Reference Number: Version Number: 3	**Date of Next Review:** 13 Sep 2019 **Previous Trust/LHB Reference Number:** T 395

Falls: Policy and Procedure for the Prevention and Management of Adult In-patient Falls

Policy Statement

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

Policy Commitment

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

Supporting Procedures and Written Control Documents

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

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

Other supporting documents are:

Mental Capacity Act 2005 Code of Practice

Assessing and Prescribing Levels of Special Nursing Observations

Restraint in the Care Management of Adults with Impaired Mental Capacity policy

Bedrails Procedure

Incident, Hazard and Near Miss Reporting Policy

NICE CG 161

Welsh Health Circular (2016) 002

Scope

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

Distribution

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

Review

This policy and procedure will be reviewed by the falls steering group every three years or sooner if appropriate.

Equality Impact Assessment	An Equality Impact Assessment (EqIA) has been completed and this found there to be no impact. *Note: if an EqIA has not been completed indicate why*

Health Impact Assessment	This was not considered necessary at the time of writing, but will be completed when the policy is reviewed as part of the new UHB process that combines the Equality and Health Impact Assessments
Policy Approved by	Quality Safety and Experience Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Falls steering group
Accountable Executive or Clinical Board Director	Executive Director for Therapies and Health Science

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	10/05/2011	13/06/2011	New Document
UHB 2	Jan 2012	09/03/2012 15/08/2012 26/09/2012 30/11/2012	Updated Appendices Appendix 23 added 15/08/12 Appendix 11 updated to UHB policy Appendix 9 updated to v 5.1
UHB 2.1	Aug 2014	19/08/2014	Updated Appendices: Appendices 1,2, 3, 4, 7, 8, 15a, 15b, 21, 22, & 23 New Appendices: Appendix 24 - Familiarisation with flat-lifting and use of Hoverjack
UHB 2.2	Jan 2015	23/01/2015	Update Appendix 5
UHB 3	13/09/2016	26/10/2016	New policy and procedure- This is a New Policy which has been added to the existing Procedure using the same UHB Number New appendices Appendix 16 Amended Frop-Com Form 2.doc Appendix 17 L&S BP Procedure Poster

			Appendix 18 L&S Procedure Reference Cards Appendix 19 Basic Bedside Vision Assessment Appendix 20 Delirium Screen the 4A's

Adult In-patient Falls Procedure

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1 Introduction

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

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

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

2 Responsibilities

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

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

Clinical Board Quality and Safety Leads are responsible for ensuring:

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

Directorate/Locality Management Teams are responsible for:

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

Lead Nurses / Senior Nurses are responsible for:

- ensuring that the policy and procedure is monitored and that any associated governance issues are highlighted through an appropriate route and corrective actions taken
- ensuring falls compliance tools audit is completed on a regular basis determined by to Clinical Board Quality Safety and experience meetings and reported to the adult In-patient Falls Steering Group

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

- The clinical environments are safe and environmental risk assessments are undertaken on an annual basis
- All frontline care staff are trained in falls Multi Factorial Assessment (MFA) and Multi Factorial Interventions (MFI) to an appropriate level for the services they provide
- Information including a leaflet is available for staff to provide to patients, attorneys, deputies, relatives and carers, as appropriate

- A post falls debriefing is held and a multidisciplinary post falls discussion takes place following any fall

The multidisciplinary team and/or individual registered healthcare professionals must:

- take decisions about reducing harm from falls in the same way as decisions about other aspects of treatment and care, as outlined in the UHB Consent to Examination or Treatment Policy 2016
- where the patient lacks mental capacity to make the decision and in the absence of an attorney (LPA) or Court appointed deputy with the appropriate authority , decide which Multi-Factorial interventions are in the patient's best interests

Workforce and Organisational Development Directorate is:

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

Estates is:

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

Directorates and Clinical Boards are responsible for:

