
Clinical Guidance

Guidance on the management of adult in-patient falls

Summary

This guidance is for all staff in the prevention and management of falls in adult in-patients. It involves a risk assessment and 5 interventions to manage the risk of falls in adults who have scored 2 or more on the risk assessment.

Document Detail	
Document Type	Clinical Guideline
Document name	Guidance on the management of adult in-patient falls
Document location	GTi Clinical Guidance Database
Version	2.0
Effective from	<i>September 2010</i>
Review date	<i>September 2012</i>
Owner	Clinical Lead, Elderly Care
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Approved by, date	Trust Falls Group, <i>May 2010</i>
Superseded documents	V 1.0
Related documents	Falls Risk Assessment Flowchart for In-patients Process of Identifying and Managing Patients with Multiple Falls
Keywords	Falls, stratify, falls pathway, falls prevention
Relevant external law, regulation, standards	NHSLA Risk Standards, Criterion 3.5

Change History		
Date	Change details, since approval	Approved by

Guidance on the management of adult in-patient falls

This document provides guidance on the assessment of all adult in-patients for the risk of falls and the prevention strategies to be used on each patient assessed to be at risk. This guidance is to be used in conjunction with the supporting documents listed below:

- Observation policy
- Weekend walking aids guidance
- Falls risk assessment flowchart
- Bed rail policy
- Delirium policy
- Falls Management Care plan
- Multiple Falls flowchart
- Guidance on the Safe Use of Falls and Injury Prevention Equipment and Resources

1.0 Introduction

Each patient must be assessed for risk of falls and should receive multifaceted clinical and environmental interventions that could reduce the risk (NPSA 2007). This guidance sets out the Trust objectives in relation to the management of the risk of falls to patients which have huge human and financial costs

Some clinical areas will be exempt from this guidance by nature of the fact that the patients in this area have high levels of nursing support i.e. one to one nursing. These areas would include intensive care and high dependency areas, maternity and theatres and recovery. Falls prevention among children in the Evelina Children's Hospital will be managed according to local policies and procedures. A&E and outpatient areas will manage falls risks as part of their clinical management of confused patients.

2.0 Rationale

Patient falls have both human and financial costs. For individual patients, the consequences range from distress and loss of confidence, to injuries that can cause pain and suffering, loss of independence and, occasionally, death. NRLS data suggest 530 patients may fracture their neck of femur in hospital each year, and 26 deaths have been reported related to falls during one year (NPSA, 2007). Although most falls are reported as causing no or low harm, some falls result in significant injury and death, and can lead to additional healthcare costs.

3.0 Scope

This policy will apply to all staff who have clinical responsibilities for patients. It will also apply to all Trust staff who individually have responsibility for maintaining a safe environment for patients, staff and visitors

4.0 Principles of Falls Risk Management

All adult in-patients (excluding those admitted to the areas that are exempt from using this guidance) will have their risk of falls assessed on admission to the clinical area and managed in the following manner:

- Each patient admitted or transferred in will be assessed for the risk of falls using Stratify – falls risk assessment tool within 4 hrs of admission or transfer
- Each patient, who has a score of 2 or greater, will have a multi-faceted care plan that will address the level of risk with specific actions within 6 hrs of admission. They are as follows:
 - Red square above the bed space
 - Level of observation prescribed
 - Appropriate equipment in use
 - Delirium assessment and care plan if appropriate
 - Appropriate position on the ward
- Each patient will have their falls risk assessment repeated weekly or if their condition changes or if they have a fall, whichever comes sooner.
- Ward staff will ensure that the appropriate equipment for the management of falls is available on the ward. Alternatively, staff should be aware of how to access the equipment via the equipment library
- Staff will be appropriately trained in the management of falls.
- Specialist team in place to advice and support staff with complex assessments or management issues

5.0 Admission Procedures

5.1 Role of Nurse

On admission or transfer in, each patient will be assessed by a nurse for the risk of falls using Stratify within 4 hours of reaching the ward. The Stratify document should be dated signed and timed.

