

The Prevention and Management of Patient Falls



Introduction

The information in this booklet is designed to support staff in undertaking their duties, give information on risk assessments, risk factors and measures to prevent falls and support effectively patients who have fallen.

Why is preventing and managing falls so important?

"Falling is the leading cause of injury-related admissions to hospital in the over 65, and costs the NHS an estimated £2.3 billion per year...A number of falls occur in hospitals with nearly 209,000 reported between 1 October and 30 September 2012...NICE has updated its guideline on falls, to help reduce the number of older people who are falling over in hospitals... NICE says that certain groups of inpatients should be regarded as being at risk of falling in hospital. These include all patients age 65 or older, and those age 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition such as dementia or stroke"

The National Institute for Health and Care Excellence, 12 June 2013

A patient falling has a wide-ranging impact – those affecting the individual patient, staff and the organisation more widely. For the patient, potential consequences include physical injury, limitations in mobility and psychological – such as fear of further falls which can then limit their independence. For staff members, they may feel responsible for the incident, lose confidence in their abilities and it may impact on the trusting relationship between them and their patients. For the Trust, injuries caused by patients can result in extra costs dealing with additional injuries and longer hospital stays, litigation from patients and families and cause reputational damage.

The Dudley Group NHS Foundation Trust is committed to preventing slips, trips and falls wherever possible and minimising risk to patients in

their care. Employees have specific duties in relation to assessing and managing the risk of falls in patients in order that preventative measures can be taken wherever possible.

The Prevention and Management of Patient Falls Policy outlines the key duties of the organisation and of employees – relating both to general duties and those specific to different staff groups. This should be read in conjunction with The Use of Bedrail Policy in Acute Clinical Settings Policy.

The National Service Framework for Older People (2001) and The National Institute for Health & Clinical Excellence Guidance (NICE) (2004 and 2013) focused in particular on older people falling and identified a number of standards to both prevent and manage falls in healthcare settings. These included actions to assess patients for their risk of falling, effective treatment and rehabilitation activity for patients who have fallen.

What is the scale of the issue?

Each year around 282,000 patient falls are reported to the National Patient Safety Agency (NPSA). In the 2012-13 NPSA slips, trips and falls data update it was reported that a significant number of patient falls resulted in death or severe or moderate injury.

In Dudley Group, the most recent data is outlined below for the twelve months between July 2012 and June 2013. This shows the amount of falls within the Trust including outpatients and community.

	July- Sept 2012	Oct- Dec 2012	Jan- March 2013	April – June 2013	Total
Total	333	385	331	283	1332

The following data shows the sub category of the falls in the same time span. The subcategory patient found on the floor has now been removed from the datix system as an option to choose. The person reporting the incident must now find out what the patient was doing prior to the fall e.g. where they on a bed, a chair, commode, toilet or where they mobilising alone.

	July- Sept 2012	Oct- Dec 2012	Jan- March 2013	April – June 2013	Total
Fall from Bed	51	68	106	44	269
Fall from Chair/Toilet/Commode	49	63	71	55	238
Fall/Trip/Slip while Mobilising Alone	106	97	116	96	415
Fall/Trip/Slip while Mobilising with Staff	23	21	13	22	79
Patient Fall resulting in FRACTURE	3	3	12	5	23
Patient found on floor	101	131	12	59	303
Total	333	385	331	283	1332

Understanding Patient Falls

Slips, trips and falls are all very different types of ways a patient may fall. All are including in the definition of a patient fall and when reporting a patient fall you will need to be as accurate as you can in describing what type of fall as well as what happened.

A slip is: To slide accidentally causing the person to lose balance. This is either corrected or causes the person to fall.

A trip is: To stumble accidentally over an obstacle, causing the person to lose balance. This is either corrected or causes the person to fall.

A fall is: An event which causes the person coming to rest on the ground or another surface lower than the person, whether or not an injury is sustained.

