

FALLS: RISK ASSESSMENT, INTERVENTION AND POST FALLS PROCEDURE

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VALIDITY – Policies should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	September 2019	<i>New procedural document. Linked to the revised Falls Policy (patient). New guidance on high risk medications included. Falls flowchart refreshed. Physical assessment of life and limb injuries included. Clear escalation processes. Clear timeframes for medical assessment.</i>
1.1	August 2022	<i>Aligns with NICE guidance in older people. Considers other additional risk factors. Additional detail regarding risk assessment in under 65s. Includes descriptors of all element of the MFRA. Includes response post fall in both in-patient and community setting. MFRA and exploration of fall form updated as part of this review.</i>
1.2	August 2023	<i>Reviewed in line with NG232 published May 2023 replacing CG176 Additional clarity regarding assessment of consciousness using GCS and escalation of patient with suspected head injury and those on anti-coagulation to reflect NICE guidance. Addition of the LOOK:FEEL:MOVE principles as aligned to Model 3 of the NAIF/RCP Best and safe practice guidance 2022. Clarification regarding pre-screening and MFRA in community and inpatient settings. Clarification as per recommendation from SI relating to roles/responsibilities. Approved at PHMD Group (9 August 2023). Update - NICE guidance CG161 (Falls in Older People) review delayed from August 2024 to 2025. Once updated, falls policy and procedure documents will both be updated accordingly. This document's review date now extended to June 2025 (approved by Sadie Milner – 16 August 2024).</i>

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1. INTRODUCTION

This procedure should be read in conjunction with the Falls Policy. This procedure provides clear guidance on the following:

- Pre-screening
- Bedside vision check
- Multifactorial falls risk assessment
- Risk factors including environment, osteoporosis and polypharmacy
- Multifactorial interventions to reduce the risk of falls
- Assessing a patient for physical injury following a fall referred to as a post falls check
- Post fall review (Exploration of fall)

The Falls Policy and Procedure aligns with the NICE guidance and Quality standards CG161 and QS86 Falls in older people; NG232 Head injury: assessment and early management (May 2023); Spinal injury: Assessment and early management; Hip fractures in adults. It describes the required assessments, intervention and post falls management in both community and inpatient settings.

When exercising their judgement, professionals and practitioners are expected to take relevant NICE guidelines fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian. However, reasons for non-compliance with applicable NICE guidance must be clearly recorded in the patient's clinical records.

In November 2022 the Royal College of Physicians in conjunction with the National Audit of Inpatient (NAIF) published 'Supporting best and safe practice in post falls management in inpatient settings' which incorporates the LOOK: FEEL: MOVE principles. The guidance recommends that organisations should develop a bespoke implementation based on their unique context taking into account inpatient population, clinical acuity, access to medical cover, and workforce skills. This falls policy and procedure reflects Model 3 as described in the RCP guidance, which recognises that Humber Teaching NHS Foundation Trust is not an acute trust and our services do not have access to a specialist falls team, 24 hours medical cover, acute trauma services, and that flat lifting equipment may not be available in all inpatient settings. See Section 7: Post Falls Check and Appendix 1: Post Falls Decision Making Flow-chart.

Model 3 requires a wide-ranging post-falls management competencies including:

- All clinical staff are trained in BLS and NEWS2
- All ward based clinical staff are able to:
 - Perform a post fall check before the patient is moved from the floor
 - Support safe movement from the floor
 - Support access to medical assessment, prescription of analgesia and on-going observation

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 falling and 50% of people older than 80 falling at least once a year. The consequences of a fall can be physical, social and/or psychological.

Physical

- Discomfort pain
- Serious injury
- Inability to look after oneself

- Long term disability

Social

- Loss of independence
- Loss of social contacts
- Loss of home
- Move to residential care
- Financial costs of help/care/hospital
- Decreased quality of life
- Changes to daily routine

Psychological

- Loss of confidence
- Loss of independence
- Fear
- Distress
- Guilt
- Blame
- Anxiety
- Embarrassment

By asking questions in routine assessments and reviews about falls and their context, health and social care practitioners can identify older people who may be at risk of falling. Multifactorial falls risk assessment and multifactorial interventions aim to address the risk factors associated with falls.

2. SCREENING AND ASSESSMENT

Community patients/non-inpatient settings:

As per NICE Quality Standard QS86 and NICE CG161 patients aged 65 years and over presenting to services should routinely be asked the following to identify if they are at risk of falling:

- Whether they had two or more falls in the past year AND/OR
- If they ever lose their balance or feel unsteady on their feet (abnormal gait or balance)

Any older people presenting for medical attention following a fall or reporting recurrent falls or abnormal gait or balance should be identified as being at risk of falling will be offered a multi-factorial risk assessment to identify any risk factors for falling.

Older people who are judged by a clinician to be at higher risk of falling because of an underlying condition will be offered a multi-factorial risk assessment.

For teams and services delivering out-patient care, for example but not limited to, where the primary focus is the provision of mental health assessment or treatment, there is not an expectation that staff in these teams will have the expertise to conduct a full MFRA. If during the consultation falls risk factors are identified it is recommended that the patient be sign posted to an appropriate service for a more comprehensive assessment of falls risk i.e. community falls team, GP.

All inpatient settings:

As per NICE Quality Standard QS86 and NICE CG161 patients aged 65 years and over admitted into an inpatient ward are deemed as being at risk of falling in hospital regardless of their fall's history or gait/balance. All patients admitted to hospital over the age of 65 should therefore have a multi-factorial risk assessment.

Adults aged 50 to 64 years

As per NICE CG161 patients aged 50 to 64 years admitted to hospital for any reason **and** who are judged by a clinician to be at higher risk of falling because of an underlying condition will be offered a multi-factorial risk assessment.

Humber Teaching NHS Foundation Trust have developed a single multi-factorial risk assessment template for inpatient setting which includes both elements:

- identify any risk factors for falling
- specific risk factors for falling in hospital

Patients under 50 years admitted to inpatient wards

NICE guidance specifically relates to older people however due to the nature of our services and client groups there may be other patients presenting with a higher risk of falling whilst in hospital. These factors may not be multi-factorial in nature. Examples include but are not limited to:

- are taking four or more medications (polypharmacy) or taking high risk medication
- intoxication due to alcohol/drug use
- memory impairment/confusion/delirium
- mental health/behavioral concerns
- sensory impairment
- poor nutrition/hydration
- postural hypotension
- underlying health conditions

Whilst in such cases a full multi-factorial risk assessment and multi-factorial interventions may not be appropriate every effort will be taken to address specific risk factors and mitigate risk and a plan of care to address this should be formulated.

