Policy:

MD 007 Nursing Homes Falls Policy

(formerly called MD 007 Falls Residential Areas Only Policy)

Executive Director Lead	Executive medical director
Policy Owner	Falls lead
Policy Author	Falls lead

Document Type	Policy
Document Version Number	2.1
Date of Approval By PGG	20/12/2021
Date of Ratification	12/01/2022
Ratified By	QAC
Date of Issue	January 2022
Date for Review	June 2025 extended December 2024 at PGG

Summary of policy

This policy provides an overview on the assessment and management of falls risk factors for residents admitted to SHSC nursing homes. The policy also covers the clinical assessment and management of a resident post-fall.

Target audience	All nursing home staff

Keywords	Falls, falls risk

Storage & Version Control

Version 2.1 of this policy is stored and available through the SHSC intranet/internet. Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
2.1	Replacement of existing policy	12/2021	Previous falls policy covering inpatient wards and residential care homes
0.1	New draft policy created	07/01/20	New policy created in response to CQC findings
1.0	Approval and issue	02/2019	Amendments made during consultation, prior to ratification.

Contents

1 Introduction

Falls are extremely common in adults with learning disabilities and older adults living in care homes. Figures for those with a learning disability estimate that 25-40% fall at least once a year. Figures for older adults estimate that 35% of people aged over 65 years, and 45% aged 80 years or older, fall each year. Risk of falling is increased if living in a long-term care facility; it has been established that the risk is three times higher for older adults. 60% of people living in care homes experience recurrent falls.

Falling has significant and devastating impact on quality of life due detrimental changes to physical health and psychological needs (NICE 2013). Physical and psychological harm post fall are associated with increased rates of morbidity and mortality. Serious fall-related injuries include hip fracture, limb fracture, spinal injury and head injury. 25% of all falls occurring in long-term care facilities cause a facture, laceration or need for hospital care (NCHR&D 2006). It is estimated that 14,000 people die annually in the UK because of an osteoporotic hip fracture (National Service Framework for Older People 2001); people with a learning disability are at greater risk of sustaining such a fracture. A fall is the leading cause of mortality in those aged over 75 years of age.

Psychological harm sustained secondary to a fall includes a fear of falling and reduced confidence, which negatively impact upon mental state and lead to reduced mobility, increased isolation and increased dependence on others (NICE 2013).

The cause of a fall is often multifactorial in nature. Understanding an individual's risk factors for falling can lead to an individualised management plan that aims to reduce the chance of someone falling and reduce the number of falls.

Appropriate management of a resident following a fall is essential to improve the chances of recovery and reduce further injury. A standardised approach to falls management must be in place.

From an organisation level, appropriate staff training regarding falls management needs to be in place. Appropriate falls data governance is required to identify any gaps or trends in practice in relation to the occurrence and outcomes following a fall. Such data could identify gaps in training needs. Falls management must be transparent and therefore this data must be presented to residents and/or their relatives. Falls governance supports lesson learning from serious incidents and should ensure that current policy is up to date.

In summary, falls management involves the need for healthcare professionals to have knowledge and understanding to be falls aware, to have the skills to assess for and address fall risk factors, as well as having the competences to act when someone has fallen.

Strategy approach

The overall aims of the falls strategy are to

1) Improve falls management within nursing home settings
2) Reduce the incidence of falls within nursing home settings
3) Improve resident outcomes following a fall

The strategy for falls management within the trust is divided into four domains, which are referred to as the '4As of Falls'. See Figure 1. The 4As approach provides a means for staff within the trust to:

- Be ***aware*** of falls – through mandatory training and governance
- ***Assess*** for falls – through provision of an individual assessment to identify falls risk factors

- ***Address*** risk factors for falls – through preventative measures taken to reduce the risk of falling (and sustaining injury)
- ***Act*** when someone has fallen – through management protocols to ensure correct procedures are followed.