A fall is not:

- Someone who is being helped to walk across a room and who staggers to hold onto furniture for support.
- Someone who is helped to the floor gradually in a controlled decent.
- Someone who slides on a slippery surface and rights themselves.
- Someone who is sliding around one end of a set of cot sides, even if the person's head is lower than the rest of his body.
- Someone who strikes his head on an overhead television.
- Someone who has a seizure who remains on a bed, or who puts herself on the floor at the start of a fit.

Examples of what a fall is:

- Someone who trips loses their balance, and whose knees strike the floor.
- Someone who moves forward in a chair, toilet or commode so far that contact is lost, and who ends up on the floor.
- Someone whose whole body rolls out of bed.
- Someone who slips on a slippery surface and lands on the floor.

Tip: If the floor stops the person's body travelling towards the centre of the Earth, it is a fall.

Employee Responsibilities

You should:

- Ensure all adult patients have a falls risk assessment completed within four hours of admission in hospital.
- Recognise risk factors leading to slips, trips, and falls.
- Take preventative measures so that the risk of falls is diminished as far as possible.

- Inform your patient and their relatives/carers of their falls risk.
- Collaborate with others when you are unsure of what to do.
- Report falls to the nurse in charge verbally, by using the DATIX system, and to the medical staff to ensure the patient is reviewed. Document in the patient's notes.
- Be safe and effective following falls incidents (Follow the post fall guidelines).
- Foster and maintain a safe environment for patients and clients, their relatives, visitors and health care workers.
- Use falls prevention knowledge, skills, and attitudes appropriate to each situation.
- Act as a role model for all, by actively using your knowledge and experience.
- Ensure bedrail assessments have been completed on all adult inpatients.

What increases the risk of falls in patients?

There are some factors that contribute to an increased risk of falls in patients. (NPSA 2007)

		Examples
Intrinsic factors	Personality and lifestyle	Activities, attitudes to risk, independence and receptiveness to advice.
	Age-related changes	Changes in mobility, strength, flexibility and eyesight that occur even in healthy old age.
	Illness and injury	Stroke, arthritis, dementia, cardiac disease, acquired brain injury, delirium, Parkinson's disease, dehydration, disordered blood chemistry and hypoglycaemic episodes in diabetes.
Extrinsic factors	Medication	Sleeping tablets, sedation, painkillers, medication that causes low blood pressure, medication with Parkinsonian side effects, alcohol and street drugs.
	Environment	Lighting, wet floors, loose carpets, cables, steps, footwear, distances and spaces.

Preventing and Assessing the Risk of Falls

Some of the risks of falls can be minimised – many of those are environmental.

In the Hospital

- Assess each adult patient for their falls risk within four hours of admission including CDU and EAU.
- If patient has a falls risk fall safe bundle to be started or document why it has not been.
- Discuss with patient and relatives/carer the outcome of the falls risk assessment and any decisions made in the best interest of the patient.
- Document the outcome of the conversation in the patient's notes.
- The nurse call bell is working, within reach, and the patient has been instructed in its use, if patient is unable to use it document the reason why.
- The bed remains in the lowest position after patient intervention with the brakes applied,
- The brakes on any equipment are in working order and are applied appropriately,
- Any faulty equipment is removed from the clinical area and reported to the person in charge of the ward or department,
- Patients belongings are kept within the patients reach,
- Night lights are used at night
- Clutter free environment.
- Adequate footwear.
- Walking aid within reach.
- Advice given on attachments.
- Bed and Chair alarms in working order.
- Bed rails used correctly following assessment.

In a Patient's home or another setting

- Community staff must identify and communicate clearly to the patient and relatives/carers any hazards and risks identified within the patient's own home.
- Discuss with patient and relatives/carer the outcome of the falls risk assessment and any decisions made in the best interest of the patient.
- Document the outcome of the conversation in the patient's notes.
- Give advice to the patients in their care on minimising risks.