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

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

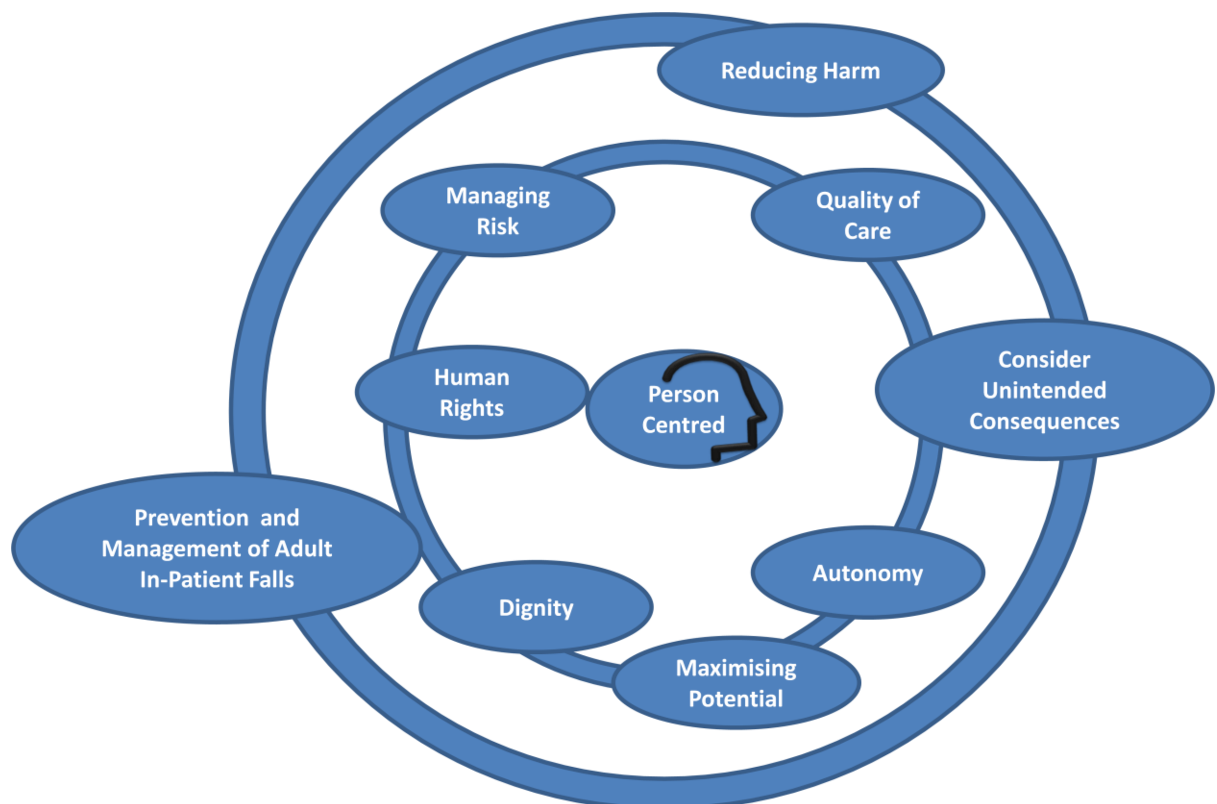
The Quality Safety and Experience Committee is responsible for monitoring, reviewing and, where necessary, approving amendments to this policy and procedure.

3 Abbreviations

MDT	Multi-Disciplinary Team
MFA	Multi-Factorial Assessment
MFI	Multi-Factorial Interventions

4 Underpinning key principles

The underpinning key principles are illustrated below:



Risks are to be modified where possible, promoting safety and quality and complying with national requirements. The procedure accompanies the flow-chart 'Falls prevention for all adult in-patients'