Patients who score 2 or more

- 5.1.1 Patients scoring 2 or more on Stratify should have a red square placed above their bed, indicating to all that this patient is at a high risk of falls
- 5.1.2 The admitting nurse with the shift leader must decide on the level of observation appropriate for this patient (Refer to observation policy) within 6 hrs of admission. If arms length nursing is required this must be reported to the matron for approval and for resource allocation and management.
- 5.1.3 The admitting nurse must consider where on the ward this patient would be best nursed within 6 hrs of admission. This may be dependent on the presenting patient behaviour and the level of risk of fall to this patient. For example, the patient may be agitated and wandering. This patient may benefit from arms length nursing and so can be nursed in a side room.
- 5.1.4 The admitting nurse must also assess the need for use of specific falls equipment to be used to ensure patient safety, for example, low bed with crash mats, Wanderguard equipment etc. Within 6 hrs of admission, the required equipment must be available for use on the ward. The matron/HON must be informed if this is not achieved, so that alternative strategies may be used in the interim.
- 5.1.5 Before the end of shift, the nurse must check that the patient has been assessed for delirium and a medical plan of care is available if appropriate. The admitting doctor must be contacted if the patient has not been assessed for delirium. The nurse must ensure that the medical care plan instructions are incorporated into the nursing plan of care for the patient.

- 5.1.6 By the end of the shift the shift leader must ensure that the patient has a care plan for the management of his/her falls risk, clearly documented in the patient records.

Patients with a Stratify Score of 1

- 5.1.7 For patients who score 1, it would be important to focus on the behaviour that resulted in the score of 1. If it is agitation, the patient would benefit from an assessment by the doctor for delirium and care planned accordingly. If the score was as a result of poor eyesight, then the focus of care for falls prevention should be orientating the patient to the environment and support with transfers, mobility etc.

5.2 Doctor's Role

Patients who score 2 or more

- 5.2.1 The admitting doctor must check that the patient has been assessed for the risk of falls using the Stratify tool and that the patient has a red square above the bed area, an observation level has been agreed and the appropriate equipment has been requested and/or is in use.
- 5.2.2 The admitting doctor must ensure that the patient is assessed for delirium and provide a plan of care if appropriate.

Patients with a Stratify Score of 1

- 5.2.3 Patients who have a stratify score of 1 may require an assessment for delirium. (Refer to delirium pathway)

6.0 Transfer Procedures

- 6.1 When a patient is transferred to a ward, the admitting nurse should assess the patient using Stratify as the move may disorientate the patient who may become unsettled. If the score is 2 or greater, the nurse must follow the instructions under 5.1.2 to 5.1.6 above.
- 6.2 The receiving medical team must ensure that the appropriate nursing management strategies to manage the risk of falls are in place. The doctor must also review the assessment for delirium and take the appropriate actions, i.e. revise the care plan, discontinue care plans of resolved etc.
- 6.3 The handover of the patients during transfer must include risk of falls, level of observation and any special equipment being used by the transferring ward
- 6.4 If the patient has been receiving arms length nursing, the nurse booked to provide arms length nursing must be transferred with the patient, until the end of the shift. This is to allow the receiving ward to make the necessary arrangements for extra resources. If the patient is transferred later in the evening and a nurse has been booked to provide arms length nursing by the transferring ward to cover night duty, the nurse must be sent to the receiving ward if it has not been able to book someone to cover night duty.

7.0 Actions following a fall on the ward

- 7.1 All falls must be recorded on the Datix incident reporting system on the same day as the fall
- 7.2 Following a fall, the patient must be reassessed for the risk of falls using stratify again, taking into consideration the possible causes for the current fall.
- 7.2.1 If the Stratify score is 2 or higher, the nurse must follow the instructions on sections 5.1.2 to 5.1.6 above.

- 7.2.2 If the patient has a score of 1 or less, please seek guidance from the multidisciplinary team or the Falls Group for advice on the management of this patient.

8.0 Multiple Falls (also refer to Flow Chart)

- 8.1 When the patient has fallen for the second time, the patient must be referred the multi-disciplinary team (MDT) for advise on the assessment and management of this patient at an immediate available opportunity and at the latest within the next working day. The MDT must consist of the ward nurse, a physiotherapist and a doctor as a minimum.
- 8.2 If the patient has a third fall, the incident must be investigated using the RCA model, to ascertain why this patient continues to fall. The patient must also be reviewed by a Falls consultant and a Falls Group member, and together with the MDT, the management of the risk of further falls or injury to this patient must be agreed and recorded in the health records. The review must take place within the next working day following the fall and extra steps to minimise the risk of further falls must be used until the review is undertaken

