THE DUDLEY GROUP NHS FOUNDATION TRUST FOI 011391
RESPONSE TO QUESTIONS 1 AND 2

Types of Fall	2012 01	2012 02	2012 03	2012 04	2012 05	2012 06	2012 07	2012 08	2012 09	2012 10	2012 11	2012 12	2013 01	2013 02	Total
(PF) Patient Fall resulting in FRACTURE	3	2	2	7	0	2	0	2	1	0	1	2	6	5	33
(PF) Fall from Bed	25	17	28	23	26	28	16	17	18	28	19	23	34	32	334
(PF) Patient Found on Floor	42	36	58	55	32	37	27	36	38	59	39	33	2	3	497
(PF) Fall from Chair/Toilet/Commode	58	46	42	25	13	19	14	18	16	22	21	21	25	19	359
(PF) Fall/Trip/Slip while Mobilising Alone	3	4	8	25	43	35	35	32	39	25	35	36	40	39	399
(PF) Fall/Trip/Slip while Mobilising with Staff	4	4	6	3	9	2	7	11	5	6	12	4	5	7	85
Totals:	135	109	144	138	123	123	99	116	117	140	127	119	112	105	1707

IF HIGH RISK ATTACH STICKER TO DRUG CHART, WHITE BOARDS AND MEDICAL NOTES

The Dudley Group NHS Foundation Trust

Patient Fall Prevention & Management Document (Hospital)

Patient Name
Patient Preferred Name
Hospital/ NHS Number
Date Implemented
Initial Score

Originator: Falls Bundle Team
Date Originated: November 2012
Version 7
Date For review: Dec 2013

Fall Prevention Lead – Sr Chris Taylor Bleep 8033

Patient Fall Prevention on Admission to hospital or Intra-hospital transfer

On admission to hospital complete Fall assessment and check medical notes for high risk sticker
If over 65 consider assessment for osteoporosis using FRAX
Complete manual handling and bed rails assessment

1. Low Risk (3-8)

Reassess weekly
Unless Patients
Condition changes or
Patient falls

2. Medium Risk (9-12)
As low risk +

Give patient information
If required wear non slip TEDs .

Signature _____

3. High Risk (13 or above
As low and medium risk +Magnet on white board sticker in medical notes and prescription chart, 4 hourly Falls Bundle
On discharge refer to Falls Prevention Clinic.

Action plan to be reviewed alongside fall risk assessment

Falls Prevention Core Values (Best Practice)

Patient /Family Communication:

- Inform patient/family of falls risk and factors
- Orientate patient to ward environment and staff.
- Involve patient/family with care plan.
- Advise patient how to use call bell for help
- Show where the toilet is located (if mobile) and what measures are in place to toilet if not mobile.
- Ensure bed height remains low and ensure bed rails in place if assessment indicates.
- Check for well fitting non-slip foot wear /TEDS (non-slip if patient is medium to high risk of falls) in place when mobilising.
- Ensure patient is aware of any invasive lines /catheter or attachments assistance/ supervision will be required.
- Check for well fitting clothes.
- Patient's sensory aids e.g. glasses/hearing aids are available and in use at all times.
- Patient may require bed/chair alarms.
- Possibly one to one nursing care or family to stay consider flexible visiting arrangements.

Team Approach:

- Review patient's condition daily.
- Pay attention to postural hypotension, balance difficulties, (acute/chronic) cognitive impairment, alcoholic withdrawal, sedation/surgery or use of prosthesis.
- Review patients drug charts on a daily basis and check for polypharmacy.
- If change in medical condition agitation or confusion consider investigations urinalysis, msu/csu, blood investigations and interpretation of results e.g. fluid balance monitoring or fluid replacement.
- Review any imaging investigations and results.
- Documentation must be clear accurate concise and timely.