People with a Learning Disability:

National policy and guidance on preventing falls focuses on older people (those 50-64 and those 65 or older). A growing body of evidence relating to people with learning disabilities suggests that much of the national policy and guidance may be equally applicable [Preventing falls in people with learning disabilities: making reasonable adjustments - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67422/preventing_falls_in_people_with_learning_disabilities_making_reasonable_adjustments.pdf). Where people with a learning disability in the community are identified as being at risk of falls it may be prudent to carry out a multi-factorial risk assessment to identify any risk factors for falling. This should be led by a health professional with appropriate skills and experience, for example specialist Occupational Therapist or Physiotherapist, Learning Disability Nurse or as part of a specialist falls service. Where a patient is in hospital a multi-factorial risk assessment to identify specific risk factors for falling in hospital should also be completed.

3. MULTIFACTORIAL FALLS RISK ASSESSMENT AND INTERVENTIONS

3.1. Multifactorial Falls Risk Assessment

The Multifactorial Falls Risk Assessment (MFRA) should be performed by a healthcare professional with appropriate skills and experience.

This risk assessment should form part of an individualised multifactorial intervention to reduce the risk of falls. There are two components to a MFRA:

- assessment to identify any risk factors for falling
- assessment to identify specific risk factors for falling in hospital

It is important that the multifactorial assessment identifies the patient's individual risk factors for falling. Following the completion of the multifactorial risk assessment, multifactorial interventions need to be initiated to address each risk identified. All risks are to be addressed in the care plan. In order to comply with contemporaneous record keeping, the multifactorial falls risk assessment

must be completed through the clinical system (Lorenzo and SystemOne). Do not routinely complete and scan paper versions onto the clinical system. However, should the clinical system become temporarily unavailable, paper copies of the [Multifactorial Risk Assessment](#) and the [Exploration of Falls](#) forms can be printed from the intranet.

The multifactorial assessment covers the following areas:

3.1.1. History of falling

History plays an important factor in the multifactorial falls risk assessment. When assessing falls history consider the following:

- Frequency, circumstances, or any patterns related to previous falls
- Before the fall: any pre-syncopal symptoms, what were they doing, any infective symptoms, how do they usually mobilise?
- During the fall: do they remember falling, was it witnessed, was there any loss of consciousness, can they describe the mechanism of the fall, were they able to do anything to stop the fall?
- After the fall: were they orientated, were they able to get up from the floor, were they able to mobilise following the fall, how long were they on the floor for?

3.1.2. Medication

Polypharmacy: when a patient is prescribed four or more drugs it is a potential risk factor for falls and potential harm in people of all ages. Taking medications significantly increases the risk for falling because:

- There are a greater number of side effects associated with multiple medication use and the side effects are often more intense
- Interactions between medications can also cause side effects
- Medications react differently in the body as a person ages which can increase the risk for falling

People who are identified as being at high risk of falling and who are on four or more medications may require a medication review if not undertaken recently, taking into account any recent medication changes or changes in clinical presentation.

Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued, if possible, to reduce their risk of falling (NICE, 2013, 1.1.7)

High risk medications, broadly speaking, are medications that:

- Affect brain function (benzodiazepines, non-benzodiazepine prescription sedatives, antipsychotics, anticonvulsants, mood stabilisers, anti-depressants. Opioids, anticholinergics, dopamine agonist, MAOI-B inhibitors),
- Act on the heart or circulation (antihypertensives, diuretics, alpha-blockers), or
- Lower blood glucose (oral or injectable diabetic medication)

Medications can increase the risk of falls through:

- Sedation
- Impaired postural stability (inability to maintain posture)
- Hypotension (low blood pressure)
- Drug induced parkinsonism (Parkinson's like symptoms)
- Visual impairment (blurred vision, dry eyes)
- Hypoglycaemia (low blood sugar)
- Vestibular damage (tinnitus, deafness)
- Hypothermia (low body temperature)
- Confusion
- Dehydration

Refer to Appendix 2 Guidance on Medication and Falls Risk.

3.1.3. Measurement of lying and standing blood pressure

Lying and standing blood pressure should always be undertaken as part of a multifactorial risk assessment [Measurement of lying and standing blood pressure: A brief guide for clinical staff | RCP London](#)

- The first BP should be taken after lying for at least five minutes
- the second BP should be taken after standing in the first minute
- the third BP should be taken after standing for three minutes
- This recording can be repeated if the BP is still falling
- Symptoms of dizziness, light-headedness, vagueness, pallor, visual disturbance, feelings of weakness and palpitations should be documented
- A positive result is:
 - A drop in systolic BP of 20 mmHG or more (with or without symptoms)
 - A drop to below 90mmHG on standing even if the drop is less than 20mmHG(with or without symptoms)
 - A drop in diastolic BP of 10mmHG with symptoms (although clinically much less significant than a drop in systolic BP)

Advise the patient of results and if the result is positive, inform the medical and nursing team immediately and take immediate actions to prevent falls or unsteadiness.

3.1.4. Alcohol

Consideration should be made for alcohol consumption related to falls and offers of support if dependence is identified. Alcohol may affect balance reactions and may also be associated alcohol neuropathy.

Patients who are on the ward and at risk of falls due to intoxication through alcohol or other substances can be supported through the use of increased Supportive Engagements without the need to complete a full multifactorial falls risk assessment as this would be deemed as a transient risk requiring short term risk mitigation. This must be documented in the clinical records and clearly state the interventions required to support the patient whilst they are at an increased risk of falls.