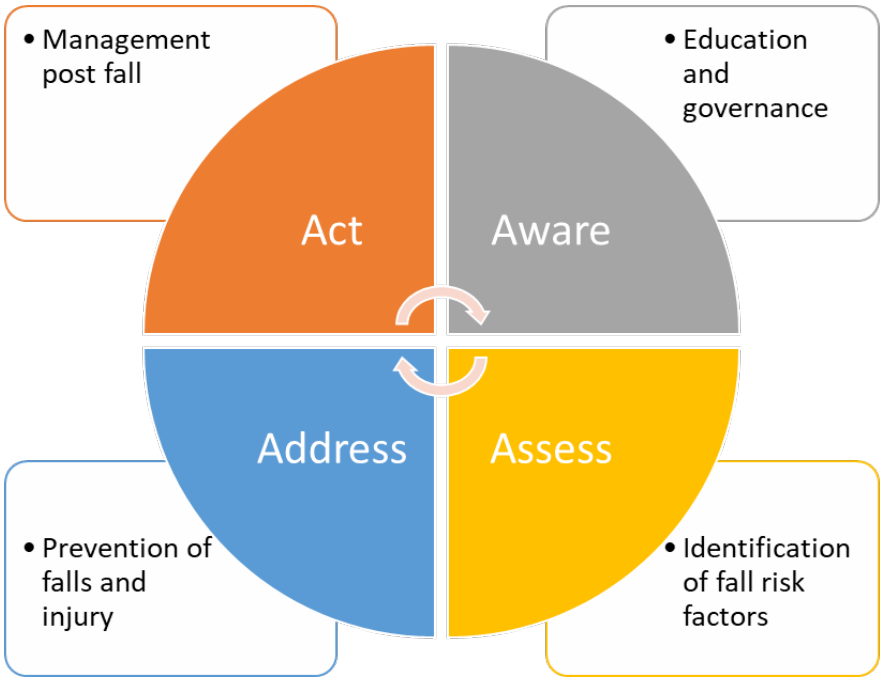

Figure 1: 'The 4As of Falls'

2 Scope

This policy addresses the assessment, prevention and management of falls within SHSC nursing homes; Woodland View and Birch Avenue.
This policy is relevant to all residents who are:

- Aged 65 years or older
- Any age with a history of previous falling
- Judged to be a higher risk of falling because of an underlying mobility problem or condition(s)

This policy applies to all healthcare professionals within the trust – substantive, bank and agency – who are responsible for planning and delivering direct patient care at Woodland View and Birch Avenue. The policy is applicable to all nursing and care staff.

The policy is based partly upon the following guideline and quality standards which have been adapted for use with nursing homes:

- National Institute of Care Excellence (NICE) (2013). Falls in older people: assessing risk and prevention. Clinical guideline 161.
- National Institute of Care Excellence (NICE) (2015). Falls in older people. Quality standard 86 (QS86).

The policy differs from the falls management policy in use within SHSC inpatient wards as the trust is not responsible for providing direct medical input.

3 Purpose

The purpose of this policy is to:

- Raise awareness amongst all staff members for the need for falls assessment, prevention and management.
- Reduce the risk of falling by means of falls risk assessment and implementation of appropriate interventions for falls prevention.
- Ensure a standardisation of assessment post fall to reduce the risk of injury.

4 Definitions

Fall – is an event which results in an individual coming to rest unintentionally on the ground or other lower surface, whether or not an injury is sustained.

Slip – is a slide accidentally causing the individual to lose their balance; this is either corrected or causes the individual to fall.

Trip – is to stumble accidentally, often over an obstacle, causing the individual to lose their balance; this is either corrected or causes the individual to fall.

Hazard – can be defined as any source of potential damage, harm or adverse health effects.

Risk – can be defined as the chance or possibility that an individual will be harmed or experience an adverse health effect if exposed to a hazard.

5 Duties

Trust Board – The Trust Board has ultimate responsibility for managing the implementation of health and safety within the trust.

Executive Directors Group – The Executive Directors Group is responsible for the ratification of this policy and ensuring it is implemented by all clinical corporate staff

6 Procedure

As described above, the inpatient falls strategy is divided into four domains; aware, assess, address and act.