9.0 Falls Group

- 9.1 The Falls Group will review policies, procedures and protocols yearly or as necessary and disseminate the information Trust-wide. This group will also act as an advisory group for staff who require advice and support in managing falls in patients
- 9.2 The Falls Group Chair will organise and support audits that monitor compliance with the guidance, incidence of falls across the trust and equipment bi-monthly.
- 9.3 The Falls Group will review the falls data monthly and analyse trends, incidences and recommend remedial actions where appropriate
- 9.4 The Falls Group will review complex cases or all incidents of multiple falls by a patient or areas considered to have higher incidence of falls and use the information to inform policy and disseminate the learning, widely across the Trust

10.0 Training and Education

- 10.1 All staff who provide care and treatment to adult patients will be offered training on how to assess and manage falls in in-patients. Staff must contact their practice development nurses for falls management training.

11.0 Equipment for the Management of Falls

- 11.1 Each clinical area should ensure that it has access to low beds and crash mats. (Refer to flow chart re access to low beds)
- 11.2 Each clinical area should have access to Wanderguard chair and bed sensors to help monitor patient movement in the management of falls either on the ward or via the equipment library
- 11.3 In addition to the above all wards where older patients are nursed should have access to the following equipment as part of its standard ward equipment:
- Frames surrounding toilets as transfer support for older patients
 - Raised toilet seats
 - Chairs of varying heights to suit patients with different heights
 - Access to walking aids out of hours to ensure safety with mobility and transfers

- Access to chair raisers to suit the needs of patients with varying heights
- Supply of approved slippers for patients who do not have footwear with them and are unable to get any during their admission
- Bars along walls to support those patients who are frail in walking independently and safely
- Access to appropriate bed rails to support patients who may be at risk of rolling or slipping out of bed (Refer to Safe and Effective use of Bed Rails Guidance)

12.0 Monitoring Compliance of this Guidance

12.1 Use of and compliance with this Clinical Guidance on the Management of Adult In-Patient Falls will be monitored by the Falls Group.

Measurable Policy Objective	Monitoring/ Audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
All appropriate in-patient adults have been risk assessed using Stratify	Case notes audit	6 monthly	Matrons/ward managers	Falls group Clinical Indicator Meeting
Existence of Care Plans for each of the patients score 2 or more on Stratify that include: <ul style="list-style-type: none"> • Red square above bed • Observation level • Equipment • Delirium assessment and actions • Position on ward 	Case notes audit	6 monthly	Matrons/Ward Managers	Falls group Clinical Indicator Meeting
All wards have the appropriate equipment for safe management of patients with a risk of falls	Case notes audit Incident reporting	6 monthly	Matrons/Ward Managers	Falls group Clinical Indicator Meeting
Evidence that all patients are assessed weekly or if their condition changes, i.e. a fall, transfer to another area etc	Case note audit	6 monthly	Matrons/Ward Managers	Falls group Clinical Indicator Meeting

PATIENTS NAME: _____ WARD: _____ HOSPITAL NO: _____

S. T. R. A. T. I. F. Y.

		Admission	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Date										
1	Did the patient present to hospital with a fall or have they fallen on the ward since admission? (Yes = 1, No = 0)									
Do you think the patient is: (Questions 2-5)										
2	Agitated? (Yes = 1, No = 0)									
3	Visually impaired to the extent that their everyday function is affected? (Yes = 1, No = 0)									
4	In need of especially frequent toileting ? (Yes = 1, No = 0)									
5	Gait Pattern Unable to walk/stand without major prompting and help (Yes = 0) Independently and safely mobile with or without a walking aid (Yes = 0) Mobile/independent with minimum assistance but unsteady (Yes = 1)									
TOTAL SCORE										
Signature of nurse assessing										

If total score is 2 or more or if the patient falls on the ward proceed to, falls intervention strategy including nursing care plan (see below)

INSTRUCTIONS FOR COMPLETION:

When completing this tool consider all patient falls risks, including falls from height (e.g. from beds, stairs etc.).

- To be completed on day of admission to ward for all patients by the nurse and to be kept at the end of bed notes until discharge
- If the STRATIFY score is 2 or more, (e.g. score for agitation and poor gait for those withdrawing from alcohol), the patient is at high risk of a fall and needs to (a) be placed on the falls pathway, and (b) have an amber or red risk square placed above the bed according to the falls risk assessment flowchart
- If the STRATIFY score is below 2, repeat STRATIFY if the patients condition changes in a way that may increase their falls risk (e.g. new onset confusion or incontinence)