3.1.5. Nutrition

Poor nutritional and hydration may increase the risk of falls. As part of the MFRA consider:

- Unintentional weight loss
- Reduced/poor appetite
- Poor food/fluid intake.
- Body weight less than 9 stone (57kg) or BMI 20kg/m² or less

A MUST should then be completed and onward referral to dietician or GP as indicated as per the nutrition and hydration guidelines

3.1.6. Sensory impairment

Sensory impairment may increase a patient's risk of falling. Consider if the patient has poor vision or poor hearing. Consider the need for onward referral if a new or changing hearing impairment is identified. See section below on how to conduct a bedside vision check.

Completing a Bedside Vision Check for Falls Prevention

The Royal College of Physicians advocates that assessment 1, 2 and 3 of the bedside vision check should be attempted for all patients at risk of falls and assessments 4 and 5 should be attempted for all patients at risks of falls whenever possible.

Follow the link for the assessment guide and document the answers into the falls care plan.
[Bedside vision check for falls prevention: assessment tool | RCP London](#)

3.1.7. Feet / footwear / clothing

A significant number of falls are the result of wearing footwear that doesn't fit properly or offer enough support. People should be advised about the importance of wearing well-fitting shoes and about the characteristics that can aid walking and gait. The NHS guidelines for safe footwear are very much in-line with those promoted by the Healthy Footwear Guide. They recommend:

- An upper made of leather or breathable natural or synthetic materials with seam-free linings.
- A deep and roomy toe-box at the front of the shoe to prevent pressure on the toes and joints on the side of the foot.
- A cushioned and flexible light rubber sole with good grip.
- A heel no more than 3 centimetres (one and a half inches) high and broad enough to provide stability.
- Laces, buckles or Velcro strap fastenings that hold the shoe comfortably and securely on the foot. Avoid slip on shoes.
- Foot conditions such as bunions, claw toes, ingrown toenails and general foot pain can all cause problems with gait and balance.

3.1.8. Balance, mobility, and gait.

The NICE guideline (CG161) recommends that older people with a history of falls, or who are considered to be at risk of falling, should be observed for balance and gait deficits.

As part of the assessment, it should be noted if the patient:

- Is unsteady on their feet
- If they shuffle
- If they hold on to furniture
- If they use a walking aid

Any of the above would indicate an abnormal gait/ balance.

The TUG (Timed up and go) test is a frequently used test of balance and gait. In the TUG test, a person is observed and timed as they rise from a chair, walk 3 metres, turn, walk back to the chair and sit down. It can be used in any setting and needs no specialist equipment. The time taken to complete the test, measured using a stopwatch, is compared with standard values. Longer times are associated with a greater risk of falls. Clinical judgement of stability, gait, stride and sway can also be used as a component of the assessment

3.1.9. Continence

Continence contributes to falls risk in several ways:

- rushing to the toilet particularly at night
- drowsiness in the day as a result of interrupted sleep
- medications used to treat incontinence such as antidepressants and anticholinergic medications can cause postural hypotension
- poor fluid intake which can exacerbate urgency, frequency, and incontinence
- people can become distracted as a result of being focused on needing to get to the toilet

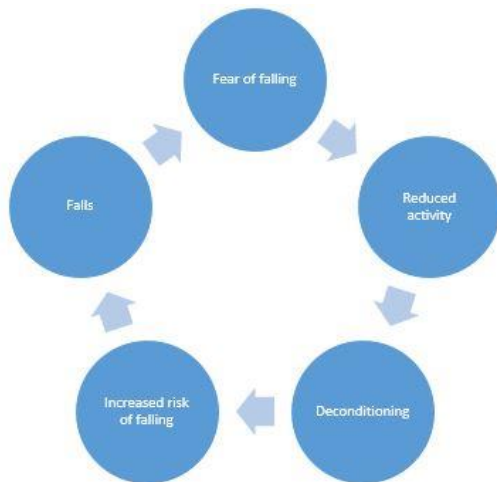
3.1.10. Osteoporosis risk

Bone fragility (Osteoporosis) occurs as a result of normal ageing and in association with identified lifestyle factors and chronic disease states. Osteoporosis results in a substantial increase in the risk of fragility fractures. One in two women and one in five men suffer an osteoporosis related fracture after the age of 50. 90% of osteoporotic fractures occur as a result of a fall. If the person presents with osteoporosis risk factors then a FRAX assessment should be completed and the patient referred on as per the local osteoporosis pathway.

3.1.11. Reduced confidence / fear of falling

Reduced confidence and the fear of falling can further increase the risk of falling. When assessing the impact consider the following factors:

- Changes in lifestyle due to falls?
- Is the patient able to get off floor?
- Is the patient able to summon help?



3.1.12. Memory / comprehension

There are different personal risk factors that cause people to fall, however, people with dementia / cognitive changes are at greater risk because they:

- are more likely to experience problems with mobility, balance, and muscle weakness
- can have difficulties with their memory and finding their way around
- can have difficulties processing what they see and reacting to situations
- may take medicines that make them drowsy, dizzy, or lower their blood pressure
- are at greater risk of feeling depressed
- may find it difficult to communicate their worries, needs or feelings

Consider:

- Is the patient disorientated, restless or highly irritable or agitated?
- Does the patient have reduced insight and/or judgement?
- Does the patient have short-term memory/comprehension difficulties that may affect ability to follow advice given?
- Are there are concerns regarding the patient's mental capacity?
- Is acute confusion/delirium present?

3.1.13. Night pattern

Falls risk is increased if the person gets out of bed frequently through the night, consider what safety measures are in place. Nocturia is where someone frequently wakes up in the night and needs to pass urine. It often increases with age. It is common with elderly people who may be getting up twice a night but more frequent visits to the toilet may indicate a problem that requires further investigation.

3.1.14. Environment Home hazard risk assessment

Adapting or modifying the home environment is an effective way of reducing the risk of falls for older people living in the community. A review of environmental home hazards undertaken in the person's home, and intervention if needed, has been identified as a component in successful multifactorial intervention programs. It is important that a review of home hazards is undertaken after a multifactorial falls risk assessment has been completed.

3.2. Multifactorial Interventions

All people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention. In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification/withdrawal
- Referral to Physiotherapy
- Referral to Occupational Therapy
- Continence assessment
- Telehealth / sensor equipment

Ensure that any multifactorial intervention:

- promptly addresses the patient's identified individual risk factors for falling in hospital; **and**
- takes into account whether the risk factors can be treated, improved or managed during the patient's expected stay.