6.1. *Fall Aware – Increasing trust, staff, resident and relative awareness of falls through education and governance*

Staff level awareness
All healthcare professionals who have contact with residents should develop and maintain basic professional competence in falls assessment and prevention. Such competence will be achieved by three-yearly mandatory training:

- All nursing and support staff will complete the e-learning package 'Preventing falls in hospital'

This e-learning package is accessible by ESR.

Nursing staff should be competent in measuring lying and standing blood pressure. Such staff members should be familiar with the Royal College of Physicians guidance on measuring lying and standing blood pressure see https://www.rcplondon.ac.uk/projects/outputs/measurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff

All staff should be aware to report all fall incidents using Ulysses. Staff should have awareness of the level of detail required for such reporting.

Trust level awareness
Root cause investigations will take place for all serious falls so that lessons can be learnt to prevent similar incidents.

The 'Falls Prevention Group' will be responsible for falls governance, training and development. Such work will include meaningful review, analysis and feedback of fall incident reports.

Resident and/or carer level awareness
Individual residents who are at risk of falling, and their relatives, should be offered information orally and in writing about falls. This will be achieved by:

1) Residents named nurse to speak to resident (if they have capacity), and/or carer, about falls risk and management and to document this conversation in the residents medical notes.

2) Residents individualised falls risk assessment and management plan being documented in their Collaborative Care Plan and a copy to be offered to the resident and/or carer.

6.2 *Assess – Assessment of individual falls risk*

Fall risk prediction (screening) tools are not recommended for use by NICE.

Required documentation

All residents admitted to a trust care home will have a 'Nursing home falls risk assessment and management plan' document completed regardless of age. See Appendix 4. This should be completed at the earliest opportunity, ideally within a 72hr timeframe following admission.

The falls risk assessment and management plan will be a 'live' documented and updated as necessary. It will require updating following a resident falling and require updating if any falls risk factors change.

Medical assessment

It is the responsibility of the GP to assess for physical health causes of falls risk. It is also their responsibility to assess for osteoporosis and fracture risk for individuals aged 50 years or older.

At Woodland View and Birch Avenue nursing homes a GP visits weekly and residents are reviewed as required. All residents have an annual review.

The GP should be made aware of any physical health issues highlighted by the 'Nursing home falls risk assessment and management plan'. Such issues concern blood pressure, heart rate, positive urine dip result, diarrhoea, constipation and adequate pain control.

Nutritional assessment

Nutritional deficiencies should be identified as these can contribute to impaired balance and strength. All residents should be weighed on admission and a BMI calculated. It should be established if the patient has recently lost weight.

Nutritional assessments are ongoing and weight is measured weekly.

Environmental factors

All environmental areas should be regularly checked for environmental risks for falls by all staff members. Any identified concerns should be addressed and/or reported to estates immediately. All staff should refer to the Slips, Trips and Falls policy.

Overview

Residents who are most at risk of falling should be easily identifiable by all staff members on shift.

6.3. *Address – Prevention of falls through addressing identified risks*

Walking aids

Nursing or support staff should label walking aids so that the resident does not use an aid that is not theirs.

Footwear

If nursing staff have identified a resident as having inappropriate footwear on admission the need for a safer replacement must be addressed immediately. If appropriate footwear cannot be provided by a carer/relative, anti-slip socks should be provided to the resident.
The condition of a resident's feet should also be assessed. If there are concerns regarding toe nails and if they require cutting the resident should be referred to podiatry.

Postural hypotension
Nursing staff should advice all residents who have been identified as having postural hypotension to slowly rise from sitting in a chair or getting out of bed.

Medical management
The residents GP should be notified if the following are identified; postural hypotension, bradycardia or tachycardia.

Management of visual impairment
If there are concerns about visual impairment the resident should be referred for an eye test. Nursing staff should liaise with a relative/carer to arrange this. Opticians can do home visits but this will be at a cost of the resident.

Medical devises to manage falls risk
Hip protectors should not be routinely offered to all patients. Hip protectors should be offered to residents who are considered at high risk of falling following discussion with the resident and/or their relatives. It should be documented in the residents notes (electronic paper record or paper notes depending on care home) and on their Care Plan if they have been offered hip protectors and if they refuse to wear them.