Falls Risk Assessment Scales (FRASE) complete on admission/transfer/following a fall and weekly

LEVEL OF RISK 3-8=LOW risk, 9-12=MEDIUM risk, 13+=HIGH risk

	Score	Date	Date	Date	Date	Date	Date	Date
Sex/Age								
Male	1							
Female	2							
60-70	1							
70-80	2							
80+	3							
Gait								
Steady	0							
Hesitant	1							
Poor Transfer	3							
Unsteady	3							
Sensory Deficits								
Sight	2							
Hearing	1							
Balance	2							
Fall History (last 12 months)								
None	0							
At Home	2							
In Ward	1							
Both	3							
Medication								
Hypnotics	1							
Tranquillizers	1							
Hypotensives	1							
Drug/alcohol withdrawal	1							
Parkinsons drugs	1							
Diuretics	1							
Long term steroid use	1							
Medical History								
Diabetes (neuropathy, sensory, eyesight)	1							
Peripheral Vascular Disease (PVD)	1							
Organic (Stroke/CVA, Parkinsons, dementia)	3							
Amputation/Prosthesis	2							
Seizures, convulsions	1							
Acute Confusion	1							
Mobility								
Fully	1							
Restless/Fidgety	2							
Apathetic (Reluctant to move/Fear of falling)	1							
Restricted (Restricted by severe pain or disease)	3							
Bed Bound (unconscious or sedated/unable to change position/Traction/cast)	1							
Chair bound e.g. Wheelchair	1							
Uses Mobility Aid	2							
Total Falls Risk Score:								
Assessor Signature/Initials:								

If score = 9 or higher – complete Falls Prevention Action Plan. Check bed rails assessment and manual handling completed in admission documentation.

Falls Action Plan

Weekly assess risks for medium and high	Intervention options to be considered	Signature	Date	Signature	Date	Signature	Date
Gait Mobility	• Refer to physio/OT • Check mobility boards updated daily and appropriate aid/ assistance in place • Walking aid correct for height • If ted stockings required ensure non-slip teds applied • Advise on appropriate footwear • Check condition of feet/refer to Podiatry/Chiropody/Orthotics (if required) • Complete Manual Handling High Risk Care Plan						
Sensory Deficits Sight Hearing	• Ensure patient is orientated to area • Ensure environment has adequate lighting • Ensure all staff are aware of the patients deficit • Ensure patient wears glasses						
Falls History Medical History Agitation/confusion or impaired judgement	• Initiate falls bundle if high risk of falls • Increase observation/monitoring • Use of bed/chair alarms • Use of bed rails (ONLY in line with Trust policy) • Refer to Mental Health Clinical Nurse Specialist for >65 yrs (dementia risk assessment) • Refer to Psychiatric Liaison Team for <65 yrs • Refer to DALT						
Urinary incontinence/frequency or need for assisted toileting	• Test urine for infection weekly • Ensure patient knows location of nearest toilet • Frequent assisted toileting • Ensure patient positioned appropriately if using bedpans • Follow Trust continence policy						
Osteoporosis risk	• Consider injury prevention strategies						
Medication	• Pharmacy/medical review						
Psychological	• Promote independence/confidence						
Hydration & Nutrition	• Ensure patient is given adequate fluid and food)						
Organisational	• Complete Falls Risk Assessment Scale (FRASE) weekly (unless clinically indicated) • Provide patient/carer with written information on falls prevention						
Other	•						

The Dudley Group NHS
NHS Foundation Trust

RISK ASSESSMENT FOR THE USE OF BED RAILS

NAME OF PATIENT	Unit /NHS Number:

PLEASE COMPLETE Y/N AS APPROPRIATE		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Rationale for decision	Date and Signature
1	Would the patient attempt to climb over the bed rails?									
2	Does the patient need to get out of bed at night and without carer assistance at night?									
3	Is there any risk of potential entrapment?									
4	Is the gap between the top of the mattress (un-laden)and the top of bed rails less than 220mm?									
5	Does the patient have a weakness or disability that would put them at high risk of entrapment?									
6	Would the patients mental state put them at high risk of entrapment?									
7	Is the patient likely to sustain an injury from impact against The bed rail? If yes Bed Rail Protectors must be used.									
OUTCOME-HIGH/ MED/ LOW (see overleaf)										
	BED RAILS TO BE USED Y/N									
	DATE AND SIGNATURE									

Risk Assessment Score

HIGH RISK: If **YES** to all questions 1-7 bed rails are unsafe and the patient is at high risk of injury from them. **DO NOT** fit bed
rails consider alternative strategies for reducing the risk of the patient from falling from the bed.