Do not offer falls prevention interventions that are not tailored to address the patient's individual risk factors for falling.

Following treatment for an injurious fall, people should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.

3.2.1. Specialist assessment

If the risk cannot be managed or reduced, escalation for a specialist assessment may be needed, which may involve a medical review. Contact the GP or local falls teams for advice.

4. ASSESSMENT OF RISKS IN INPATIENT ENVIRONMENTS

Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed at point of admission into in-patient services.

5. ASSESSMENT OF RISKS IN A PATIENT'S HOME

Patients at risk of falling should receive at home should receive a multi-factorial risk assessment including a review of environmental home hazards. This is particularly important following an admission to hospital following a fall at home.

6. PATIENT ENGAGEMENT, INFORMATION AND LEVEL OF OBSERVATION

6.1. Patient Engagement

- Healthcare professionals involved in the assessment and prevention of falls should discuss what changes a person is willing to make to prevent falls.
- Information should be relevant and available in languages other than English.
- Falls prevention programmes should also address potential barriers and fear of falling, and encourage activity change agreed in conjunction with the patient.

Practitioners who are involved in developing falls prevention programmes should ensure that such programmes are flexible enough to accommodate participants' different needs and preferences and should promote the social value of such programmes.

6.2. Information and Support

Provide relevant oral and written information and support for patients, and their family members and carers if the patient agrees. Take into account the patient's ability to understand and retain information. Information should include:

- explaining about the patient's individual risk factors for falling in hospital
- showing the patient how to use the nurse call system and encouraging them to use it when they need help
- informing family members and carers about when and how to raise and lower bed rails [Bed Rails Policy](#)
- providing consistent messages about when a patient should ask for help before getting up or moving about
- helping the patient to engage in any multifactorial intervention aimed at addressing their individual risk factors
- providing the Falls Prevention Patient Information leaflet:
 - For community-based patients please use [Get up and go - a guide to staying steady](#)
 - For inpatients please use [Falls prevention in hospital: a guide for patients, their families and carers | RCP London](#)

6.3. Level of Observation for inpatient units

There are four observation levels in relation to falls prevention. The level of required observation is based on multiple factors including but not limited to; falls risk assessment, clinical presentation, social factors and environment factors. Clinical judgement is required when agreeing with the patient an appropriate level of observation. Evidence that such observations have taken place should be recorded in the clinical records.

- Level 1: Routine observation
- Level 2: Enhanced observation with increased care rounding at 15–90-minute interventions
- Level 3: Enhanced observation with the patient kept within line of sight
- Level 4: In exceptional circumstances close care is used with the patient kept within arms'-reach. Consideration must be given to Deprivation of Liberty Safeguards and Reducing Restrictive Interventions.

Any person who has fallen, explore the fall with the patient and or carer where possible and document any change to the level of observation within the care plan.

7. POST FALL CHECK

[Supporting best and safe practice in post-fall management in inpatient settings | RCP London](#) outlines in detail the Post Falls Check. As recommended by RCP, the guidance should be used to reflect local services and therefore this procedure takes into account the variety of inpatient services delivered by HTFT recognising that we are not an acute hospital setting, limited access to 24/7 medical cover and flat lifting equipment may not be available within all inpatient settings.

The post fall check is a brief assessment with the purpose of:

- checking whether there is a serious medical cause of the fall that needs an immediate medical response
- identifying important injuries resulting from the fall that may influence the way in which a patient is moved from the floor and the subsequent medical response

The post-fall check seeks to identify potential injuries, not to make a formal diagnosis. Suspicion of injury will then guide how the patient is moved from the floor, subsequent observation and assessment and the urgency of a post-fall medical review.

The assessments and actions recommended presume the competency of the clinical staff who are expected to undertake them.

Community/Outpatient settings:

Whilst the RCP guidelines have been produced to support post-falls management in an inpatient setting it is acknowledged that these practical steps can also be employed following a fall in a community/outpatient setting where clinically competent staff are available to carry out an assessment of the fallen patient. Where staff in a community/outpatient setting do not have skills/training in post falls management and there are any concerns that the fall has resulted in actual or potential injury then call 999. If the patient who has fallen has no actual or potential injuries, they should be advised to seek urgent medical assessment if their condition deteriorates, or if they develop any of the following signs/symptoms:

- Unconsciousness or lack of full consciousness
- Confusion, for example not knowing where they are, getting things muddled up.
- Drowsiness (feeling sleepy) for more than an hour when they would normally be wide awake.
- Difficulty waking the person up.
- Problems understanding or speaking.
- Loss of balance or problems walking.
- Weakness in one or both arms or legs.
- Problems with their eyesight.
- Very painful headache that won't go away.
- Vomiting (being sick).
- Fits or seizures (collapsing or passing out suddenly).
- Clear fluid coming out of their ears or nose.
- Bleeding from one or both ears.
- New deafness in one or both ears.

STEP 1: IMMEDIATE RESPONSE

Is the patient responsive?

If the patient is **unresponsive** check airway and breathing and follow the [Medical Emergencies and Resuscitation Policy](#). If breathing is absent/abnormal initiate Basic Life Support considering DNACPR status. Dial 999.

If the patient is **unresponsive** but breathing normally, dial 999. If they are unresponsive and there is no suspicion of spinal injury, place the patient in the recovery position.

If the patient is **less responsive** carry out observations (NEWS2/BM where feasible). If NEWS2 is 4 or above dial 999.

Whilst waiting for the ambulance undertake continuous NEWS2 observations, leave the saturation probe in place, watch the patients at all times for changes in respiratory rate and level of consciousness, perform blood pressure measurement and repeat regularly if abnormal, observe for any seizure activity

If the patient is **responsive** confirm 'Did the patient lose consciousness?'. If yes, carry out observations (NEWS2/BM where feasible). If NEWS2 is 4 or above immediate medical response is required (this will require a 999 response if medic is not immediately available). If the patient did not lose consciousness move to the next step 'Assess for Head Injury'

STEP 2 POST FALLS CHECK – LOOK: FEEL: MOVE

Healthcare professionals must check people who fall for signs or symptoms of head injury, spinal injury, hip fracture and other fractures. The post fall check must be carried out by a competent registered practitioner. LOOK: FEEL: MOVE assessments should be carried out in the order indicated below starting with LOOK progressing to FEEL and then MOVE if indicated.