- Ensuring a plan of care is formulated regarding any hazards and risks so the patient can make an informed choice to adapt their environment.
- Community staff remain a guest within the patient's home, and therefore must seek permission before removing any identified at risk items.
- If a patient declines the advice given, the community staff member must ensure that a record is made within the patient's health record and report to the appropriate line manager.
- The General Practitioner (GP) and multi-disciplinary team should ensure that all effective measures are taken to protect the patients' safety.

Completing a Falls Assessment

In order to help identify those patients at risk of falling, and to put the right measures in place to prevent falls, you must follow the Prevention and Management of Falls Policy which states that:

- Each adult patient should be falls assessed within 4 hrs of admission including CDU and EAU.

An example of the Falls Assessment to be completed is below.

Falls assessment for all adult patients within 4 hours of admission/transfer to EAU, CDU or Ward		
Ward	Date and Time	
1. Does the patient have any history of falls or broken bones e.g. fall from standing height or less that resulted in a fracture.	Yes	Details
	No	
2. Is the patient's admission due to a fall?	Yes	Details
	No	
3. Is the patient unsteady on their feet? Does the patient have mobility problems and/or use a walking aid?	Yes	If yes what type of aid do they use and is it available?
	No	If not available actions taken to provide aid.
4. Is the patient over 65 years of age or over 50 who are judged by a clinician to be at higher risk of falling due to underlying medical conditions?	Yes	
	No	
5. Does this patient have a fear of falling?	Yes	Details
	No	
6. Does the patient have appropriate footwear/ non slip anti embolic stockings?(Please check if the patient has their own footwear available before issuing slipper socks)	Yes	Action taken to provide footwear;
	No	
7. Does the patient have any sensory deficits? (visual/hearing)	Yes	If so what?
	No	
8. Is the call bell within reach and can the patient use it?	Yes	If not achievable, details;
	Not Achievable	
9. If urine dip has not already been performed on this admission please action to screen for a urinary tract infection?		Result; If indicated send urine sample to microbiology for MC&S.
10. On clinical judgment does the patient have additional factors in which they may be at risk of falls during this admission. i.e. drip stand, walking aid. Consider past medical history. Current medication.	Yes	Please state reasoning;
	No	
If you have answered yes to any of the yellow boxes above and using your clinical judgment, please continue to complete the falls care plan. Please document your reasoning for not completing or discontinuing the falls care bundle in the box below and in medical notes.		
Signature:		

Falls Assessment Instructions

The Falls Assessment should be completed within four hours of admission to the Trust including CDU and EAU. If you have entered Yes in any of the yellow boxes on the assessment form and using clinical judgment then continue to complete the Falls Care Plan. If a patient is at risk of falls then consider using the Falls Bundle. You must clearly document the reasons why you are completing or not completing the Falls Bundle on the Falls Risk Assessment. If on admission the patient is classed as not at risk of falls then has a fall the Falls Bundle should be commenced.

For patients in the community, all patients with an underlying medical condition should have a falls risk assessment completed at their initial visit on admission to the caseload.

For Community patients the Falls Assessment should be repeated when there is a change in the patient's condition or medication or if the patient discloses a fall.

Pre-operative assessment should include falls risk, and forms should be properly stored in patient notes.

In summary, a patient should be assessed:

- On admission
- Following a fall

Actions required following the Falls Assessment

If it is indicated to start the Fall Safe Bundle then:

- This should be highlighted on the white board, the patient's notes and prescription card using the falls stickers.
- The Fall Safe Bundle should commence four hourly checks unless more frequent observations need to take place..
- Give patient written and oral information on falls prevention.
- Patient Handling Assessment should be completed on the patient on admission and updated as required or at least weekly.
- Bedrail assessment should be completed on all patients.
- On discharge if the patient is going home by ambulance inform the crew of the patients falls risk.
- Consider referral to the Dudley Falls Service.