If a resident is deemed at high risk of falling use of a bed and/or chair alarm should be considered by the nurse on admission. The role of a bed alarm is to alert nursing staff when a resident is mobilising so that assistance can be provided. A bed/chair alarm does not prevent falling alone.

If a resident requires a bed and/or chair alarm nursing staff should bear in mind how far the residents bedroom is from the nursing office; the further the distance, the longer the time it will take for nursing staff to respond and so the higher risk of a resident falling on mobilising from their bed and/or chair.

If a resident is not compliant with assistive technology this should be documented in the notes and removal considered.

All staff members should bear in mind that a residents level of risk in terms of falls may not remain static and therefore their falls management plan may change.

7.4 Act – Acting when a fall has occurred
A resident's chances of making a full recovery when a fall has occurred are dependent upon safe manual handling and prompt assessment and treatment.
If a resident is falling staff should not attempt to catch them as this can result in both injury to the resident and staff member. If safe to do so, the staff member should assist the resident downwards and safely to the floor.

Initial actions post fall
If a resident falls the Post Falls Protocol should be followed. See Appendix 5. This protocol should be easily accessible to all staff members, e.g. laminated and placed in the nursing office.

Initial focus post fall is rapidly identifying and treating any resultant injury. Physical observations (use of NEWS2) and assessment for injury should be performed immediately post fall.

Assessment post fall should include enquiries for comfort and pain.

All residents who have fallen should be checked for signs or symptoms of a hip fracture, spinal injury and head injury. See Table 3.

Spinal injury	Hip fracture
Unnatural posture/position Pain in neck or back Step/twist in curve of spine Pale, cool, clammy skin Slow pulse Difficulty breathing Loss of bladder/ bowel control Loss of feeling &/or movement	Pain Limb shortening & rotation Difficulty mobilising Difficulty weight bearing
Head injury	
Unconsciousness/lack of full consciousness	
Problems understanding, speaking, reading or writing	
Loss of feeling in part of the body	
Problems balancing or walking	
General weakness	
Any changes in eyesight	
Any clear fluid running from ears or nose	
A black eye with no obvious damage around the eye	
Bleeding from one or both ears	
New deafness in one or both ears	
Bruising behind one or both ears	
Amy evidence of scalp or skull damage	
Seizure	

Table 3: Signs and symptoms suggestive of injury post fall

Neurological observations should be performed if the resident

- Has been observed to hit their head on falling.
- Reports hitting their head if they have fallen.
- Has been observed to fall and it is unclear if they have hit their head.
- Has been found on the floor.

If a fall has not been witnessed, e.g., the resident was found on the floor, or the resident cannot recall events, it should be presumed that they have hit their head and so possibly sustained a head injury.

Moving a resident with a potential spinal injury or suspected fracture before an injury has been appropriately immobilised can cause severe harm.

Any obvious environmental hazards which appear to have contributed to the fall should be made safe if possible.

If the resident is unable to stand themselves appropriate manual handling techniques and/or equipment (e.g., a hoist) should be used if it is safe to move the resident.

It is the responsibility of nursing staff to assess a resident post fall to establish if any injury sustained and to escalate if necessary. It is the responsibility of nursing staff to ensure that all residents are followed-up post fall to establish what caused the fall; this can be addressed by following escalation advice below or requesting the GP to review.

Escalation for help

If there is evidence or concern about a significant injury being sustained due to a fall, different routes of escalation are available dependent upon the severity of injury or concern.

Any signs and symptoms present from Table 3 would require a 2222 response and the request for an urgent ambulance.

Enhanced Care Practitioners (ECPs) are available in Sheffield. The service is available 7 days a week from 07:00 to 02:00. The ECP Desk can be contacted on 0300 330 0275.

ECPs cover the following:

- Falls with no apparent/significant injury and FAST -negative (i.e. no evidence of stroke).
- Minor head injury/wounds (not eyes/mouth), no on anticoagulants and no LOC
- Wound assessment, cleaning, and closure (unless numbness, weakness, significant bleeding, foreign body)
- Any suspected musculoskeletal sprain/strain injury
- COPD patients (SpO2 >92% on air) unless documented normal range for patient
- Abdominal problems or mild abdominal pain
- Suspected UTI and ENT problems (vertigo)
- Mild to moderate respiratory problems

Residents prescribed an anticoagulant medication should have a CT head performed if they have hit their head or if there is any suspicion that they may have hit their head. The attending paramedic or ECP is responsible for arranging this.