LOW RISK: If **NO** to all questions 1-7 consider bed rails. Bed rails are an appropriate response where a patient is at high risk of falling from bed and being injured but at a low risk of injury from bed rails.

MEDIUM RISK: If **MIXED** answers to questions 1-7 it is necessary to consider the risk of injury from fitting bed rails with the level of risk from falling from bed-use professional judgement to determine whether it is more appropriate to fit bed rails or use alternative strategies.

Post Patient fall protocol

- Check environment safe to approach and remove any immediate danger
- Assess patient for injury check for cervical spine injury
- Undertake clinical observations check ABCDE.

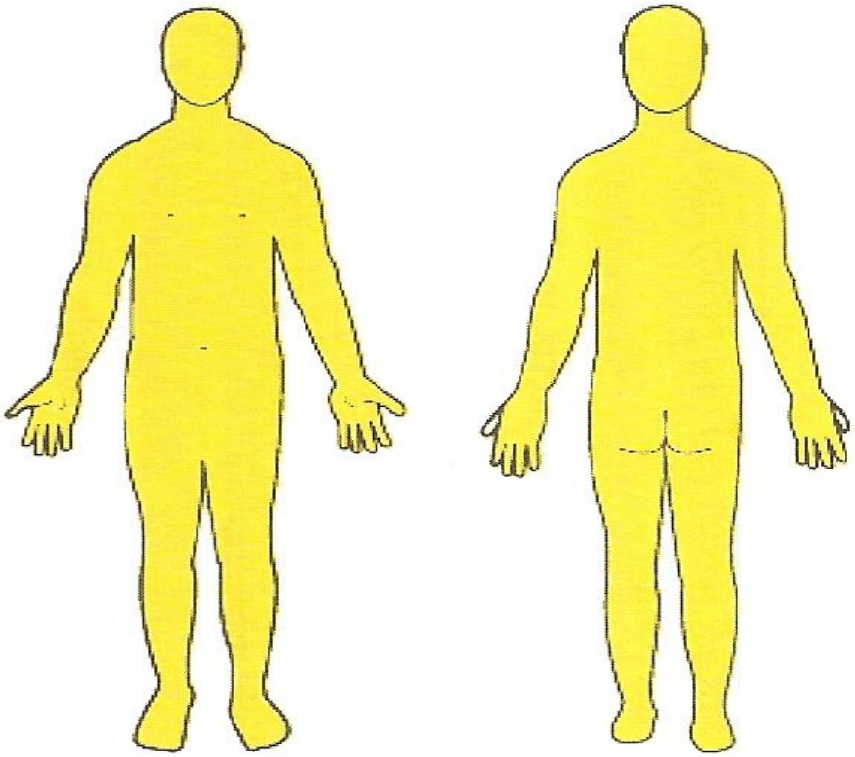
- Does the patient require urgent medical attention?
  Is there loss of consciousness, significant haemorrhage or any red parameter in track and trigger observations

- Is patient out of immediate danger?

- Is the patient in pain.
- Trained Nurse or Doctor to check for head/ spinal injuries before moving
- Medics to review patient within half hour
- Use correct manual handling technique
- Reassure patient and make comfortable
- Provide immediate first aid – analgesia, dressings
- Neurological observations following fall if un-witnessed or head injury sustained until seen by medics and advised
- Follow medic's instructions
- Complete body map for any injury bruising, skin tears, bleeding
- Complete datix
- Reassess patient falls risk assessment and action plan accordingly reassess bed rails and manual handling risks
- Initiate falls bundle
- Inform relatives
- Clearly document in medical notes
- Provide falls prevention documentation to patient/relatives
- Ensure MDT on the ward aware of fall

- Immediate attention from medical team (MET CALL SBAR handover)
- All of the orange box actions
- If suspected hip fracture refer to hip practitioner 8am-8pm (Bleep No 7704) or Orthopaedic SHO
- Ensure Matron , Lead Nurse or Site Coordinator is aware of the severity of injury.
- If out of hours ensure manager on call aware of severity of injury
- Ensure MDT on the ward aware of fall