If a person has had a history of falls:

The medical staff should consider a multifactorial assessment and a multifactorial intervention. (NICE 2013) These may include:

- Falls history, including causes and consequences (such as injury and fear of falling).
- Health problems that may increase their risk of falling.
- Footwear that is unsuitable or missing.
- Review of the patient's medication.
- Assessing the patient's vision.
- Assessing the patient's cognition following the NICE Delirium Guidelines, (NICE 2010).
- Assessing the balance of the patient, postural instability, mobility problems.
- Syncope syndrome.
- Continence problems.
- Making records and liaising with the appropriate member of the multidisciplinary team involved.

Ensure that any multifactorial intervention:

- Promptly addresses the patients identified individual risk factors for falling in hospital and
- Takes into account whether the risk factors can be treated, improved or managed during the patients expected stay.
- DO NOT offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling.
- Provide relevant oral and written information and support for the patient and their family members and carers if the patient agrees. Take into account the patient's ability to understand and retain information.

Actions required for Patients in the Community

The assessment tool used is broadly similar for community patients but there are variations in actions required.

Other measures you need to consider

As part of the assessment of risk, you also need to check that:

- Bed rails assessments are undertaken as indicated following the falls risk assessment

- Bed and chair alarms are utilised as indicated following the falls risk assessment within the hospital setting, and potentially at home in a domiciliary setting.
- If a 1-1 is required in hospital use the appropriate care plan available on the hub. Look under Departments, Mental Health, Mental Health Documents.

What to do if someone falls in your area or you observe a patient fall

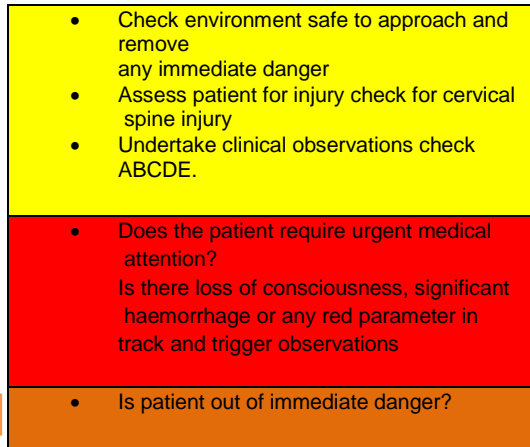
During:

- Do not try to grab the falling person, this may injure you too.

Moving and handling a falling person is considered to be extremely high risk for staff.

- Follow post fall protocol.
- Make area safe for other people.

What to do if you discover a patient has fallen



- 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

Intervention in the community setting

If the fall is witnessed by a health care professional then the procedure for Intervention in a clinical area must be followed. The health care professional must then use specialist professional clinical judgement as to whether to call an ambulance or to inform the General Practitioner (GP) of the incident. The incident must be documented in the patient's health record and report on DATIX.

If the fall is not witnessed and the healthcare professional was not present at the time of the fall, and the patient reported an earlier fall, the health care professional must examine the patient and document the findings. The healthcare professional must then use professional clinical judgement to inform the GP or decide if further treatment is needed.

Reporting a fall

You must report a patient fall as soon as is reasonably practicable after a fall event. This will be as soon as is possible after you have made sure the patient is safe and steps have been put in place to prevent further falls.

Making a report:

Report the incident to a line manager who might need to take further action to make the area and the people involved as safe as quickly as possible.

Write a full report using the DATIX links, within 24 hours of the event. For those with clinical responsibility for a patient, a record needs to be made in the patient file notes.

How to report a fall:

Be clear and factual about what happened. Legally there is a difference between a slip, trip, or a fall.

Try to be clear about the name of the person, who fell, with the time, date, location of the event, and names of the witnesses to the incident or accident.

If you were providing a report to another person, you might say

“I have just witnessed Mr X slipping and falling onto his knees.”

“I have just witnessed Mrs Y fall from a chair to the floor.”

Do not state patient found on floor. Find out where they were or what they were doing prior to the fall.

If you are waiting for a doctor to review or tests to be completed update as soon as details or results confirmed.