HEAD

LOOK:

Did the patient hit their head when they fell?
Do they have obvious facial or head injuries (bruises or lacerations)
Was the fall unwitnessed?
Does the patient have **new** asymmetry of pupils?
Is the patient on anticoagulant or anti-platelet medication, do they have a blood clotting disorder, or have they had recent brain surgery?
Has the patient had any **new** reduction in level of alertness, loss of consciousness or seizures since the fall?

FEEL:

Is the patient complaining of **new** headache, memory loss, dizziness, double vision or vomiting after the fall?

NICE Head Injury: assessment and management guidance NG232 (2023) states "Community health services [including GPs, NHS walk-ins, and minor injury centres] and inpatient units without an emergency department should refer people who have sustained a head injury to a hospital emergency department, using the ambulance service, if necessary, if there are any of these risk factors"

A **Glasgow Coma Scale (GCS)** score of **less than 15** on initial assessment
Any **loss of consciousness** because of the injury
Any **focal neurological deficit** since the injury
Any **suspicion of a complex skull fracture** or **penetrating head injury**
Amnesia for events before or after the injury
A **persistent headache** since the injury
Any **vomiting** episodes since the injury
Any **seizure** since the injury
Any previous **brain surgery**
A **high energy head injury**
A history of **bleeding or clotting disorder**
Current **anticoagulation and antiplatelet** (except aspirin monotherapy) treatment
Current **drug or alcohol intoxication**
Any **safeguarding concerns** (i.e., possible non-accidental injury or a vulnerable person is affected)
Continuing concern by the profession about the diagnosis

Assessment in the emergency department will include assessment for undertaking a CT head scan noting that “For people who have sustained a head injury and have no other indications for a CT head scan, but are on anticoagulant treatment (including vitamin K antagonists, direct-acting oral anticoagulants, heparin and low molecular weight heparins) or antiplatelet treatment (excluding aspirin monotherapy), consider doing a CT head scan” (May 2023)

Therefore, where the patient has suspected, or potential head injury and they are on anti-coagulation the patient should be escalated for further assessment to an emergency department.

For more information see [Head injury: assessment and early management \(nice.org.uk\)](https://www.nice.org.uk/guidance/ng117)

MOVE:

Continue with the post-fall assessment, paying particular attention to assessing the neck **before moving.**

If a head injury is suspected along with ANY of the risk factors outlined above:

call for an emergency ambulance on 999 and report a suspected head injury while waiting for support, continue with regular ABC, NEWS2 observations, neurological observations (GCS), reassure the patient and keep them warm.
Proceed with SPINE and HIP assessment

A patient with any risk factors will require transfer to an emergency department who will follow their local pathways.

SPINE

LOOK:

Was the fall from higher than standing height (i.e., down the stairs or over the rails of a raised bed)?
Is there obvious **new** neck or spinal deformity?
Have you already identified external evidence of head or facial injuries?
Does the patient have a history of spinal fracture, or do they have osteoporosis or another condition that affects bone composition (such as cancer with metastases)?

FEEL:

Is the patient complaining of **new** pain in the neck or spine?
Is the patient complaining of **new** weakness or sensory changes (eg pins and needles or loss of sensation) in the arms or legs?
If you suspect a spinal injury after ‘looking and feeling’, STOP - do not continue to the ‘move’ section and do not move the patient – call 999 and report a suspected spinal injury.
Aim to keep the patient as still as possible until emergency services arrive.
Do not use a sling hoist to transfer the patient. Following assessment, the paramedics will safely transfer a patient with a suspected spinal injury using appropriate manual handling techniques/specialist equipment such as a scoop board/head blocks.
If, you do not suspect a spinal injury after completing the ‘look’ and ‘feel’ assessment, proceed to ‘move’ section below

MOVE:

Can the patient rotate their neck 45° to the right and left?
Is the patient able to move both arms and legs?
If following completion of LOOK FEEL MOVE spinal injury is not suspected continue to HIP assessment.

HIP FRACTURE

LOOK:

Is either leg shortened or rotated?
Is there any new deformity (is the leg misshapen)?

FEEL:

Is the patient complaining of new pain in the hip?
MOVE:
Can the patient raise each leg, keeping the knee straight and lifting the heel from the ground without significant pain (one at a time)?
Always consider the patient's condition prior to the fall (ie – did they already have pain, shortening, deformity or weakness). If the patient is confused or unable to give accurate answers, look for non-verbal signs of pain.
If a hip fracture is suspected and there is access to flat lifting equipment AND medical cover Call 999 Consider transferring the patient to the bed using flat lifting equipment however extreme caution should be applied – do not use a sling hoist. Conduct an urgent medical assessment Give analgesia within 30 minutes of the fall
If a hip fracture is suspected in a setting without access to flat lifting equipment or medical cover: Call 999 and report a suspected hip fracture Consider keeping the patient comfortable on the floor if ambulance transfer likely to be rapid – to avoid unnecessary transfers Conduct urgent medical assessment (if medical cover is available) Consider giving analgesia if ambulance support is likely to take longer than 30 minutes If a prolonged wait for ambulance support is anticipated, consider the risks of moving the patient (increased pain) against the risks of a prolonged period on the floor (pressure ulceration, hypothermia, rhabdomyolysis) and if indicated, arrange to use an alternative safe moving and handling technique to move the patient into bed. In such an event, it may be necessary to use a sling hoist or other lifting device however caution should be applied.