If the fall has been witnessed, there is no evidence of injury, the resident is not complaining of pain, the resident is not prescribed an anticoagulant and no other concerns it may not be necessary for a medical review to occur.

Further post fall actions

The resident's relative should be informed by the nurse in charge as soon as possible of the fall, actions taken to treat injury if applicable and actions to manage risk of further falls.

An incident report should be completed as soon as possible by nursing staff following a fall and should provide sufficient details for analysis and review purposes.

The residents risk assessment should be updated immediately following a fall.

A fall should trigger a review of the falls management plan.

Residents who deliberate place themselves on the floor or fall

Deliberate placement on the floor or deliberate falling can result in significant injury and post fall assessment must not differ from residents who non-deliberately fall. It should be borne in mind that such residents can experience non-deliberate falls as well.

Exploration of reasons why residents deliberately place themselves on the floor or fall should occur.

7 Development, Consultation and Approval

This section should include details of:

This policy was developed by the falls lead. The policy is based on relevant NICE guidelines. Elements of the policy were discussed in the falls prevention group.

This policy was reviewed by Policy Governance Group.

The policy will be reviewed in August 2022.

8 Audit, Monitoring and Review

Falls data will be reviewed monthly in the Falls Prevention Group. Quarterly reports of data will be provided to the Patient Safety Group.

Compliance with NICE standards, as encapsulated by this policy, will be audited on an annual basis.

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Provisional falls risk management plan will be in place on admission	Timely completion of nursing falls risk on admission assessment tool	Falls prevention group	Annual	Falls prevention group	Falls prevention group	Falls prevention group
Thorough nursing assessment of injury post fall	Review of electronic patient record/Completion of proforma	Falls prevention group	Annual	Falls prevention group	Falls prevention group	Falls prevention group

As this policy involves significant changes from the previous policy a review by the Falls Prevention Group will occur in July 2021. Routinely, however, this policy will be reviewed on a three-yearly basis or sooner in accordance with changes to NICE guidelines.

9 Implementation Plan

This policy was developed as part of the 'Back to Good' Programme and included as part of the Physical Health Project. More details of implementation are awaited from the Physical Health Project.

Action / Task	**Responsible Person**	**Deadline**	**Progress update**
Identified e-learning modules to be linked to mandatory training on ESR	Jennie Wilson		e-learning modules currently not available due to national issue
Nursing home falls risk assessment and management plan to be uploaded to Insight	IT	*ASAP*	

10 Dissemination, Storage and Archiving (Control)

This policy will be available to all staff via the trust intranet.

This policy replaces the policy titled ‘MD 007 Falls (inpatient and residential areas)’.

A communication email will be distributed notifying staff of the new inpatient falls policy and the main changes that this involves.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0				
2.1	January 2022	January 2022	January 2022	

11 Training and Other Resource Implications

All healthcare professionals who have contact with residents should develop and maintain basic professional competence in falls assessment and prevention. Such competence will be mandatory and will be provided at induction and three-yearly thereafter.

Mandatory training will be delivering by e-learning, which is accessible by ESR. All nursing and support staff will complete the e-learning package ‘Preventing falls in hospital’.

Nursing staff should be competent in measuring lying and standing blood pressure. Such staff members should be familiar with the Royal College of Physicians guidance on measuring lying and standing blood pressure.

All nursing home staff should be aware to report all fall incidents using the trust incident report system Ulysses.