Points of contact:

Your line manager needs to know reasonably quickly if:

1. There has been a near miss with a slip trip or fall, as a real accident may happen later.
2. If there has been a real witnessed or non-witnessed fall.
3. If a fall has been reported – in a community setting.

If a manager is not available, please contact the site coordinator out of hours.

The Falls Action plan:

A Falls Action Plan can be using following the Falls Assessment to identify what further assessment and liaison is needed following a fall.

Possible Risk Factors	Intervention Options To Be Considered	Signature and Date
Gait Mobility	Refer to physio/OT. <ul style="list-style-type: none"> • Check mobility boards updated daily and appropriate aid/ assistance in place • Walking aid correct for height • If anti embolic stockings required ensure non-slip applied • Advise on appropriate footwear. • If no footwear available give nonslip socks • Check condition of feet/refer to Podiatry/Chiropody/Orthotics (if required) Complete Manual Handling Care Plan	
Sensory Deficits Sight Hearing Communication	<ul style="list-style-type: none"> • Ensure patient is orientated to area • Ensure environment has adequate lighting Ensure patient wears glasses/hearing aid etc	
Falls History Agitation/ confusion or impaired judgement.	<ul style="list-style-type: none"> • Initiate falls bundle if at risk of falls • Increase observation/monitoring (cohort) • Use of Close observation monitoring (1-1) • 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.	<ul style="list-style-type: none"> • Test urine for infection weekly • Ensure patient knows location of nearest toilet • Frequent assisted toileting • Ensure patient positioned appropriately if using bedpans 	
Patient/Carer Information	<ul style="list-style-type: none"> • Does the patient understand their Falls Risk? <input type="checkbox"/>YES <input type="checkbox"/>NO • Has Falls Prevention Information been given? <input type="checkbox"/>YES <input type="checkbox"/>NO • Can Relative/carer assist with care plan e.g. increased visiting? 	
Clinical Assessment	<ul style="list-style-type: none"> • Baseline observations including lying and standing B.P. Is increased observation of the patient required in addition to Intentional rounding?	

Following a fall which includes a head injury or suspected head injury.

(NICE guidelines for Head Injury, 2007)

The person who has sustained a head injury or suspected head injury should be assessed using the 15 point Glasgow Coma Scale as soon as is practically possible. This initial assessment score will provide evidence for the frequency of the following investigations, which may include a computerised scan of the head and neck.

Perform and record half hourly observations using the Glasgow Coma Scale until G.C.S. = 15/15

Continue half hourly observations for further 2 hours.

If the patient continues to remain stable: then perform one hourly observation for 4 hours

If the patient deteriorates to G.C.S. <15 revert to half hourly observations again.

If the patient continues to remain stable then do two hourly observations for 12 hours

The minimal acceptable documented neurological observations are:

- GCS
- blood pressure,
- pupil size and reactivity
- temperature
- limb movements
- blood oxygen
- respiratory rate levels
- heart rate

The following also need to be taken into consideration:

- Has any agitation or abnormal behaviour developed?
- Is there severe or increasing headache developed or is there persistent vomiting?
- Are there new or developing neurological symptoms or signs, such as pupil inequality or asymmetry of limb or facial movement?

Management of the frequent falling patient

Some patients, due to a range of factors, have frequent falls. For those patients, it is important for relevant staff to follow the guidance below.

Responsibilities of Nursing Staff

Complete a Falls Risk Assessment within four hours of admission
If there is a Falls risk - implement Falls Action Plan.
Consider commencing the Fall Safe Bundle.

Complete a bedrail risk assessment.
Assess for bed/chair alarms
consider one-to-one nursing

Check that there is:
A call bell and instruct patient on usage
A clutter-free environment
Faulty equipment is removed and reported
The bed is at the lowest level position and brakes are on
Patient's belongings are within patient's reach
Night lights are used

Complete a manual handling assessment on admission

Document and review appropriately.