OTHER FRACTURE
LOOK:
Did the patient fall onto an outstretched arm? Is there any obvious new deformity/asymmetry/laceration/significant bruising in the chest, arms or legs?
FEEL:
Is the patient complaining of new pain in the ribs/chest when moving/coughing/taking a breath in? Is the patient complaining of new pain anywhere?
MOVE:
Ask the patient to lift and move both arms and legs (one at a time). Ask the patient to take a deep breath.
If the patient is confused or unable to give accurate answers, look for nonverbal signs of pain
If other fracture is suspected and there is access to flat lifting equipment AND following clinical assessment by senior registered practitioner Call 999 Consider using flat lifting equipment if a humeral, rib or pelvic fracture is suspected For other fractures the patient can be moved from the floor using the most appropriate method (accounting for other injuries and their ability to get up independently) Conduct an urgent medical assessment Give analgesia within 30 minutes of the fall
If other fracture is suspected in a setting without access to flat lifting equipment: Call 999 and report a suspected fracture Consider keeping the patient comfortable on the floor if ambulance transfer likely to be rapid – to avoid unnecessary transfers Conduct urgent medical assessment (if medical cover is available)

Consider giving analgesia if ambulance support is likely to take longer than 30 minutes
If a prolonged wait for ambulance support is anticipated, consider the risks of moving the patient (increased pain) against the risks of a prolonged period on the floor (pressure ulceration, hypothermia, rhabdomyolysis) and if indicated, arrange to use an alternative safe moving and handling technique to move the patient into bed. In such an event, it may be necessary to use a sling hoist or other lifting device however caution should be applied.

7.1. On-going monitoring and medical review (in-patients)

If following the post fall check an emergency response and transfer to the acuter hospital is not required, the patient must receive on-going monitoring and a medical review. A medical review must be completed within 12 hours (QS86 Quality Statement 6) within an inpatient setting, but sooner if clinically indicated. This should include a medication review.

Following a fall ensure a full set of physical observations is recorded on the NEWS2 chart. Monitor and escalate as per [Deteriorating Patient Policy](#). The NEWS2 tool should be used as an aid to clinical assessment. It is not a substitute for competent clinical judgement. Any concern about a patient's clinical condition should prompt an urgent clinical review, irrespective of the NEWS. This may include an emergency response by dialing 999.

Whilst the NICE Head injury guidance on neurological observations are clearly outlined for a patient admitted to an acute hospital with a head injury, they are less clear for patients in a non-acute in-patient setting when a patient has been assessed as having no risk factors on initial assessment. It is therefore prudent to continue to monitor neurological observations (GCS) for patients who were witnessed to have sustained an impact to their head (with no risk factors on initial assessment) or patients who had an unwitnessed fall where an impact to the head cannot be ruled out, escalating any deterioration by dialing 999

- 30 minutes in the first hour
- Hourly for the next four hours
- Two-hourly until 24 hours of observation

7.2. Safe Handling following a fall

7.2.1. In an in-patient environment

Following assessment of the patient for injuries and having completed vital signs monitoring and if considered safe to do so, ensure safe methods of handling the patient to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery.

Safe manual handling methods should be used as per the [Moving and Handling Policy](#) and Procedure.

7.2.2. In a community-based service/patient's home

Following assessment of the patient for injuries and having completed vital signs monitoring and if considered safe to do so, ensure safe methods of handling the patient to avoid causing pain and/or further injury. This is critical to their chances of making a full recovery.

If potential head, spinal injury or fracture is suspected **do not** move the patient until a review by medical/paramedical staff has taken place.

Safe manual handling methods should be used as per the [Moving and Handling Policy](#) and Procedure. Community staff without the necessary equipment or staff expertise will achieve this with support from other agency for example the emergency services. If the response from the emergency services is delayed a risk assessment should be completed taking in to account the patient's nutrition / hydration / skin condition and supportive measures put in place to minimise harm whilst awaiting response from the emergency services.

7.3. Medical Examination and a Review of Medication

7.3.1. Inpatient units/ward setting

In addition to the immediate response and post fall check as outlined above by a clinical competent registered practitioner, it is important that the patient receives prompt medical examination. This is critical to their chances of making a full recovery. Medical examination should be completed within a maximum of six hours or within one hour if superficial injury is sustained. If a more urgent response is deemed appropriate, dial 999. Medical examination should include a physical assessment of the patient and a structured, critical examination of the patient's medications. People on high-risk medication, for example psychotropic medications, should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling again. See NICE guidance NG5 [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes \(nice.org.uk\)](https://www.nice.org.uk/guidance/ng5)

7.3.2. Community based services/patient's home

In addition to the immediate response and assessment of injuries by a clinical competent registered practitioner, it is important that the patient receives prompt medical examination. This is critical to their chances of making a full recovery. Patients should be escalated to their GP for medical review if an ambulance response is not required.

7.4. Reporting and Recording

Following a patient fall within an inpatient setting an Exploration of Falls assessment and post falls Multifactorial Falls Risk Assessment will be carried out and must be completed through the electronic patient record. Do not routinely complete and scan paper versions onto the clinical system. Care plan will be updated accordingly. Document the full details of the fall and any injuries sustained in the electronic clinical system. Review the level of observation and enhance observation levels as deemed appropriate.

Ensure the patient and family are informed in line with the [Duty of Candour Policy and Procedure](#).

All inpatient falls will be reported via Datix. All falls occurring in a community/out-patient setting should be reported on datix.

Judgement should be used in relation to patients who fall in their own homes. Incidents that occur in the presence of a health care professional should be reported via datix. Incidents that occur at other times may need to be reported i.e., if there has been missed opportunities to reduce the risk of falling, lack of risk assessment or environmental home hazard assessment, or lack of appropriate risk reduction interventions.

8. TRAINING AND COMPETENCY

All staff have duty of care to prevent a fall were possible and to ensure that all patients receive the right care and treatment following a fall.

Clinical staff working for HTFT have access to comprehensive training and competency assessment in relation to falls prevention, post fall assessment and the care and management of the deteriorating patient. These are core competencies and there is an expectation that clinical staff will undertake these to a level that reflects their core role and function. The trust acknowledges the wide variety of patient groups and specialities and note that the training and competency requirements cannot be explicitly outlined in this document for all services and professional groups. All staff are responsible for their own practice; however, it is the responsibility of all team leaders and ward managers to ensure that all staff **within their sphere of responsibility** have the appropriate skills and competency to meet the needs of their patients.

It is also acknowledged that following the review and update of the trust's policy and procedure in July 2023 following the publication of the NICE Head injury guidance (NG232), 18th May 2023

and the NAIF Supporting Best and Safe Practice in post-falls management in inpatient settings, additional training and competency requirements are required. GCS has been introduced as a role specific competency for some areas (see below) The roll out of training and competency assessment in relation to GCS will take 12 months from the approval date of this document.