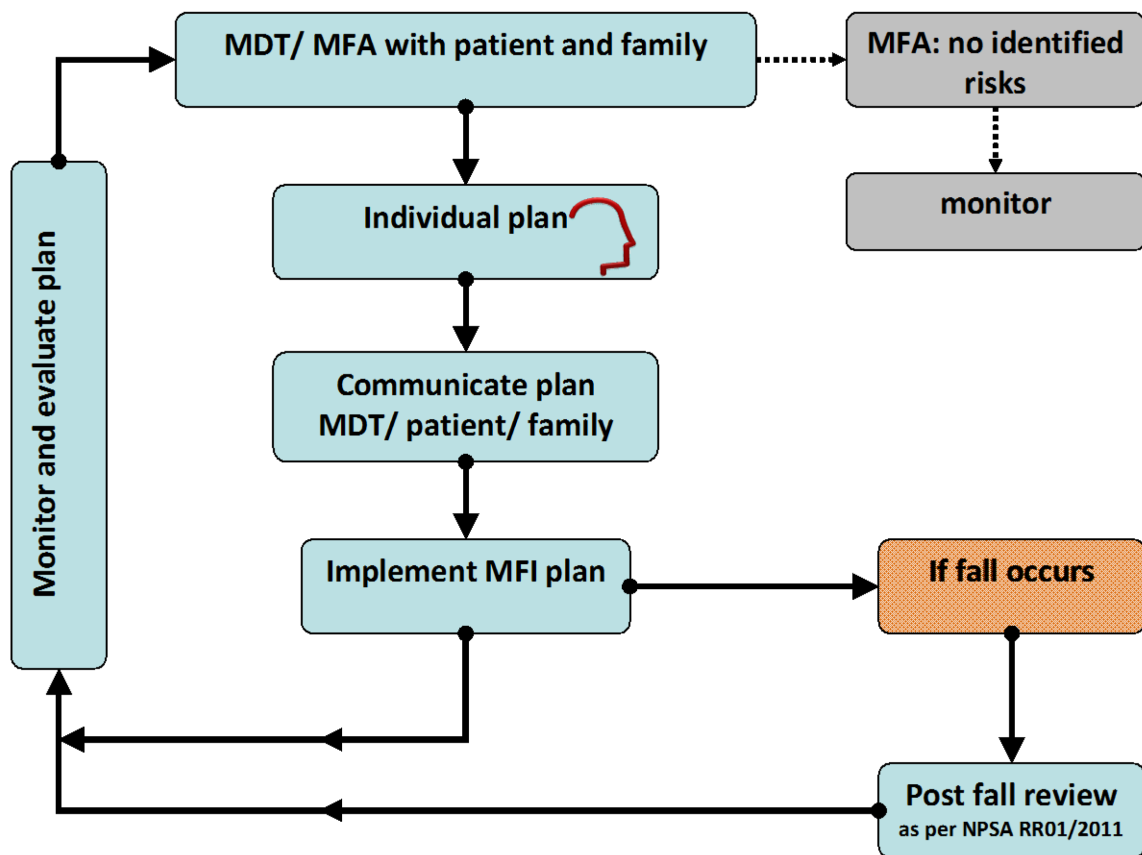
The MFA must be completed in conjunction with the MFI care plan.

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

- Implementation of standard falls prevention strategies for all adult in-patients
- Patient information "Reducing Patient "Falls should be available to all adult in-patients, family, carers, etc
- Undertake MFA of the potential factors that could cause a fall
- Implement an MFI care plan
- Undertake a post-falls assessment for all patients who fall on the ward

5 Framework for assessment

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



6 Standard Guidance for falls prevention actions and Interventions for all adult In-patients

Standard Guidance

The NICE Clinical Guideline[1] provided new recommendations for falls prevention and includes standard guidance to be given to all adult in-patients. These are incorporated into the MFA as mandatory actions.

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

Standard guidance: applicable to all adult in-patients

Call bell

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

Advise on safe transfer/mobility

- promote consistent messages.

Advise on safe footwear

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

[1] NICE (2013) Clinical Guideline 161

Information leaflet

- Make the reducing harm from falls information leaflet available to the patient and their family.

Patient is anticoagulated or at risk of bleeding

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

Environment and or equipment

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

Post anaesthetic/procedure

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

Falls History

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

Trolley/ Bedrail Assessment

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

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

7 Multi-Factorial Assessment and Multi-Factorial actions and Intervention

A MFA and MFI care plan is required for all patients aged 65 years and over and patients who are judged to be higher risk of falling because of an underlying condition[2].

Additional elements of the Multi-Factorial Assessment to reduce harm from adult in-patient falls
Recent falls history • Fall in hospital • Fallen since last assessment   ○ If yes and on anticoagulants liaise with doctor
Bone health/ fracture history • Low trauma/ fragility fracture • Osteoporosis/ lives in care home
Underlying medical conditions • Physical/ physiological review (including Lying /Standing BP) • Prescribed medication

[2] NICE Clinical Guideline 16, 2013

Cognitive/ mental state

- Delirium screen ≥ 65 years old (e.g. 4-AT)
- Cognitive assessment – (e.g. Abbreviated Mental Test)

Mobility needs

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

Sensory impairment

- Vision and or hearing
- Numbness, weakness or spatial or perceptual problems

Essential care issues

- Continence
- Nutrition, hydration
- Communication

Promote MDT falls review

8 Additional targeted interventions

Targeted interventions.

