.

- Accident/Incident form to be sent to relevant Manager via email as per process along with staff statement as soon as possible following the incident.

- Coordinator to update risk assessment on Liquid Logic and falls management plan in the white file.

Appendix 7: Falls RCA Data Gathering Tool

Falls Root Cause Analysis (RCA) Data Gathering Tool
(For Grade 4 and 5 incidents)

1. The questions are designed to assist in the collection of information required in order to complete the RCA.

2. The tool does not replace the requirement to implement a High-Level Investigation and should be appended to the HLI document for information.

3. Complete this as soon as possible after the incident

Service User's Name:

Service User's DOB:

Person completing form:

Date of Admission:

Reason for Admission

Ulysses Number:

Severity:

Actual effect on Patient:

Section 1: RISK ASSESSMENT

Aspect of Care	Delete as Appropriate	Details
Did the service user have any of the following:		
Any history of falls?	Yes/No	
Has the service user had a previous fall during this admission?	Yes/No	
Did the service user try to walk alone, but was unsteady/ unsafe?	Yes/No	
Significant problems with sight/balance?	Yes/No	
Any history of Delirium or Dementia?	Yes/No	
Recently prescribed sedatives/hypnotics?	Yes/No	

Incontinent or frequency affecting safety?	Yes/No	
Did the initial assessment identify the need for the use of aids (Walking Aids, Glasses, Bed Rails, Hearing Aid any other equipment)?	Yes/No	
If yes to the above please state what the aid was.		
Were all aids necessary in place and being used at the time of the fall?	Yes/No	
Were there any environmental factors contributing to the fall?	Yes/No	
If yes please describe what these were.		
Was the service user wearing appropriate footwear?	Yes/No	
Were there any issues with continence or hydration of the service user?	Yes/No	
Was lying and standing BP done on admission and post fall? (where applicable)	Yes/No	
Was the medication reviewed pre and post fall?	Yes/No	
Section 2: Service User Management		
Was the service user screened for falls risk on admission?	Yes/No	
If assessed as at risk was the Falls Management Plan completed	Yes/No	
Was this dated and signed by the assessing member of staff?	Yes/No	
Was the care plan updated with the interventions required to reduce the risk of falls?	Yes/No	
Was a mobility assessment done on admission?	Yes/No	
If, yes, does the service user have a		

mobility care plan?		
Was a mobility assessment repeated after the fall?	Yes/No	
Has the staff taken any action to reduce risk of falls?	Yes/No	
What measures have been taken to reduce incidence of fall (i.e. equipment, bed rails)?	Yes/No	
Was call bell, drink, glasses within easy reach?	Yes/No	
Was the service user easily observable by staff?	Yes/No	
Where was the service user located in their room?	Yes/No	
Had the service user required sedation prior to the fall?	Yes/No	
Was a further assessment completed post fall?	Yes/No	
Remedial action plan in place post fall?	Yes/No	
Was the action plan adhered to?	Yes/No	
On reflection was the original falls risk assessment correct?	Yes/No	
Is care and documentation in line with Policies	Yes/No	
Section 3: Practice Environment		
Aspects of Care		
Was the care setting staffed to required levels?	Yes/No	
Is the environment clean and free from clutter?	Yes/No	
Section 4: Interventions Post Fall		
How was the service user moved off	Describe	

the floor		
Was a medical professional informed	Yes/No	
Date and time seen by medical professional		
Date and time relatives informed		
Was a medication review completed post fall	Yes/No	
All risk assessment documentation provided details of ward, patient name, date of birth, hospital number and date?	Yes/No	
Could anything different have been done to prevent the fall occurring?	Yes/No	

Appendix 8: Environmental Risk Assessment

Date:
Assessor:
Designation:

	Yes/ No	If no, record action to be taken, if practical	Date of action completed
OUTSIDE AREAS			
Steps with rail and edge markings			
Resident able to open doors (if appropriate)			
Entrance clear of obstacles			
Firm surfaces on garden walkways			
Paving in good repair			
Adequate lighting			
		GENERAL AREAS	
Good natural or fluorescent lighting. Reduce shadows causing uneven lighting			
Flooring – Non-slip floor covering. Carpet same colour, not patterned or multiple changes. Secure and well maintained. Flat floor.			
Contrasting colours in furniture and rails so easier to see			
Ensure walkways are clear of obstacles and trailing wires			
Ensure chairs have arms supports and are correct height for residents			
		STAIRS	
Easy grip rails on both sides			
Adequate lighting			
		BATHROOM(S)	
Non-slip floors			
Non-slip mat for bath and shower/ next to bath or shower			
Grab rails at bath and toilet			
Specialised			

equipment as required e.g. Bath hoist or seat, shower chair, commode, raised toilet seats			

Appendix 9: Falls Management Audit

The Falls Audit tool can be found at the link below:

http://teamsites.bolton.gov.uk/sites/cs/PPR/Quality%20Assurance%20and%20Improvement%20Team/Falls%20Governance%20Group/Falls%20Audit%20Tool%20V3.xlsx

Falls Champions/Managers will conduct an audit of six case files bi-monthly and report the findings to the Quality Governance Board through their individual Quality Accounts.