As a minimum the Trust recommends the following:

Registered Nurses and Advanced Care/Nurse Practitioners working within an **in-patient setting** to have skills and competency in relation to falls risk assessment and post falls check including ILS (which will include ABCDE assessment and GCS) and NEWS2. They will complete and maintain the core competencies in relation to deteriorating patient, falls and GCS.

Registered nurses will maintain compliance with moving and handling training as outlined in the [Moving and Handling Policy](#)

Non-registered nurses and AHPs working within an **inpatient setting** to have skills to support registered and medical staff in post falls check including BLS and NEWS2. They will complete and maintain the core competencies in relation to deteriorating patient and falls as is relevant to their role. They will maintain compliance with moving and handling training outlined in the

[Moving and Handling Policy](#)

Registered Nurses and AHPs working within a ***core community teams** to have skills and competency in relation to falls risk assessment and post falls management to enable them to conduct a post falls check and support a fallen patient within their home until additional support from emergency services arrives (if required). This will include as a minimum BLS and NEWS2. They will complete and maintain the core competencies in relation to deteriorating patient and falls. They will maintain compliance with moving and handling training as outlined in the [Moving and Handling Policy](#)

***core community teams** refer to the community teams at Ryedale, Scarborough, Whitby and Pocklington

Non-registered nurses working within a ***core community teams** to have skills to support a fallen patient within their home until additional support arrives (if required). They will not be expected to carry out a post fall check if working independently but should have skills to support registered staff in post falls management including BLS and NEWS2.

They should complete and maintain the core competencies in relation to deteriorating patient and falls as is relevant to their role. They will maintain compliance with moving and handling training outlined in the [Moving and Handling Policy](#)

***core community teams** refer to the community teams at Ryedale, Scarborough, Whitby and Pocklington

Registered Nurses, Advanced Care/Nurse Practitioners working in the **Urgent Treatment Centre and Primary Care settings** to have the skills and competency in assessing a patient attending their service following a fall. This should include as a BLS or ILS, NEWS2 and GCS. They should complete and maintain the core competencies in relation to deteriorating patient and falls and were deemed relevant to their role the GCS competency. They will maintain compliance with moving and handling training as outlined in the [Moving and Handling Policy](#). Following review within such setting patients should be given safety netting advice and be provided with information on signs and symptoms to observe for post head injury.

Medical staff

It is recommended that medical staff, as deemed appropriate to their role, complete the CareFall: Reducing inpatient falls risks and post fall management which can be accessed through ESR and E-Learning for Health. This module has been developed for foundation level doctors and includes interactive information about patient and environmental falls risk factors, the patient assessment and post fall management.

It is also recommended the medical staff working in inpatient settings, urgent treatment, and primary care settings are able to undertake GCS.

[Core Clinical Competencies \(humber.nhs.uk\)](#)

[Role Specific Clinical Competencies \(humber.nhs.uk\)](#)

E-Learning via ESR:

000 Preventing falls in hospital

000 CareFall: Reducing inpatient falls risks and post fall management

Face to face training:

338 Falls prevention and management

GCS refresher training – included as part of annual ILS training

GCS training video [Glasgow Coma Scale](#)

9. ADDITIONAL RESOURCES

[Supporting best and safe practice in post-fall management in inpatient settings | RCP London](#)

[Overview | Head injury: assessment and early management | Guidance | NICE](#)

[Falls in older people: assessing risk and prevention | Guidance | NICE](#)

[Falls in older people | Quality standards | NICE](#)

[Hip fracture in adults | Quality standards | NICE](#)

[Spinal injury: assessment and initial management \(nice.org.uk\)](#)

[Bedside vision check for falls prevention: assessment tool | RCP London](#)

[Royal College of Physician: Falls Prevention in Hospitals](#)

[Get up and go - a guide to staying steady English version | The Chartered Society of](#)

[Physiotherapy \(csp.org.uk\)](#)

[NHS England » Development of the 'Avoiding Falls Level of Observation Assessment Tool'](#)

Relating policies and procedure:

Falls Policy

Bed Rails Policy

Head injury guidance

Deteriorating patient Policy and Procedure

Medical Emergencies and Resuscitation Policy

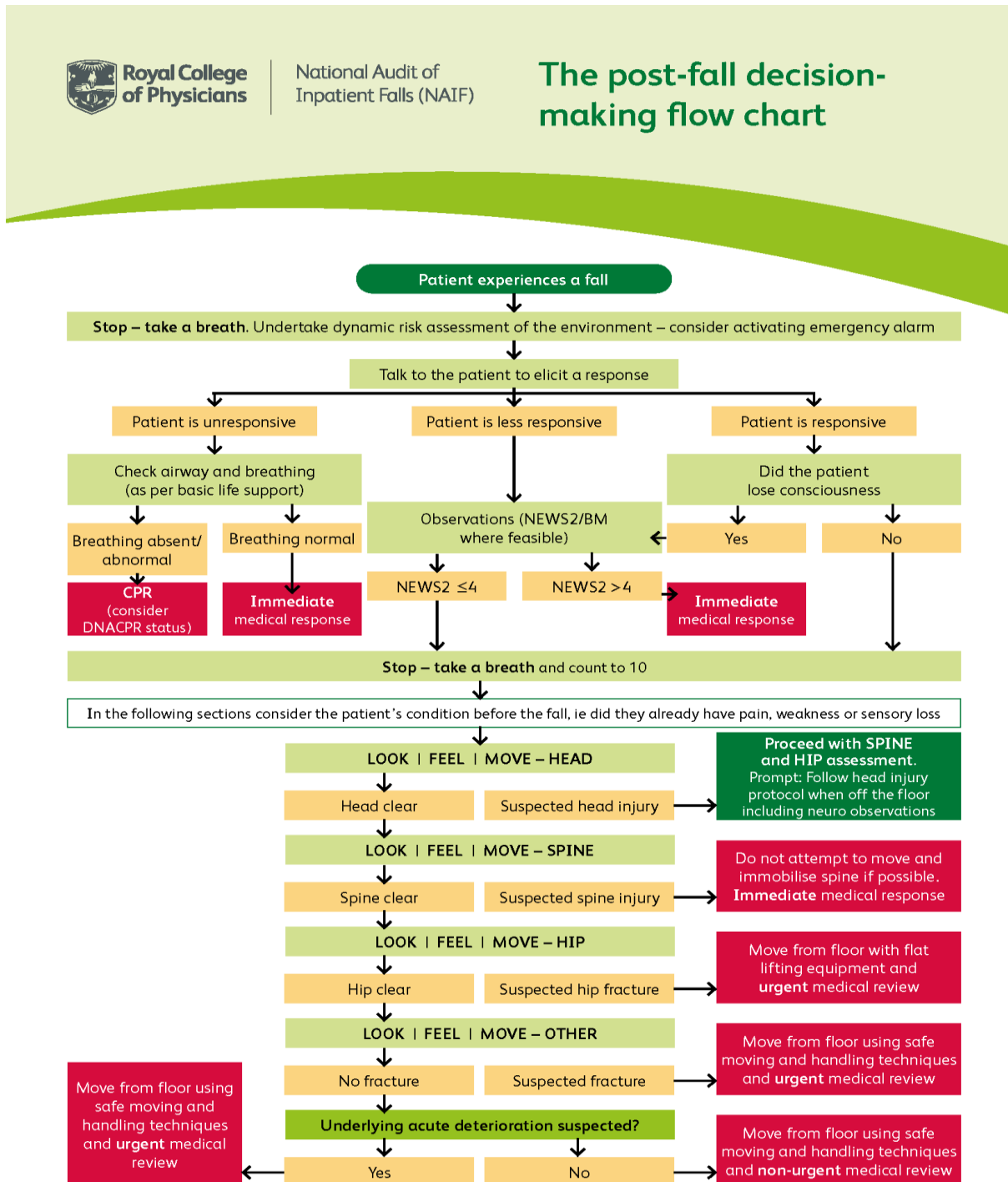
Duty of Candour Policy and Procedure

Moving and Handling policy

Consent Policy

Appendix 1: Post-fall decision making flowchart

Humber Teaching NHS Foundation Trust's Falls policy and procedure reflects Model 3 as described in the RCP's Supporting best and safe practice guidance (2022). It is recognised that HTFT is not an acute trust and our services do not have access to a specialist falls team, 24 hours medical cover, acute trauma services, and that flat lifting equipment may not be available in all inpatient settings. This should be taken into consideration as part of the post falls decision making process. Unresponsive patients, or patients with suspected head injury, spinal injury, hip fracture or other fracture will require an emergency response via 999.



Please use in conjunction with the post-fall management resource [Supporting best and safe practice in post-fall management in inpatient settings](#).

Appendix 2: Guidance on Medication and Falls Risk

Falls can be caused by almost any drug that acts on the brain or on the circulation. Usually the mechanism leading to a fall is one or more of:

- **sedation**, with slowing of reaction times and impaired balance
- **hypotension**, including orthostatic (postural) hypotension
- **bradycardia, tachycardia or periods of asystole**

Falls may be the consequence of recent medication changes but are usually caused by medicines that have been given for some time. Polypharmacy also increases the risk of falls.

Drugs acting on the brain

Drug class	Effect
Sedatives: Benzodiazepines	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Sedatives: Z drugs	Drowsiness, slow reactions, impaired balance.
Sedating antidepressants (tricyclic and related drugs)	All have some alpha-receptor blocking activity and can cause orthostatic hypotension. All are also histamine-H2 blockers and cause drowsiness, impaired balance and slow reaction times.
Monoamine Oxidase Inhibitors	Now seldom used. All (except moclobemide) can cause severe orthostatic hypotension.
SSRI antidepressants	In population studies, cause falls as much as other antidepressants however the mechanism of effect is unknown
SNRI antidepressants	As for SSRIs but also commonly cause orthostatic hypotension.
Drugs for psychosis and related conditions	All have some alpha-receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Opiates (and opioids) analgesics	Drowsiness, slow reactions, impair balance, cause delirium,
Anti-convulsants	May cause permanent cerebellar damage and unsteadiness in long term use at therapeutic dose. Excess blood levels cause unsteadiness and ataxia.
Anti-convulsants	Drowsiness, slow reactions. Excess blood levels cause unsteadiness and ataxia.
Parkinson's disease Dopamine agonists	Can cause orthostatic hypotension and delirium.
Parkinson's disease MAOI-B inhibitors	Can cause orthostatic hypotension
Anti-muscarinics	Dizziness, blurred vision, confusion.
Anti-dementia drugs: AChEIs	Dizziness, bradycardia, syncope, muscle spasm.
Anti-dementia drugs:	Commonly causes dizziness and balance disorders
Muscle relaxants	Drowsiness, reduced muscle tone.
Vestibular sedatives/ antiemetics Phenothiazines	Orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Vestibular sedatives Antihistamines	Sedation likely to contribute to falls.
Antihistamines for allergy (sedating)	Sedation likely to contribute to falls.
Anticholinergics acting on the bladder	Sedation likely to contribute to falls.

Drugs acting on the heart or circulation

Drug class	Effect
Alpha receptor blockers (used for hypertension or for prostatism in men)	Commonly cause severe orthostatic hypotension.
Centrally acting alpha-2 receptor agonists	Can cause severe orthostatic hypotension. Sedating.
Thiazide diuretics	Cause orthostatic hypotension. Muscle weakness due to lowered sodium and potassium plasma levels.
Loop diuretics	Dehydration causes hypotension. Muscle weakness due to lowered sodium and potassium plasma levels.
Angiotensin converting enzyme inhibitors (ACEIs)	Can cause severe orthostatic hypotension.
Angiotensin receptor blockers (ARBs)	Cause less orthostatic hypotension than ACEIs but still carry significant risk.
Beta blockers	Can cause bradycardia and hypotension.
Anti-anginals	Commonly cause syncope due to sudden blood pressure drop. Cause hypotension and paroxysmal hypotension
Calcium channel blockers that only reduce blood pressure	Cause hypotension and paroxysmal hypotension
Calcium channel blockers which reduce blood pressure and slow the pulse	Can cause hypotension and/or bradycardia
Other antidysrhythmics	Can cause bradycardia and other arrhythmias. Data on digoxin and falls probably spurious due to confounding by indication.