Body Map



Site of injury	Type of Injury	Dressing applied	Initials	Date

Please Document Date & Time for the following:	Date	Time	Initials
• DATIX incident number:			
• DATIX incident form completed post fall:			
• MDT advised of patient fall:			
• Patient relatives/carer informed of fall:			
• Falls Prevention equipment fitted to bed/chair:			

FALL SAFE Bundle for Prevention of Inpatient Falls (4 hourly) 

2 days	Date:						Date:					
√ **Tick in box when activity performed, I for intervention required X if problem identified or *(N/A to patient)*** **Trained nurse to be informed of any problem or continuous intervention required**												
Time:												
Situation												
Comfortable (pain free, warm & dry, position, mattress inflated, chair cushion)												
Able to reach bedside table, water jug, glass, food, glasses												
Access TV/DVD, music, book												
Orientation and reassurance For Fear of falling												
Wandering (1:1 nurse)												
Actions (from the Falls Prevention Action Plan)												
Sensory (glasses, hearing aid)												
Observation/Monitoring (BP lying /standing)												
Continence/Toileting (assist)												
Facts												
High falls risk identified on white board/ handover												
Environment												
Adequate lighting												
Adequate Footwear / TEDS												
Walking aid within easy reach for patients who have been assessed as safe to mobilise without assistance												
Call bell within easy reach and patient shown how to use or if can't use highlight												
Clutter free table												
Advice given on attachments consider(IVI, tubes, catheters drains, clothes) mark as x if noncompliant												
Bed height (lowest if possible)												
Brake bed/,chairs,/commode												
Bed rails used correctly and clicked into place. Alarms checked												
Date of weekly urinalysis or following new/acute confusion												
Assessor Signature/Initials												
Trained Nurse Signature/Initials shiftly												

Discharge from hospital
To be completed if medium / high risk of falls

- If patient going home by ambulance inform crew of falls risks
- Inform relatives of falls risk
- Give patient information on discharge
- Inform GP of falls risks
- Consider referral to falls prevention clinic, complete referral form – fax information to 4605
- Refer to fracture clinic if required
- Does the patient agree to be referred to community continence team or G.P. Practice Nurse

I confirm that the above actions have been undertaken.

Date:.....

Time:.....

Signature:.....

Preventing Falls in Hospital (No: v2, July 2010)
Medicines and Falls in Hospital (No: March 2010)

If you require any further information regarding our services, you can contact:

Chris Taylor Falls Prevention Lead Bleep 8033
The Dudley Group NHS Foundation Trust.
Telephone: 01384456111 Extension: 4280

www.dgoh.nhs.uk
www.bgs.org.uk/campaigns/fallsafe/NPSA
www.nice.org.uk/CG021
www.patientsafetyfirst.nhs.uk
www.ageuk.org.uk
www.institute.nhs.uk
www.nhs.uk

The Dudley Group NHS
NHS Foundation Trust

PLEASE COMPLETE TO REFER PATIENTS TO THE FALLS CLINIC.

NAME	
HOSPITAL NUMBER	
CONTACT NUMBER	
HISTORY OF FALLS/TYPE OF FALL	
MOBILITY AIDS/GAIT	
COMMUNICATION PROBLEMS **IF ANY PLEASE PROVIDE ALTERNATIVE CONTACT NUMBER e.g. NOK**	
BALANCE	
MENTAL STATUS	
DIZZINESS	
VISUAL IMPAIREMENT	
FOUR PLUS MEDICATIONS	
ANY OTHER COMMENTS	