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

Chairs

- As chairs are provided in different styles and heights, each patient will require an

individual assessment to ensure the chair is appropriate to meet their needs

Ultra Low Beds

- Consider for those patients that have fallen from the bed and are at risk of further falls from the bed
- Indicated for patients who are at risk of climbing over or around bedrails
- May be required to assist with safe transfers if the patient is of a petite stature
    - If an ultra low bed is considered necessary, in the first instance scope availability of ultra low beds within the ward
    - If there is no available ultra low bed in the ward order from the bed supplier (medstrom 0844 811 3676)
        - If none are available, discuss with the Senior Nurse or, if Out of Hours, the Site practitioner
        - Document in clinical notes
        - Report unavailability of bed on the eDatix incident reporting system

Safe Use of Bedrails

- Undertake assessment of use as per UHB bedrails procedure and document decisions using the bedrails record and decision aid

Floor safety mat

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

Assisted Technology Solutions

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

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

9 Ongoing Multi-Factorial Assessment, actions and Interventions

Ongoing Multi-Factorial Assessment, actions and Interventions

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

Occasional additional equipment use

- Hip protectors: evidence base is unclear
  - Assess tolerability and patient acceptance as many patients do not manage them well. If used supply a minimum of 3 pairs to facilitate laundering and continued availability

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

Patient and family perspective

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

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

10 Consider Unintended Consequences

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

For example, with advancing age, it becomes increasingly likely that even a brief, clinically mandated period of rest could cause a serious decline in muscle strength and functional capacity, i.e., a "tipping point" from which some may not fully recover (*English & Paddon-Jones, 2010*). Therefore, maintaining a level of mobility or physical activity for people who fall or are at risk of falls is a fundamental level of care that must be actively considered by the multidisiciplinary team and can be enhanced by specific physiotherapy exercises.

11 Assessment and Immediate actions following an adult in-patient fall

This procedure is to be adhered to following an adult in-patient fall, ensuring that safe and quality care is given to a patient and to comply with national requirements [3]. The procedure accompanies the flow-chart **'Immediate actions following adult in patient fall** which gives a sequential approach to the screening and assessment for suspected:

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

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

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

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[3] NPSA Rapid Response Report 001

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

Assess the scene (make safe if necessary) and mechanisms of injury; quickly establish what happened if possible. Follow instructions in Box 1:

Box 1

Question 1

Did the fall or incident history involve?

- Altered or loss of consciousness?
- Obvious injuries to head/face/neck including minor abrasions?
- Fall over bedrails?
- An un-witnessed fall?
- A fall from a trolley?
- Fall/jump from a height?
- Fall down stairs?

Remember! Any of the above increases the risk of a spinal injury, head injury and fracture

If answer to question 1 is **yes**

Refer to Box 2- possible/actual spinal injury

- Refer to Box 3 -potential head injury

  If the mechanism of the fall (Table 1), including unwitnessed falls, and/or patient response indicates a possible head injury or where a head injury cannot be excluded commence neurological observations (box 3)

  If there is a suspicion that the patient also has a spinal injury, treat with caution and await a medical assessment

- Do not move the patient. Commence primary survey of Airway; Breathing; Circulation; Disability (alert, voice, pain, unresponsive) and Exposure and Examination assessment; NEWS score
- Provide emergency care as necessary
- Clinical judgment must be made about moving the patient to assess or treat, for example, if bleeding heavily or requiring resuscitation
- Be aware of distracting injuries**,** e.g. a fractured tibia may present as more painful than a spinal injury**.**
- If NEWS score has deteriorated to $\geq$ 9 or peri arrest, call resuscitation team: 2222. For off-site areas (not UHW or UHL) dial 999. Commence resuscitation UNLESS there are specific recorded instructions to the contrary
- Continue to avoid unnecessary patient movement. Instruct the patient to keep still and for all patients who have had a fall follow the instructions in Box 2

Box 2

Ask the following questions to screen for a possible/actual spinal injury:

Question 1

- Do you have any new or increased pain or tenderness in midline back, neck, buttocks or lower back (lumbar region)?

Question 2

- Are you unable to move fingers and toes?

Question 3

- Do you feel any new pins and needles or tingling in any part of your body?

Question 4

- Do you have any new loss of sensation?

Question 5

- Do you have any electric shock type sensation or burning sensation in trunk or limbs?

Remember! Do not move but clinical judgement must be made regarding patient movement in life threatening situations

If yes to any of the above questions (Box 2), continue to avoid unnecessary patient movement and escalate (follow the instructions in Box 4).

If no to the above questions and spinal injury is not suspected, then check for head injury and other injury (follow the instructions in Box 3).