12 Links to Other Policies, Standards (Associated Documents)

Health and Safety Policy
Incident Reporting Policy
Risk Management Strategy
Back Care and Manual Handling Policy

13 Contact Details

Title	*Name*	*Phone*	*Email*
Older adult inpatient lead	Dr Claire Pocklington	0114 2716659	Claire.Pocklington@shsc.nhs.uk

Appendix 1

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – **Relevance -** Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement. **I confirm that this policy does not impact on staff, patients or the public.**	***I confirm that this policy does not impact on staff, patients or the public.*** Name/Date: C Pocklington 10/12/21	**YES,** Go to **Stage 2**

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision -** Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age			
Disability			
Gender Reassignment			
Pregnancy and Maternity			

Race			
Religion or Belief			
Sex			
Sexual Orientation			
Marriage or Civil Partnership			

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Name /Date

Appendix 2

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	Y
2.	Is the local Policy Champion member sighted on the development/review of the policy?	N/A
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	Y
5.	Has the policy been discussed and agreed by the local governance groups?	Y
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	Y
	Template Compliance	
7.	Has the version control/storage section been updated?	Y
8.	Is the policy title clear and unambiguous?	Y
9.	Is the policy in Arial font 12?	Y
10.	Have page numbers been inserted?	Y
11.	Has the policy been quality checked for spelling errors, links, accuracy?	Y
	Policy Content	
12.	Is the purpose of the policy clear?	Y
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	Y
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	N
15.	Where appropriate, does the policy contain a list of definitions of terms used?	Y
16.	Does the policy include any references to other associated policies and key documents?	Y
17.	Has the EIA Form been completed (Appendix 1)?	Y
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	Y
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	Y
20.	Is there a plan to i. review ii. audit compliance with the document?	Y
21.	Is the review date identified, and is it appropriate and justifiable?	Y

Appendix 3 – Nursing home falls risk assessment and management plan

Nursing Home Falls Risk Assessment and Management Plan			
Name: **Insight if applicable:** **Date of admission:** **Nursing home:**		**Review date(s) if applicable:**	
Sources of information: Patient Y / N Relative/carer Y / N Previous medical documentation Y / N		Physical health assessment by GP Y / N	
History of falls (within past 2 years):			
Previously fallen?	Y / N	How many times? Date(s)/frequency: Time of falls:	
Cause identified?	Y / N	Cause:	
Circumstances of last fall:	Time: Activity at time: Where: Pattern: Other information:		
Any black outs/LOC before falling?	Y / N	Alert GP if 'yes'	
Any dizziness?	Y / N		
Past psychiatric and medical history:			
LIST			
FALLS PREVENTION ASSESSMENT			
Current presentation:			
State mental state and how might contribute to falls risk			
Current physical health issues:			
State			
Balance and gait:			
Unsteady on feet	Y / N	Consider referral to community physiotherapy services	
Problem with balance	Y / N		
Problem with muscle strength/ joint ROM	Y / N		
Abnormal gait	Y / N		
Difficulty standing	Y / N		
Slower reaction times	Y / N		
Fear of falling	Y / N		
Walking aid	Y / N	Type: Appropriate (size, not damaged) Y / N Requires removing due to safety Y / N	
Mobility impaired by pain	Y / N	Alert GP if yes	
Footwear:			
Appropriate footwear?	Y / N	Slip socks provided if no	Y / N
		Safe alternative provided from family	Y / N
Toenails ok?	Y / N	Refer to podiatry	Y / N
Cardiovascular:			
Assessment of postural hypotension:	Alert GP if: Dizzy/lightheaded on standing		

Lying BP reading - Standing BP reading - Pulse rate -		Legs 'give way' on standing Difference in lying and standing BP >20mg/Hg Pulse <60 or >90	
Cognitive impairment/confusion:			
Chaotic behaviour	Y / N		
Able to summon help post fall	Y / N		
Able to use nurse call bell	Y / N		
Vision:			
Visual impairment:	Y / N	Cause:	
Has glasses	Y / N	Will wear Y / N Action if broken:	
Date of last eye test:		Consider need for eye test	
Toileting:			
Urinary symptoms present	Y / N	Circle: urgency/ frequency/ dysuria/ nocturia	GP to review
Bowel symptoms present	Y / N	Circle: diarrhoea/ constipation/ having to strain	
Incontinent	Y / N	Type: Urinary/faecal/both Aids:	
Can locate toilet independently	Y / N		
Can use toilet independently	Y / N		
Medication:			
Prescribed sedative	Y / N	Ongoing need for such medications should be reviewed by GP Date of last medication review:	
Prescribed antihypertensive/anticoagulants/ anticholinergics	Y / N		
Prescribed medication that affects pulse	Y / N		
Prescribed other psychotropic medication	Y / N		
Polypharmacy (≥4 medications)	Y / N		
Adequate analgesia	Y / N		
Nutrition:			
BMI <22	Y / N	Consider referral to dietitian	
Nutritional concerns	Y / N		
Special dietary needs	Y / N		
Difficulty eating	Y / N	Consider SALT referral	
Concerns about fluid intake	Y / N		
Additional information:			