NAME OF PERSON REFERRING

CONTACT NUMBER

WARD

FAX TO 4605 FOR THE ATTENTION OF SISTER CHRIS TAYLOR

Falls Action Plan

Weekly assess risks for medium and high	Intervention options to be considered	Signature	Date	Signature	Date	Signature	Date
Gait Mobility	• Refer to physio/OT • Check mobility boards updated daily and appropriate aid/ assistance in place • Walking aid correct for height • If ted stockings required ensure non-slip teds applied • Advise on appropriate footwear • Check condition of feet/refer to Podiatry/Chiropody/Orthotics (if required) • Complete Manual Handling High Risk Care Plan						
Sensory Deficits Sight Hearing	• Ensure patient is orientated to area • Ensure environment has adequate lighting • Ensure all staff are aware of the patients deficit • Ensure patient wears glasses						
Falls History Medical History Agitation/confusion or impaired judgement	• Initiate falls bundle if high risk of falls • Increase observation/monitoring • Use of bed/chair alarms • Use of bed rails (ONLY in line with Trust policy) • Refer to Mental Health Clinical Nurse Specialist for >65 yrs (dementia risk assessment) • Refer to Psychiatric Liaison Team for <65 yrs • Refer to DALT						
Urinary incontinence/frequency or need for assisted toileting	• Test urine for infection weekly • Ensure patient knows location of nearest toilet • Frequent assisted toileting • Ensure patient positioned appropriately if using bedpans • Follow Trust continence policy						
Osteoporosis risk	• Consider injury prevention strategies						
Medication	• Pharmacy/medical review						

Psychological	• Promote independence/confidence						
Hydration & Nutrition	• Ensure patient is given adequate fluid and food)						
Organisational	• Complete Falls Risk Assessment Scale (FRASE) weekly (unless clinically indicated) • Provide patient/carer with written information on falls prevention						
Other	•						

The Dudley Group of Hospitals NHS

NHS Foundation Trust

FALLS RISK ASSESSMENT SCALE						
NAME:	**UNIT NUMBER:**		**CONSULTANT:**			
			WARD:			
DATE OF ASSESSMENT:						
SEX						
MALE	1	1	1	1	1	1
FEMALE	2	2	2	2	2	2
AGE						
BELOW 60	0	0	0	0	0	0
60-70	1	1	1	1	1	1
71 – 80	2	2	2	2	2	2
81+	3	3	3	3	3	3
GAIT						
STEADY	0	0	0	0	0	0
HESITANT	1	1	1	1	1	1
POOR TRANSFER	3	3	3	3	3	3
UNSTEADY	3	3	3	3	3	3
MOBILITY						
FULL	1	1	1	1	1	1
USES AID	2	2	2	2	2	2
RESTRICTED	3	3	3	3	3	3
BED BOUND	1	1	1	1	1	1
SENSORY DEFICITS						
SIGHT	2	2	2	2	2	2
HEARING	1	1	1	1	1	1
BALANCE	2	2	2	2	2	2
FALLS HISTORY						
NONE	0	0	0	0	0	0
AT HOME	2	2	2	2	2	2
IN WARD	1	1	1	1	1	1
BOTH	3	3	3	3	3	3
MEDICAL HISTORY						
DIABETES	1	1	1	1	1	1
ORGANIC BRAIN DISEASE/CONFUSION	1	1	1	1	1	1
FITS	1	1	1	1	1	1
MEDICATION						
HYPNOTICS	1	1	1	1	1	1
TRANQUILLIZERS	1	1	1	1	1	1
HYPOTENSIVES	1	1	1	1	1	1
TOTAL RISK SCORE						
ASSESSING NURSE:						
SCORE OF: 3 – 8 = LOW RISK	**9 - 12 = MEDIUM RISK**			**13+ = HIGH RISK**		

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Would the patient attempt to climb over bed rails? Does the patient want to get out of bed independently? If YES to either questions DO NOT use bed rails. If NO to either question complete the bed rail assessment documentation.

GUIDELINES OF "FALL" PAPERWORK

- Complete **FALLS RISK ASSESSMENT** [FRASE] on admission/transfer for all adults admitted to the Trust.
- Reassessment weekly, or if the patients condition changes significantly.
- Implement a **FALLS PREVETION ACTION PLAN** if patient scores 9 or above
- Complete **USE OF BEDRAIL RISK ASSESSMENT**

THE DUDLEY GROUP NHS FOUNDATION TRUST

Falls Alarms / Pressure sensitive seating or bed and pillow pads purchased from Turun UK Ltd