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

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

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

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

Potential head injury

Box 3

If head injury cannot be excluded:

Commence neurological observations and a full set of vital signs

Alert doctor if patient is receiving heparin, warfarin or other anti-coagulant, platelets or with a known clotting disorder

Repeat neurological observations every 30 minutes for 2 hours

then

If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or

vomiting: follow with neurological observations for every 1 hour for a further 4 hours

then

If GCS equal to 15 (or previous best) with no new deficit, no new amnesia or vomiting: follow with neurological observations every 2 hours thereafter/ seek medical review. As long as the patient has remained stable cessation of standard neurological observations at 12 hours is considered reasonable (medical staff may sometimes authorise cessation sooner than this)

or

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

Escalation procedures

Box 4

The escalation procedure is informed by NEWS and SBAR

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

12 Triple immobilisation

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

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

Box 5

Information to familiarise and raise awareness for ward staff of safe retrieval procedures is found in the appendicies xxx

Triple immobilising, log-rolling and flat-lifting using

Hoverjack and scoop for suspected spinal injuries

Safe retrieval for suspected lower limb fracture, including neck of femur using Hoverjack

Hoverjack Quick Guide

A pictorial PowerPoint presentation is also available that demonstrates the above procedures

13 Urgent Escalation to Doctor

Is necessary for any deterioration in consciousness or if serious injury is

suspected e.g. patient unconscious, skull fracture, clear fluid running from ears and or nose, bleeding from ears, new deafness, bruising behind one or more ears, or black eye with no associated trauma around the eye.

- Medical assessment must consider need/no need for CT scan
- "For patients who have sustained a head injury with no other indications for a CT head scan and who are having warfarin treatment, perform a CT head scan within 8 hours of the injury" NICE CG 176

Remember! There can be a potential delay in onset of symptoms. In older patients, this can be > 72 hours

14 Screen for a possible or actual fracture

Though a fall from a height is more likely to result in a fracture; all patients must be screened due to the risk of osteoporosis. Follow the instructions in Box 6.

If following careful assessment of patient, there is no obvious injury or minor injury only, follow the instructions in Box 7 and treat appropriately**.**

Box 6

To screen for a possible or actual fracture, identify if the patient has any:

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

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

If the answer is yes to any of the above, keep affected limb immobilised and escalate to doctor. For safe retrieval of a patient with a fractured neck of femur, the use of a Hoverjack is the preferred method for patient comfort and dignity. Where this is unavailable, continue to use the hoist or other lifting equipment. Maintain observations of the patient as a fracture may not be obvious for several hours or even days.

Box 7

For no obvious injury or minor injury only:

- Where appropriate treat minor injuries
- Record observations, including temperature, pulse, respiration rate, blood pressure, oxygen saturation and if patient has diabetes check blood

glucose level

- Use clinical judgement as to when to discuss with doctor, for example a minor skin tear would not require urgent medical attention

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

15 Reporting and record keeping

Any incidents, accidents, or situations where an adult in patient falls MUST be reported using e-Datix – please see the Incident, Hazard and Near Miss Reporting Policy.

Additionally:

- Complete the post falls action log within the generic assessment booklet
- Document in the patients clinical notes
- Reassess multifactorial assessment and modify (if appropriate) multifactorial interventions
- If appropriate, and with the patient's consent or in patient's best interests, notify designated family member
- For injurious falls, commence completion of the 'Significant Injury following fall investigation'
- Consideration must be given to a need for a full root cause analysis investigation
- Communicate falls history at patient safety briefing / board or ward round as appropriate
- Communicate falls history to any receiving care environment including GP if returning home

16 Resources

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

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

17 Training

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

18 Implementation

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

19 Equality

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

20 Audit

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

21 Distribution

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

22 Review

This procedure will be reviewed by the falls steering group every three years or sooner if appropriate.

23 Appendices

Appendix 1	Flow Chart A3 Prevention
Appendix 2	MFA MFI Tool
Appendix 3	reducing harm from falls Information leaflet doc
Appendix 4	AU Falls Assessment
Appendix 5	Use of Bedrails Decision Aid
Appendix 6	Flow Chart May 2016 Immediate Actions

Appendix 7	Neurological Observation Chart A3 Spreads Layout
Appendix 8	Hoverjack Quick Guide
Appendix 9	Flat lifting procedure for suspected lower limb fracture, including fractured neck of femur.docx
Appendix 10	Familiarisation with Flat Lifting and use of Hoverjack
Appendix 11	Triple Immobilising Document
Appendix 12	Low Trauma Fractures and Osteoporosis Doc
Appendix 13	Second Stage I&S Procedure
Appendix 14	NPSA Guidance on Post Falls Incident Reports
Appendix 15	FInal Injurious Investigation Tool Sept 2015
Appendix 16	Amended Frop-Com Form 2.doc
Appendix 17	L&S BP Procedure Poster
Appendix 18	L&S Procedure Reference Cards
Appendix 19	Basic Bedside Vision Assessment
Appendix 20	Delirium Screen the 4A's
Appendix 21	Ward Compliance Audit Tool