Responsibilities of Medical Staff

Review the patient's medication

Assess the patient's vision

Start a neurological assessment

Cardio-vascular assessment

Cognitive status assessment

NICE Guidance on Falls Management

In Community Setting, all Patients are asked about falls in the previous year

Patients who present at Medical facility following a Fall should follow the 'Recurrent Falls' Pathway

Recurrent falls

Single Fall

No Falls

Full Evaluation by Professionals with appropriate experience and skills

Check for Gait/Balance problems

No Intervention Required

Assessment:

History, Medications,
Gait and Balance, Vision,
Lower limb joints, Neurological,
Incontinence, Cardiovascular,
Fear and Function,
Osteoporosis risk

Gait/Balance Problems
Refer for Assessment

No Further problems =
No Intervention required

Multi-Factorial Intervention (As Required)

Gait, Balance, Exercise programmes
Medication modification
Postural hypotension treatment
Environmental hazards modification
Cardiovascular Disorders Treatment

Equipment

A range of equipment is available to support patients. However, every piece of equipment holds added risk for some patients so careful assessment is essential prior to use. In addition, the patient and relatives will normally need some instruction in safe usage before it is used. For example:

Beds of various designs:

Some beds can be lowered to within about 12” or 30cm of the floor.

Many beds are now electrically operated.

Alarm sensors for both the chair and the bed

Bed safety rails

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

Use the risk matrix above in combination with nursing judgement, remembering:

- Patients with capacity can make their own decisions about bedrail use.
- Patients with visual impairment may be more vulnerable to falling from bed.
- Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bedrails are used, may need padded covers.

Date	Time	Bedrails recommended?*	Comment if necessary	Sign	Print name
		Yes/no/with care			

Bed rail bumpers

Pressure relieving mattresses.

Normally the need for these would be assessed by the nurse who is looking after a patient.

Please note that the mattress height plus the pressure relieving mattress height should not be so tall that it makes cot sides or safety rails ineffective. There is a real added risk of falls if the equipment does not match each other or the specific needs of the patient.

Appropriate footwear for patients

Safe footwear has the following features:

An enclosure which encases the whole foot.

- ✓ Lots of room for toes.
- ✓ A cushioned sole
- ✓ Soft uppers with no seams
- ✓ An upper made of natural materials, i.e. leather preferably
- ✓ A lace or a Velcro strap rather than lace fastening
- ✓ A firm back to control the heel when walking
- ✓ A heel height of less than 1.5 inches (3-4cm)
- ✓ Non-slip soles, especially on polished floors

Available in the Dudley Trust are:

Anti embolic stockings with grips on the soles for those who are medium to high risk of Deep Vein Thrombosis and been prescribed them by a doctor.

Non slip slipper socks

Preventing Falls: Information for Patients

Most patients can help to reduce the risk of falling by doing the following:

- Being honest with the nurses if you feel anxious about moving around or are scared of falling
- Bringing in any prescribed medicines you are currently taking, in their original packaging
- Keeping the nurse call bell within reach and use it if you need assistance to move around the ward
- Being careful when standing up or getting out of bed
- Not using hospital furniture, such as bed tables, to help stand up
- Wearing lightweight shoes or well fitting slippers
- If wearing or have a walking aid, using it when moving around
- Taking time when moving, and not rushing
- Listening to the advice the therapy team or nurses provide
- Remembering the hospital is not as familiar to you as your home
- Keeping personal items within easy reach.

If you are a relative, carer or a friend you can help by:

- Sharing any information you have on previous falls the patient has had
- Making sure you put your chair away after visiting times and ensure you leave the bedside area uncluttered
- Making sure the patient realises you are leaving
- Placing the nurse call bell near the patient as you leave
- Ensuring that any items of clothing or footwear you bring are well fitting clothing and lightweight
- Bringing in any walking aids that may have been left at home, as well as items such as spectacles, dentures, hearing aids and prescribed medication
- Informing the nursing staff if you have any concerns.