Period : Sep 2010 to Apr 2013

FOI 011391

Financial Year	Product Code	Description	Quantity
2012 - 2013	25023	TABS Professional Voice + with wire Bracket	35
	70700T	Safepresence Bed sensor 6 pin	35
	70850T	Safepresence Chair sensor 6 pin	35
2011 - 2012	25023	TABS Professional Voice + with wire Bracket	6
	26001	TABS royal blue Chair Sensor Pads	6
	26550	One year over mattress bed sensor	6
2010 - 2011	25023	TABS Professional Voice + with wire Bracket	16
	26001	TABS royal blue Chair Sensor Pads	15
	26550	One year over mattress bed sensor	13

The Dudley Group NHS
NHS Foundation Trust

Trust Headquarters
Russells Hall Hospital
Dudley
West Midlands

Date: 12/04/2013

FREEDOM OF INFORMATION ACT 2000 - Ref: FOI/011391

With reference to your FOI request that was received on 06/03/2013 in connection with 'FALLS'.

Your request for information has now been considered and the information requested is enclosed

Further information about your rights is also available from the Information Commissioner at:

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
Tel: 0303 123 1113
Fax: 01625 524510
www.ico.gov.uk

Yours sincerely

Information Governance Manager
Room 34a, First Floor, Esk House, Russells Hall Hospital, Dudley, DY1 2HQ
Email: FOI@dgh.nhs.uk

The Dudley Group NHS
NHS Foundation Trust

Please find the responses to your request attached and below:

1. How many falls have been reported as occurring within your organisation between January 2012 and February 2013 (broken down by month)

2. Do you insist upon any categories or classifications of falls by patients such as falling from a toilet, fall in bathroom, fall from bed etc and if so, please also include the breakdown of these categories alongside the totals in question 1 (ie numbers of falls from bed/toilet etc in month x and the total number of falls for each month).
Please find the response to questions 1 and 2 attached (011391 PDF)

3. Do you utilise any definition or test to distinguish between falls and other events such as faints or slips; what is this and how is it applied.
There are codes on DATIX, the Trusts incident reporting system,to distinguish all such events, a factual account would be entered by the person completing the entry on DATIX. Medical staff also review a patient following any event which would distinguish between a mechanical fall or collapse etc.

4. Does your organisation utilise a risk assessment tool for falls such as the MORSE assessment. If so;
YES – FRASE tool attached, PDF frase 2010
Are there any specific criteria used to target the use of the assessment (ie age, sex, history)
YES – see FRASE tool attached, PDF frase 2010
How long has this been in use - More than 5 years

5. Does your organisation utilise any care plans to guide the support for patients in regard to falls, are they informed by any local or national best practice and if so, what. I would like to request copies of these care plans if used (blank or anonymised). - Care plan attached, guided by RCP – FALL SAFE project, PDF Falls Care Plan

6. Does your organisation have, or intend to purchase in the next 3 months any of the following pieces of falls preventative technology.

For each, can you please disclose the manufacturer for each, the number of each item available and the date they were first introduced if within the past financial year.

Low rise / floor level beds

The Trust has been approached by several companies to trial, which we have agreed to do

Falls alarms / pressure sensitive seating or bed and pillow pads

Already in use, purchased more than 12 months ago. Please see attached details for numbers under PDF Summary of item order Sept.....

Hip protectors Not used

Floor mats

The Trust has been approached by several companies to trial, which we have agreed to do

7. Does your Trust have a specialist officer tasked with promoting and ensuring falls prevention or reducing falls across the organisation.
If so, how long have they been in post
YES, we have a Falls Co-ordinator who has been in post more than 5 years

8. Does your organisation routinely identify patients who have fallen on more than one occasion during their stay. What extra measures do you employ to escalate these instances and prevent further incidents.
The Trust participates in safety thermometer audits which identify patients who have fallen within the last 72 hours. We also reassess patients falls risk following a fall and introduce measures to reduce risk ie, bed/chair alarms, increase frequency of patient observation and one to one nursing if required.

9. Does your organisation utilise any measures, processes or procedures to be followed after a fall has taken place. If yes, what is this process and please release any checklists or procedural documents used to guide this.
Falls prevention document attached, which is currently being piloted