Summary off falls since admission: (add additional rows as required)	
Date	Details (circumstances of fall, cause, etc.)

FALLS RISK MANAGEMENT PLAN
Summary of main risks:

Goals of falls risk management plan:
To reduce number of falls that occur To reduce severity of injury sustained if a fall does occur
Actions taken to address risks:
State specific actions in response to identified risks above.
Equipment ordered/issued:
e.g. bed alarm, chair alarm, door sensors, etc.
Involvement of other services:
Y / N
If yes, state what:
Additional notes

Appendix 4 – Nursing post fall assessment form

Nursing Assessment Post Fall

Call for help
Check ABCDE
Ensure staff safety
Establish if in pain
Establish what happened
Look for injury/deformity
Calculate NEWS2 score

Call for ambulance (Tel: 2222) and start ILS if:
Unresponsive
Cardiorespiratory arrest
Periarrest

DO NOT MOVE PATIENT UNTIL FULLY ASSESSED BY THE APPROPRIATE PERSON

SUSPECTED HIP FRACTURE

Features:		Actions if Yes to any features:
Limb shortening & rotation	Y/N	Call ambulance (Tel:2222)
Difficulty mobilising/weight bearing	Y/N	Keep patient still
Pain around hip	Y/N	No food or drink to be given

SUSPECTED LIMB FRACTURE

Features:		Actions if Yes to any features:
Pain/tenderness at site	Y/N	Call ambulance (Tel:2222)
Deformity	Y/N	Keep patient still, stabilise limb
Difficulty mobilising/weight bearing	Y/N	Do not move unnecessarily
Deep wound/bone visible	Y/N	No food or drink to be given
Swelling/bruising	Y/N	

SUSPECTED SPINAL INJURY

Features:		Actions if Yes to any features:
Pain in neck/back	Y/N	Call ambulance (Tel:2222)
Unnatural posture/position	Y/N	Do not move patients position
Step/twist in curve of spine	Y/N	Keep patient still
Pale/cool/clammy skin	Y/N	No food or drink to be given
Slow pulse	Y/N	Hold their head still
Difficulty breathing	Y/N	Keep head in neck in line with upper body
Loss of bladder/bowel control	Y/N	
Loss feeling and/or movement	Y/N	

Nursing Assessment of Suspected Head Injury Post Fall

Resident has fallen – witnessed head injury, unwitnessed or not sure if head injury

↓

Nursing staff to start neurological observations and ask for a medical review

↓

Medications: must be inspected for anticoagulants, antiplatelets, etc.
Try to ascertain the cause of the fall: e.g. syncope, clip, postural hypotension, etc.
Further immediate investigation as indicated: ECG
Avoid use of sedative medication if possible

↓ ↓

If GCS 15/15 and other observations normal, neuro obs should be done:

- Half hourly for 2 hours then;
- Hourly for 4 hours then;
- 2 hourly until medical review and 12 hours have passed since fall

It should be handed over at shift changes that a head injury has occurred and medical advice sought if worrying signs develop.

If GCS <15/15 **or** subsequently drops **or** worrying signs are present, neuro obs should be continued half hourly and a CT brain considered:

Worrying signs include:

- Development of agitation, confusion or abnormal behaviour
- A sustained (at least 30 minutes) drop of one point in GCS – especially motor
- Any drop of two or more points in the GCS motor, or three in any other
- Development of headache or persisting vomiting
- New or evolving neurological symptoms or signs
- If there is concern from a carer/family

Residents who are at an increased risk of bleeding (e.g. anticoagulated, liver disease) should be considered for a CT brain in the absence of worrying signs.