If a patient is at high risk of falling we may:

- Put the bed in a different position
- Put the mattress on the floor
- Move the patient's position within the ward
- Use the safety sides on the bed
- Use a lower bed

Osteoporosis

If your patient is over 65 years old or has high risk of osteoporosis then use FRAX to assess your patient.

In England and Wales:

- Over 2 million women have osteoporosis
- 180,000 osteoporosis-related fractures occur annually
- 1 in 3 women over 50 years of age will sustain a vertebral fracture
- 2 million bed days annually are a result of fractures
- Annual social and hospital costs are £1.8 billion

Clinical Need

- Fragility fractures are the clinically apparent outcome of osteoporosis.
- In the absence of fracture osteoporosis is asymptomatic.
- Hip fractures are associated with increased mortality.
- 50-70% of vertebral fractures do not come to clinical attention.

Risk Factors

Independent clinical risk factors for fracture:

- Parental history of hip fractures
- Alcohol intake of 4 or more units per day.
- Conditions affecting bone metabolism e.g. inflammatory diseases such as R.A., hyperthyroidism, C.R.F. and coeliac disease.
- Low body mass index below 22 kg/m²
- Ankylosing Spodylisis.
- Crohn's Disease.
- Conditions resulting in prolonged immobility.
- Untreated premature menopause.
- Smoking
- Corticosteroid use for longer than 3 months
- Men with low testosterone.

Prevention

- Interventions such as:
- Weight bearing exercise.

- Smoking cessation.
- Reduce alcohol intake.
- ANY ADULT WHO HAS EXPERIENCED A FRACTURE RESULTING FROM A FALL FROM STANDING HEIGHT OR LESS SHOULD BE REFERRED FOR FURTHER INVESTIGATION.

Treatment

Depends upon the patients symptoms

Follow Frax.

Consider nogg guidance.

Consider N.I.C.E. guidance.

Does the patient require a DEXA SCAN

References and further help

Dudley Falls Service: Incorporates Dudley Falls Community Service and the Falls and Syncope :

Referral is made by completing the Referral letter on the back of the Falls Bundle or available from the Emergency Department and faxing to 01384 815459. Triage will take place and if appropriate the patient will be seen either in clinic or in the community.

Links of information about slips, trips, and falls

<http://www.ageuk.org.uk/health-wellbeing/keeping-fit/preventing/falls/>

www.independentliving.co.uk/fall-prevention.html

www.bgs.org.uk/campaigns/fallsafe/NPSA

www.nice.org.uk/CG021

www.patientsafetyfirst.nhs.uk

www.institute.nhs.uk

www.nhs.uk

Complete questionnaire and submit with

Questions for the Falls Training Please note there may be more than 1 answer to the question. Pass rate 80%.

1. Falling is the leading cause of injury related admissions to hospital in the over 65's and costs the NHS an estimated:
 - £23 billion a year.
 - £2.3 billion a year.
 - £230 billion a year.
 - £23 million a year.

2. NICE Guidelines state that certain groups of inpatients should be regarded as being at risk of falling. These include:
 - All patients 75 years and over.
 - All patients 50 years and over.
 - All patients 65 years or older and those 50-64 and judged by a clinician to be at higher risk of falling due to underlying medical condition.

3. Each year around 282,000 patient falls are reported to:
 - N.P.S.A
 - R.S.P.C.A.
 - R.S.P.B.
 - R.S.V.P.

4. Examples of a fall are:
 - A person who intentionally comes to rest on the ground or some other lower level.
 - A person who is helped to the floor in a gradual controlled decent.
 - A person who unintentionally comes to rest on the ground or some other lower level.
 - A person who collapses due to a decline in their medical condition.

5. A Falls Risk Assessment should be completed :
 - Within 24 hours of admission.
 - Within 48 hours of admission.
 - Within 2 hours of admission.

- Within 4 hours of admission.
6. If a Falls Risk is identified the professional should:
- Take preventative measures so the falls risk is minimised.
 - Do nothing.
 - Take measures to maximise the risk.
7. What could increase a person's risk of falling:
- Decreased mobility.
 - Illness or injury.
 - Being fit and well.
 - Some medications.
8. How could we help prevent falls:
- Do not assess for the use of bedrails.
 - Turn bed/chair alarm off.
 - Move nurse call bell away from patient
 - Ensure a clutter free environment.
9. The Falls Bundle should be started:
- On all patients
 - On all independently mobile patients.
 - Should not be started on any patients.
 - On patients who have been assessed at risk of falling and using clinical judgement of the assessor.
10. The Falls Bundle:
- Cannot be discontinued once started.
 - Can be discontinued if you want.
 - Can be discontinued following reassessment and using clinical judgement.
11. A multifactorial risk assessment should not include:
- Falls History
 - Assessing the balance of the patient.
 - Cognitive assessment.
 - Assessing the balance of the carer.

12. Ensure multifactorial interventions:
 - Do not address the patients identified risk factors for falling.
 - Offers prevention interventions tailored to address the patient's individual risk factors for falling.
 - Does not take into account whether the risk factors can be treated.

13. If you observe a patient falling you should:
 - Grab the falling patient.
 - Jump out of the way.
 - Try to prevent the patients head from injury.

14. Following a patient fall you should:
 - Put out a MET call on all patients that fall.
 - Ignore the patient.
 - Assess the patient for any injuries before moving them.

15. If a patient falls in the community the healthcare professional should:
 - Call an ambulance straight away.
 - Assess the patient then use their clinical judgement.
 - Leave them there for the family to get them up.

16. To report a fall the healthcare professional should:
 - Tell the next door neighbour or the patient in the next bed.
 - Write a full report on datix within 24 hours and document in the patients notes.
 - Just document in the patients notes.

17. The report should be:
 - Clear and factual.
 - Long and fictional.
 - Short and obscure.

18. When should a doctor to examine an inpatient who has fallen:
 - Only if they are injured.
 - All patients that have fallen.
 - Only if you remember to ask.

- Only if the doctor has the time.
19. Relatives, carers, next of kin should be informed of a patients fall:
- As soon as reasonably possible.
 - Never.
 - Only if the patient is injured.
 - Two days later.
20. Following a fall which includes an head injury or suspected head injury the following should be performed:
- Record blood pressure and pulse once only.
 - 15 Point GCS recorded once.
 - 15 Point GCS recorded following NICE Guidelines.
21. Responsibilities of the medical staff of frequent fallers are:
- Review of the patients medicines.
 - Leave it to the Nurse.
 - Tell the patient not to fall again.
22. To use bedrails:
- Patients need to be assessed for their safety before use.
 - Use bedrails on any one.
 - Use bedrails on confused, mobile patients to keep them in bed.
23. Information for patients and their consent.
- Patients do not need to be kept informed it's for their own safety.
 - There is patient information available and this should be given to all patients at risk of falling and their consent gained for any interventions.
 - Patients do not need to consent.
 - Discuss with the patient, relatives/carers the patients falls risk and interventions needed in their best interest and document the discussion in the patients notes.
24. How do we assess for Osteoporosis within the Trust.
- Use FRAX to assess.
 - We don't assess for osteoporosis.

- Use FRAT
- Use FRASE

25. How much is the annual and social costs of osteoporosis?

- £1.8 million
- £1.8 billion
- £18 million
- £18 billion

The Prevention and Management of Falls declaration

I confirm that I have read and understand the contents of the “Preventing slips trips and falls” booklet.

I understand that the booklet is supported with appropriate advice necessary for my role.

I understand that it my responsibly to seek further advice regarding policies from my line manager.

By signing this document I understand that I am making a declaration that I understand the requirements of me in my role in relation to the duties outlined in the Prevention and Management of Falls Policy.

Print your name:

Role:

Department / directorate:

Signed:

Date: