Barnsley Hospital NHS
NHS Foundation Trust

POLICY CONTROL SHEET

Policy Title And ID number	**SE 3.3 Slips, Trips and Falls (Patients)**			
Sponsoring Director:	**DIRECTOR OF QUALITY AND PERFORMANCE**			
Implementation Lead:	Clinical Risk Advisor			
Impact:	*(a) To patients*	Safe delivery of care, in line with recommended best practice		
	(b) To Staff	Guidance to ensure safer practice		
	(c) Financial	Possible reduction in the number of incidents resulting in litigation		
	(d) Equality Impact Assessment (EIA)	Completed: **Yes**		
	(e) Counter Fraud assessed	Completed: **Yes/Not required** (delete as applicable)		
Additional Costs:			*Budget Code*	*Revenue or Non Revenue*
	(a) Training:	*£*	Within Divisions	
	(b)Implementation:	*£*		
	(c) Capital:	*£*		
	(d) Other	*£*	Audit Department	
Training implications:	*To be incorporated into induction:* **Yes**		*Other:* *Local induction*	
Date of consultation at:	*Board of Directors*			
	Executive Team			
	Divisional Medical Directors			
	Assistant Divisional Directors/Heads of Department			
	Board Committee			
	Health & Safety Committee			
	Senior Nurse Forum:			
	Inpatient Falls Management Group:			
Alignment	*HR:*		Training and Development	
	Strategic Direction:		Improving clinical care standards	
	Board Assurance:		Risk reduction	
	Clinical Governance:		Ensuring excellence and safety	
Date of Final Draft:			Issue Number:	1
Date of Final Approval:			Approved by:	
Implementation Date:				
Date of last review:	November 2011	Date of next review:	November 2013	
Circulation Date:				

Circulation:		Yes	Comment
	Directors		
	Non Executive Directors		
	Divisional Medical Directors/Clinical Directors		
	Medical Staff Committee/SMSF		
	Assistant Divisional Directors		
	Assistant Nursing Directors		
	Heads of Department		
	H&S Committee Members		
	Policy database/warehouse		
	Others (to be listed):		

Barnsley Hospital NHS
NHS Foundation Trust

SLIPS, TRIPS AND FALLS POLICY (PATIENTS)

NHSLA SE 3.3

SPONSORING DIRECTOR
DIRECTOR OF QUALITY AND PERFORMANCE

November 2011

Slips, Trips and Falls (Patients) Policy

Contents

Abbreviations and Acronyms

BHNFT – Barnsley Hospital NHS Foundation Trust
BS – British Standard
FRAT – Falls Risk Assessment Tool
GCS – Glasgow Coma Score
HSE – Health and Safety Executive
MEU – Medical Emergency Unit
MHRA – National and Healthcare Related Products Agency
N/A – Non Applicable
NICE – National Institute of Clinical Excellence
NPSA – National Patient Safety Agency
PPE – Personal Protective Equipment

1. STATEMENT OF INTENT

Barnsley Hospital NHS Foundation Trust recognise that patient slips, trips and falls occur frequently, and are one of the main causes of major injuries within the Trust. A clear defining line can be drawn between those trips, slips and falls which occur because a patient is being helped on their road to recovery, or because they value their independence, and those which are caused by accidents which are avoidable.

The Trust is aware of its responsibilities under the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999, the Workplace (Health, Safety and Welfare) Regulations 1992 and National Service Framework for Older People (DoH 2001) to provide a safe environment to prevent slips, trips and falls to its patients, so far as is reasonably practicable. The Trust is also committed to protecting the safety of patients and is aware of its responsibility to preventing patient slips, trips and falls.

This policy will be co-ordinated with other Trust health and safety policies and human resources policies to avoid conflict.

The Trust is committed to ensuring, so far as is reasonably practicable, the way we provide services to the public and the way we treat our patients, reflects the individual needs and does not discriminate against individuals or groups on any grounds.

2. INTRODUCTION

Health and Safety legislation includes duties to prevent or control slip, trip and fall risks within the Trust premises.
The Health and Safety Executive (HSE) define: -

- Slips occur when the foot and floor surface cannot make effective contact or grip, usually caused when something has been spilt or when the patient is wearing inappropriate footwear and floor surface are unsuited;

- Trips are obstructions on floor surfaces, uneven floor surfaces, cables and items left on floor surfaces;

- The National Institute of Clinical Excellence 2004 define fall as ‘an unexpected event when the person falls to the ground from any level, this also includes falling on the stairs and onto a piece of furniture with or without loss of consciousness;

- The Management of Health and Safety at Work Regulations 1999 requires appropriate arrangements for effective planning, organisation, control, monitoring and review of any measures to safeguard health and safety.

- The Workplace (Health, Safety and Welfare) Regulations 1992 requires floors to be suitable, in good condition and free of obstruction.

- National Service Framework for Older People (DoH 2001) requires to reduce the number of falls and subsequent injury and ensure effective treatment and rehabilitation for those who have fallen.

3. IMPLEMENTATION

The implementation of the policy and procedure requires the total co-operation of all Trust employees, patients, contractors, voluntary workers and visitors.

The Trust will provide suitable floor surfaces with anti-slip properties and strictly enforces the rules on good housekeeping.

The Trust will ensure that any patient's safety is adequately controlled and in any case, reduced to the lowest level which is reasonably practicable.

Staff will take action to prevent patient falls resulting in possible fractures and injury by assessing the risk of all patients admitted to adult wards with the exception of Maternity Services and Intensive Therapy Unit.

The Trust will endeavour to supply any falls prevention equipment required and will seek additional funding through risk management processes when a shortage of equipment is identified.

To comply with legislation, the Trust will: -

3.1 Plan

- Overall arrangements to manage slip, trip and fall risks;
- Assess the patient risks (by undertaking Falls Risk Assessments);

3.2 Organise

- So that employees, patients, contractors, voluntary workers and visitors know their responsibilities;
- Maintenance programmes;
- Training programmes;

3.3 Control

Control the risks by taking action on measures that have been identified

3.4 Record

- Risk assessments on Trust Falls Risk Assessment forms (FRAT) for all adult inpatients with the exception of Maternity services and patient in ITU ;
- Incorporate a Falls Risk Assessment Action plan into the patient plan of care according to the risk identified on Trust assessment forms;
- Report to the HSE as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

3.5 Monitor

Achievements to ensure action is taken following slip, trip and fall accidents, incidents and near misses. Patient falls are to be agenda items for the Clinical Governance Committee.

4. MANAGEMENT ARRANGEMENTS

4.1 Role of the Trust Board of Directors

The Trust Board of Directors have overall responsibilities to provide the necessary resources to enable health, safety and welfare requirements and equipment to eliminate slips, trips and falls.

4.2 Role of the Chief Executive

The Chief Executive is responsible for ensuring the current slips, trips and falls legislation is met and that its requirements are implemented in all Trust premises and grounds. The appropriate assurance will be given from the Chief Operating Officer to the Chief Executive.

4.3 Role of Directors

The responsibilities of Directors is to provide the necessary resources to enable health, safety and welfare requirements and necessary equipment to eliminate slips, trips and falls in their area of responsibility. This will be based upon risk assessment and identified risks. Also, the compliance with statutory health and safety legislation.

To ensure that there are adequately trained employees to undertake risk assessments for slips and trips and employees to act as Fire Marshals within their area of responsibility.

4.4 Role of the Non Clinical Risk Advisor

The responsibility of the Non Clinical Risk Advisor is: -

> To provide training objectives, training programmes and teach staff to undertake risk assessments, fire marshal duties to ensure exit routes are clear of slip and trip hazards. Induction training programme on slip, trip awareness and reporting hazards and incidents;

4.5 Role of the Clinical Risk Advisor

The responsibility of the Clinical Risk Advisor is to: -

> Support the Divisions with the implementation of this policy and to ensure that it is complied with;
> Periodic monitoring, review and audit of the implementation and application of this policy and associated procedures and guidelines;
> Be an active member of the Trust Patient Falls Prevention Group.

4.6 Role of the Falls and Syncope Nurse Specialist

The responsibility of the Falls and Syncope Nurse Specialist is to: -

- To provide training in accordance with Training Needs Analysis (TNA) on patient falls risk assessment and falls prevention to all nursing staff and AHP's within the Trust;
- Give guidance to staff on how to manage individual inpatients at risk of falls on the ward area;
- Give guidance to staff on how to observe, investigate, care for and treat patients who have fallen;
- To be an active member of the Trust Patient Falls Prevention Group.

4.7 Role of the Lead Nurses

The role of the Lead Nurse is to: -

- Ensure all nursing staff undertake falls prevention training in accordance with the Training Needs Analysis.
- Analyse falls reports 3 monthly for their area and formulate an action plan to reduce the number of falls;
- Feed back quarterly to the Trust Patient Falls Prevention Group

4.8 Role of Acute Rehabilitation and Therapy Service (ARTS)

The responsibility of ARTS therapy staff is to:-

- The Lead Therapist to ensure their staff attend training in the prevention of slips, trips and falls in accordance with the TNA,
- Provide falls prevention training and education to patients at risk of falls and also to their carers
- Provide evidenced based rehabilitation programmes for falls patients
- Update and provide guidance to therapy staff on how to manage inpatients at risk of falls on the ward areas
- Participate in relevant falls audits
- To prompt referrals to specialist falls services
- Be an active member of the Trust Patient Falls Prevention Group

4.9 Role of Physiotherapists

The role of the physiotherapist is to:

- The Lead Therapist is to ensure their staff attend training in the prevention of slips, trips and falls in accordance with the TNA.
- Ensure all patients that are referred to them having fallen or having being identified as being at risk of falling have a comprehensive falls assessment completed within 3 working days of referral.
- To provide appropriate walking aids / equipment for inpatient ward use (and for home if required).
- Give guidance to ward staff on how to manage an individual that has fallen or is at high risk of falling in the ward area.
- To ensure ward stock of walking aids (zimmer frames / elbow crutches and walking sticks) are accessible at all times

- Give guidance to ward staff on how to mobilise patients on the wards with appropriate walking aids.

- To refer appropriately to falls prevention / treatment services e.g. Assessment and Rehabilitation Therapy Service, Falls and syncope nurse, Community physiotherapy etc.

4.10 Role of Occupational Therapists

Role of the Occupational Therapist in the prevention of falls:

- The Lead therapist to ensure their staff attend training in the prevention of slips, trips and falls in accordance with the TNA.

- Identify patients who are at risk of falls prior to, and during, initial assessment before treatment commences

- Where appropriate, carry out environmental visits to identify potential slip/trip/fall hazards

- Provide aids/equipment/adaptations to help reduce the risk of falls on the ward and within the home environment

- Provide education in ways to carry out activities of daily living in order to reduce the risk of falls

- Refer to appropriate falls prevention services i.e. Assessment and Rehabilitation Therapy Services and Falls and Syncope nurse

4.11 Role of Employees, Voluntary Workers and Contractors

The role of employees, voluntary workers and contractors are as follows: -

- Report to management in confidence any medical conditions that may increase the risk of slips, trips and falls of patients;
- Attend training and comply with any instruction which is provided in relation to the control of slips and trips;
- Comply fully with safe systems of work;
- Any environmental problems relating to slips, trips and falls are reported to a responsible person or report to the Estates fault desk on extension 2451;

4.12 Role of the Trade Union Safety Committee

Trade Union Safety Representatives must be: -

- Meaningfully consulted and involved in risk assessment, safe systems of work involving slips and trips, any planned audits, inspections and accident investigations involving slips and trips;
- Meaningfully consulted and involved in the procurement of safety footwear, floor surfaces and any other safety equipment.

4.13 Role of the Divisional Directors

The role of the Divisional Director is to ensure that all Doctors receive a copy of the policy at the Divisional Local Induction

5. POLICY REVIEW

This policy shall be reviewed every 4 years or sooner if appropriate, or if there is a change in legislation.

6. SUPPORTING DOCUMENTS

Reference

1. Management of Health and Safety at Work Regulations 1999
2. Workplace (Health, Safety and Welfare) Regulations 1992
3. Slips and Trips HSG 155
4. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
5. Slips and Trips in the Health Service Sheet No. 2
6. National Service Framework for Older People (DoH 2001)
7. National Institute of Clinical Excellence 2004
8. Medicines and Healthcare related Products Agency
9. National Patient Safety Agency
10. Patient Safety First

Cross Reference Documents/Policies

1. Health and Safety Management Policy
2. Risk Management Policy
3. Reporting of Accidents/Incidents Policy
4. Risk Assessment Guidance Manual
5. Health and Safety Management Guidance Manual
6. Risk Assessment Form, Action Plan, Risk Register
7. Accident/Incident electronic reporting system
8. Falls Risk Assessment Tool
9. Glasgow Coma Score
10. Observation guideline for patients at risk of falling and absconding

APPENDIX A

Guidelines for the Prevention and Management of Patient Falls

Introduction

These guidelines may be used by any professional in a patient area to help assess and manage patients at risk of falling, or following an in-patient fall.

It is the responsibility of all staff to ensure that they are aware of, and comply with the guidelines to maintain patients' safety.

A fall is defined as 'An unexpected event when the person falls to the ground from any level'; this also includes falling on the stairs and onto a piece of furniture with or without a loss of consciousness (National Institute of Clinical Excellence 2004).

Falls in hospital are common and problematic for patients, staff and the Trust. Serious injuries may result from patient falls and although fractures and closed head injuries are the most worrying, even minor soft tissue trauma may significantly impair function and rehabilitation.

Aim

The aim of the guideline is to reduce the number of falls and subsequent injury and ensure effective treatment and rehabilitation for those who have fallen, as recommended by the National Service Framework for Older People (DoH 2001).

Whilst it is not possible to prevent every fall, prevention strategies must be dignified, safe and appropriate.

Risk Assessment

Identifying those at risk is the first stage in falls prevention.

All patients admitted to adult in-patient wards, with the exception of Maternity and ICU, will have a Manual Falls Risk Assessment Tool (FRAT) assessment completed within 6 hours of admission. See Appendix B
If the patient is assessed 'at risk of falls' A Core care plan with the problem :- Patient at risk of falls must be added to the patients individual care plan with associated actions to be implemented to reduce the risk of falls. See Appendix C

Paediatric patients are not assessed for the risk of falls.

The training for undertaking a FRAT assessment will be covered in the local preceptorship package.

The majority of falls occur in patients over 65 years of age. The majority of patients in Maternity Services are well women. If a woman with a potential high risk of falls was admitted a risk assessment would be performed. Patients in ICU are nursed under close one to one supervision and are predominantly too ill to move unaided.

'Stickmen' visual displays must be placed behind each patient bed to signify the patients risk of falls
FRAT score 0-11 Green Stickman
FRAT score 12 and above Amber Stickman
Patient has fallen during this admission-Red Stickman.
See Appendix D

Older people are at greater risk of falling in hospital. It is vital that all members of the ward team are aware of those who are 'at risk' of falling; this should be apparent from care planning and the visual stickman displays, but should also be communicated verbally at 'handover'. The Trust has introduced a '2 minute' Safety Brief to be completed at the start of each shift. See Appendix E

The Huntleigh Enterprise Electronic beds used throughout the Trust have the capability to be lowered to a height of 30 cms from floor to bed base.
Any patient assessed 'At Risk' must be nursed with their bed at the lowest height when direct care is not being given.

The Assessment of falls risk should be repeated if there is a change in the patients' condition or if the patient has a fall.

Any patient admitted as a result of a fall, or sustaining a fall whilst an in-patient, should be offered a referral to the falls service for a multifactorial falls risk assessment. (NICE 2004). For in-patients within the Medical Division a nurse referral can be made to the Falls Nurse Specialist. Patients within other specialties a Doctor must make a referral to the Falls and Frailty Clinic or the Syncope Clinic.

Any patient who has sustained 2 or more falls whilst an inpatient, inform the Lead Nurse and/or Matron and consider referring to Falls and Syncope CNS. (See appendix F)

Use of Bed Rails

Bedrails (also referred to as cot sides or safety sides) have often been used to prevent patients from injuring themselves through falling from the bed. However, nationally there have been a number of adverse incidents involving bedrails that have led to injury and death. In addition, bedrails are a form of restraint, which can deprive an older person of their dignity and autonomy. See Appendix G for guidelines to the safe use of bedrails.

Management of a patient who has fallen in hospital

When a patient has fallen an attempt to identify the circumstances surrounding the fall should be made and relevant preventative action taken, where possible, to prevent a further fall occurring. This must include making safe any environmental hazard that contributed towards the fall. A care plan must be completed for problem:
- Patient has sustained an inpatient fall See Appendix H.
The patient's relatives must be informed. On admission it should have been ascertained if the relatives wanted informing of any incident occurring during the night. If the patient sustains a fall during the night and the relatives do not want informing they should be contacted by the morning shift.

Where appropriate they should be involved in any actions planned to reduce the risk of further falls.
This should be clearly documented on the Incident report form.
In the event of a fall in hospital the Patient Falls Care Pathway should be followed. See Appendix I.
Falls can be an indication of an underlying illness, or a sign that a patients condition has deteriorated.

When a patient has fallen they should be examined for any obvious signs of injury. If no obvious signs of injury are present and the patient is able to move they should be assisted onto a bed. The patient should be assessed for any pain and decreased movement or deformity of the limbs. The clinical signs for a fractured neck of femur are external rotation and shortening of the affected limb. If this is suspected the patient should be given some analgesia before being moved. A hoist should be used to place the patient onto a bed. If a potential spinal injury is suspected the patient must not be moved until assessed by a Physician. If a spinal injury is confirmed the Emergency Department should be contacted for advice and assistance in moving the patient. (NPSA /2011/RRR01).
Medical staff should be informed immediately. Clinical observations and any other significant findings should be given to enable the Doctor make a decision on the urgency for a medical examination.

Early detection and treatment of fracture neck of femur is associated with reduced mortality.

An Incident report form must be completed for all fall occurrences. It must contain all the relevant information required in the falls care pathway. If there is serious injury sustained a full root cause analysis must be undertaken.
The nursing documentation must be clear and comprehensive and contain information about all injuries, including cuts and bruising, sustained as a result of the fall.
If the patient has sustained a serious injury i.e. a fracture or a sub-dural haematoma, the Health and Safety Co-ordinator should be contacted at the earliest opportunity to establish whether the accident requires reporting to the Health and Safety Executive (HSE) to comply with the RIDDOR Regulation (Reporting of injuries, diseases and dangerous occurrences regulations). If the accident requires reporting to the HSE this will be undertaken by the Health and Safety Co-Ordinator.

If a patient with a history of confusion has suffered an unobserved fall or a fall by any patient where they have been observed to hit their head, the nursing staff must monitor the patient for possible adverse events. It is important that there is a baseline of Glasgow Coma Score (GCS) observations in order to compare recordings, otherwise it would be extremely difficult to recognise when a patients neurological status deteriorates. Following the NICE Guidelines 2007 the neurological observations should be performed every 30 minutes for a minimum of 2 hours. If the GCS remains at 15 after 2 hours then the observations can be performed hourly for 4 hours. If the patients condition should deteriorate at any point the observations should be increased to half hourly again and then to follow the previous steps. If the patients' condition remains stable on the hourly GCS observations then they can be reduced to two hourly, and to remain on two hourly until discontinued by a Doctor.

PATIENT CHANGES REQUIRING REVIEW

- Agitation or abnormal behaviour developed
- GCS dropped by 1 point and lasted for at least 30 minutes (give greater weight to a drop of 1 point in the motor response score)
- Any drop of 3 or more points the eye-opening or verbal response scores, or 2 or more points in the motor response score
- Severe or increasing headache developed or persistent vomiting
- New or evolving neurological symptoms or signs, such as pupil inequality or asymmetry of limb or facial movement

If any of the above changes have occurred a second member of staff competent to perform observations should confirm the change and urgent medical reappraisal should be sought and consideration given to an immediate CT scan after re-assessment of the patients clinical condition.

Interventions to Prevent and Manage Falls

Whenever possible discuss falls prevention strategies with the patients family and consider family involvement if applicable.

Causes of falls are normally multifactorial and single interventions alone will not stop the patient falling.

All patients deemed at risk of falling should have a falls care plan, individualised to meet their needs. This should outline specific interventions appropriate to that individual. Once risk factors likely to cause problems have been identified, where possible they need to be treated.

Interventions for good practice should include: -

- Reviewing medication associated with a risk of falls
- Detecting and treating causes of delirium
- Detecting and treating cardiovascular illness
- Detecting and treating or managing incontinence or urgency
- Detecting and treating eyesight problems and having the right glasses
- Providing safer footwear
- Physiotherapy, exercises and access to walking aids
- Placing patients with urgency near to toilets
- Toileting at risk patients routinely
- Instructing male patients prone to dizziness to void whilst sitting

Environmental interventions: -

- Nurse call buzzer to be within easy reach
- Using bedrails if the benefit outweighs the risk
- Bed to be at the lowest level unless care delivery is being given

- Improved lighting
- Mopping up spillages immediately i.e. Water, talcum powder
- Decrease clutter around bed area
- Ensuring brakes are applied to beds and commodes

The patients most likely to fall are also the patients most vulnerable to injury, and the least able to recover when serious injury is added to the illness they were admitted to hospital for. Approaches to preventing falls must be individualised as each patient is affected differently by the interplay between a range of risk factors.

REVIEWED August 2010
UPDATED November 2010
UPDATED January 2011
UPDATED July 2011

APPENDIX B

Barnsley Hospital NHS
NHS Foundation Trust

Name…… DOB…….... Unit No……..……
Consultant…… Ward……NHS No……

Falls Risk Assessment Tool (FRAT)

Date, time and initial each assessment	**Score**						
Gender							
Male	**0**						
Female	**1**						
Age							
<64	**0**						
65-79	**1**						
>80	**2**						
Mental State							
Orientated at all times	**0**						
Learning Difficulties	**1**						
Fear of Falling/anxiety	**1**						
Unconscious	**1**						
Feels low in mood or depressed	**2**						
Apathetic/lethargic	**2**						
Confused at all times	**3**						
Cognitive/perceptional impairment	**3**						
Intoxication	**4**						
Intermittent Confusion	**4**						
Memory Loss	**4**						
Hallucinations/delusions	**5**						
Disability							
None	**0**						
Visual Impairment	**2**						
Physical Impairment	**2**						
Eliminations							
No problems	**0**						
Catheterised	**1**						
Diarrhoea	**2**						
Frequency of micturition	**2**						
Stress incontinence	**2**						
Incontinent of urine	**3**						
Incontinent of faeces	**3**						
Incontinent of urine & faeces	**3**						
Nocturia	**3**						

Name…… DOB…….... Unit No……..……
Consultant…… Ward…… NHS No……..……

Date, time and initial each assessment							
Mobility	**Score**						
Fully mobile	**0**						
Immobile	**1**						
Assistance to transfer/mobilise	**3**						
Mobilises with walking aids	**3**						
Evidence of balance or gait deficiencies	**4**						
History of falls							
No falls history	**0**						
Has experienced dizziness in last 6 mth	**2**						
1 or 2 falls in last 6 months (excluding la 48hrs)	**3**						
>2 falls in last 6 months (excluding last 48hrs)	**4**						
Has fallen in the last 48hrs	**6**						
Medication							
None	**0**						
1 or more CNS suppressants or BP low medication	**3**						
TOTAL							

Record Falls Risk Assessment Score

Date, time and initial each assessment						
<4 No Intervention						
5-11 Low Risk (Add problem to care plan)						
12-16 Medium Risk (Add problem to care plan)						
>17 High Risk (Add problem to care plan)						

APPENDIX C

Barnsley Hospital NHS
NHS Foundation Trust

Patient Name…….. DOB……. Unit No……..
NHS No……..

Problem:- Patient at risk of falls
Outcome:- To minimize risk of falls

Tick or N/A actions below		Comments		Comments
1. Nurse patient in an easily observed area of the ward				
2. Ensure nurse call system within easy reach.				
3. Ensure personal belongings are within easy reach.				
4. Consider environmental risk factors. **Specified:-**				
5. Encourage patient to summon help for mobilising				
6. Ensure patient nursed on low height bed.				
7. Provide assistance with activities of daily living as required, (see patients care plan)**.**				
8. Raise patient awareness of personal risk factors.				
9. Mobilise/transfer patient with assistance; **Circle degree of dependency:- 1 Nurse / 2 Nurses**				
10. Encourage patient to use mobility aid. **Specify aid:-**				
11. Ensure mobility aid is kept within easy reach of patient**.**				
12. Ensure glasses are clean, and encourage patient to wear.				
13. Advise patient to wear appropriate footwear.				
14. Observe condition of feet, inform medical staff of any problems. **Specify:-**				
15. Nurse patient close to toileting facilities. **Specify any toileting regimes:-**				
16. Ensure bed rails are used, (document rationale in care plan).				
Date, time & sign				

Document to be stored in Nursing Records

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Barnsley Hospital NHS
NHS Foundation Trust

Patient Name…….. DOB…… Unit No…… …..
NHS No…….

Tick or N/A actions below		Comments		Comments
17. Bed rails should <u>not</u> be used, (document rationale in care plan)**.**				
18. Record lying & standing BP and pulse on x3 consecutive mornings.				
19. Request medical staff to review patient as necessary. (Specify reason in nursing records)				
20. Encourage relatives/carers involvement.				
21. Place patient on observation and activity cart **Specify level of supervision:-**				
22. Ensure constant supervision by nursing staff.				
23. Refer patient to:- **Please circle** Physiotherapist. O.T. Social Services				
24. Ensure appropriate 'Stickman Sign' displayed at bed area.				
25. Reassess patient using FRAT , if patient condition changes or following each inpatient fall.				
26. Record FRAT scores in nursing records				
27. Nurse patient on mattress on floor.				
28. Consider referring patient to:- Falls & Syncope Nurse Specialist, bleep 564 (Medical Unit)				
29. Patient offered referral to falls prevention services on discharge. (Circle) **ACCEPTED DECLINED**				
30. Patient referred to falls prevention services. **Specify;-**				
31. Provide patient/relative or carer with information on to reduce risk of falls.				
32. Provide patient, relatives or cares with information on how to maintain healthy bones.				
Date, time & sign				

Document to be stored in Nursing Record
Page 2 of 2

STICKMEN
Guidance for the Use of Visual Identification for In-patients at Risk of Falls

Slips trips and falls are the highest clinical risk for patients and staff in acute hospitals. (NPSA)

We are committed to promoting patient safety and reducing falls.

Visual indicators of a patient's risk status have been successfully used in other organisations. At BHNFT we have adopted the 'stickmen' indictor to highlight patients who have fallen or who are at risk of falls.

- All patients admitted to adult in-patient wards, (with the exception of Maternity and ICU), will have a Falls Risk Assessment (FRAT) completed within 6 hours of admission *(Guidelines for the Prevention and Management of Falls in the Clinical Setting, BHNFT*. 08.09)

- If the patient is assessed as low, medium or high risk of falls, the problem must be added to the patients' individual care plan with associated actions to be implemented to reduce the risk of falls.

- Where a patient is assessed as **AT RISK** of falls a visual display (stickman) should be used. This should be displayed behind the patients bed to identify the risk of falls as below:

For a FRAT score of between 0 and 11 – low risk GREEN stickman

For a FRAT score of 12 and above – at risk AMBER stickman

Any patient who has suffered an in-patient fall during this admission should have a RED stickman

- On discharge please remember to remove the visual display from behind the bed as part of the discharge process.

Thank you

The In Patient Falls Risk Management Group
November 09

Barnsley Hospital NHS
NHS Foundation Trust

APPENDIX E

To Be Completed At Start of EVERY Shift

Guidance

'2 minute' Safety Brief Triggers – In Patient Areas

The aim is for all staff to understand the key safety risks associated with all patients on / or to be expected within the ward environment. It is thought through this type of briefing that the numbers of incidents will reduce, it will improve patient experience and communication between professionals and patients/relatives.

- The safety brief must be completed at **EVERY** staff handover in accordance with the BHNFT 'Nursing Strategy' using the handover book.

- The Safety brief must be given to **ALL** staff for the duration of duty, and include all patients on the ward/ or to be expected.

- The Safety brief must be given by the Nurse who is about to be in-charge of that shift, this will be complimented by use of the handover Book, to illustrate

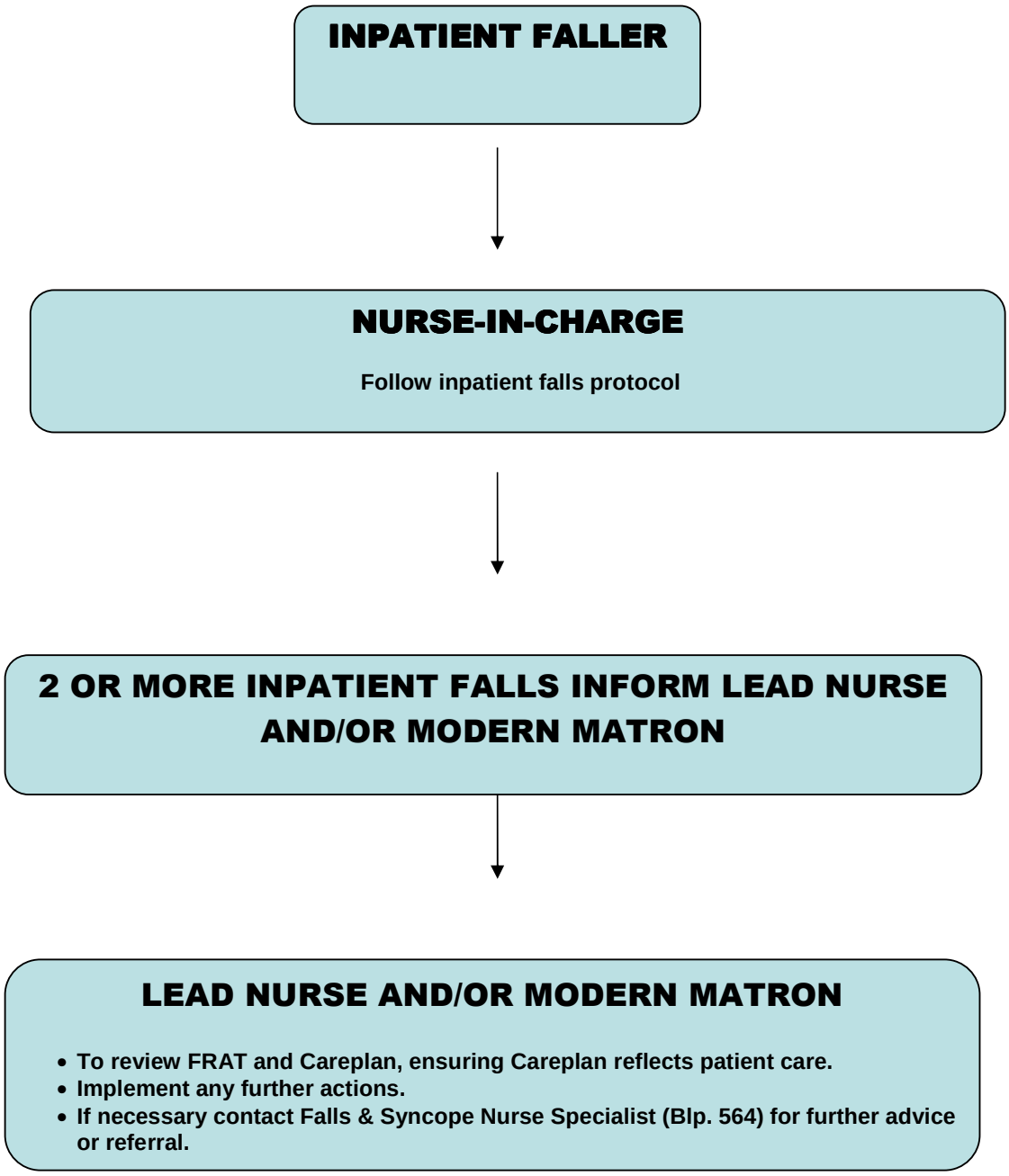
  (a) Location/ name of patient
  (b) Safety risk identified
  (c) Allocated member of staff on that shift

- Safety Risks have been identified as the following:
  i. Do not resuscitate (DNR)
  ii. Infection status
  iii. Falls
  iv. Absconding
  v. Pressure area care
  vi. Communication needs
  vii. Dementia
  viii. Safeguarding issues
  ix. Violence & aggression
  x. Hourly care

Note: This is not an exhaustive list and can be added to where necessary.

Appendix F

FLOWCHART FOR REFERRAL TO FALLS & SYNCOPE NURSE SPECIALIST



APPENDIX G

Guidelines for the safe and effective use of bedrails

1. Scope
This guideline is relevant for all staff caring for adult patients in in-patient areas.

2. Purpose
These guidelines aim to: -

- Reduce harm to patients caused by falling from beds or becoming trapped in bedrails.
- Support staff and patients to make individual decisions around the risks of using and of not using bedrails.
- Ensure compliance with Medicines and Healthcare Related products Agency (MHRA) and National Patient Safety Agency (NPSA) advice.

3. Evidence
These guidelines have been based on: -

- MHRA Device Bulletin 2006(06): *Safe use of bedrails* and Device Alert 2007/009: *Bedrails and grab handles;*
- NPSA safer practice notice: *Using bedrails safely and effectively;* 2007
- NPSA bedrails literature review 2007

4. Introduction
Bedrails are safety devices intended to reduce the risk of patients accidentally slipping, sliding, rolling or falling from a bed. They may be used as reassurance for patients who are anxious about falling from their bed. Bedrails used for this purpose are not a form of restraint. Restraint is defined as *'the intentional restriction of a person's voluntary movement or behaviour.'* Bedrails will not prevent a patient leaving their bed and falling elsewhere, and should not be used for this purpose. However there have been a number of adverse incidents involving bedrails that have led to injury and in some cases death. Bedrails are not designed to function as grab handles to aid movement, nursing staff should explain this to patients. When using bedrails both rails should be in the upright position. These guidelines have been developed to support staff to identify patients who require bedrails.

5. Definitions
For the purpose of these guidelines the term bedrails will be used. They refer to the rails on the sides of adult beds, although other names e.g. cot sides, safety sides or safety rails are often used. Medicines and Healthcare Regulatory Agency (MHRA).

6. Patients at risk
The MHRA who investigates adverse incidents has highlighted that certain groups of patients are more at risk of hurting themselves through entrapment, than others.

Those at risk are: -

- Some older people.
- People with dementia.
- People with physical disabilities e.g. cerebral palsy.
- People with micro or hydrocephalus.

Care should be taken when using bed rails with these groups of patients and use should only be considered after a risk assessment has been carried out.

7. Individual patient assessment
See also Flowchart for patient selection Appendix J

Bedrails **should not usually** be used: -

- If the patient is agile enough and confused enough, to climb over them.
- If the patient would be independent if the bedrails were not in place.

Bedrails **should usually** be used: -

- If the patient is being transported on their bed;
- In areas where patients are recovering from anaesthetic or sedation and are under constant observation.

If bedrails **are not used**, how likely is it that the patient will come to harm: -

- How likely is it that the patient will fall out of bed?
- How likely is it that the patient would be injured in a fall from bed?
- Will the patient feel anxious if the bedrails are not in place?

If bedrails **are used,** how likely is it that the patient will come to harm: -

- Will bedrails stop the patient from being independent?
- Could the patient climb over the bedrails?
- Could the patient injure themselves on the bedrails?
- Could using bedrails cause the patient distress?

The MHRA suggest that 'often bedrails are used not because the individual needs them, but because of association with the environment, their condition or their age'.

Questions that need to be considered include: -

- Is the person likely to fall out of bed?
- If so, are bedrails the most appropriate solution?
- Can an alternative method be used?
- If a disabled person requires some kind of positioning device can this be used instead?
- Could the use of bedrails increase the risk e.g. could a confused patient try to climb over them?
- Is their head or body small enough to pass between the side bars?
- Is their head or body small enough to pass through the gap between the lower bed rail and the mattress?

- Is their head or body small enough to pass through and gap between the bed rail and side of the mattress?
- How high is the risk that they will fall out of bed without bed rails being fitted?
-

8 Using bedrails with air mattresses/pressure damage prevention mattress overlays.

Special care should be taken when using bedrails with the above mattresses because: -

The reduction in the effective height of the bedrails relative to the top of the mattress may allow the patient to roll over the top of it.

The mattress edge is easily compressible the risk of entrapment is increased.

9 Alternatives to using bedrails

The use of bed rails needs considerable care to ensure that the patient is not placed at risk.

Alternative methods of bedcare/management should be considered, such as;

Variable height beds used at the lowest position.

Placing a mattress on the floor. A manual handling risk assessment should be carried out before using this method.

Nurse the patient near to the nurse station or on the corridor for closer observation

Place the patient on one to one supervision.

Regular toileting of the patient.

10 Fitting of bedrails

The majority of beds are electronic with integral bedrails, but there are still areas within the Trust where mechanical beds are still in use which use detachable bedrails. The training for the correct and safe fitting of bedrails will be covered in the local induction package.

Fitting of bedrails correctly is essential if accidents are to be avoided. When fitting or using bedrails the following should be considered: -

- Is there a gap between the lower bar of the bedrail and the top of the mattress which could cause entrapment?
- Does the mattress compress easily at the edge creating an entrapment hazard. Consider the use of padded sides.
- Will the gap at the end of the bedrails and the headboard/foot of the bed allow entrapment.

Once fitted the bedrails should be regularly inspected to ensure that: -

- The locking mechanism provided on the adjustable crossbars, which locate under the mattress, are properly engaged.
- The mechanism is locked in the correct position when the bedrail is being used.

REVIEWED August 2010

REREVIEWED July 2011

APPENDIX H

Barnsley Hospital NHS
NHS Foundation Trust

Patient Has Sustained an Inpatient Fall

Patient Name…….. DOB……. Unit No…….
NHS No……..

Date and time of fall…….
…….

Brief description of circumstances of fall…….
……
……..

Problem: - Patient has sustained an inpatient fall
Outcome:- To reduce risk of further falls

(N/A in comments, if action not appropriate)

Date, time & Sign

	Comments	Date, time & sign
1. Examine patient for any injuries.		
2. Complete Incident Reporting Form (IR1 Form)		
3. Inform medical staff .		
4. Inform Emergency Contact.		
5. Document circumstances of fall in nursing records.		
6. Reassess patient using Falls Risk Assessment Tool (FRAT)		
7. Ensure patient has red 'Stickman Sign' displayed at bed area.		
8. Patients with recurrent inpatient falls , refer to:- Falls/Syncope Nurse Specialist, Bleep 564 (medical unit)		
9. Ensure flow chart is followed for patient falls, as documented in the Slips, Trips and Falls Policy.		
10. Record clinical observations **Specify:**		
11. Record neurological observations		

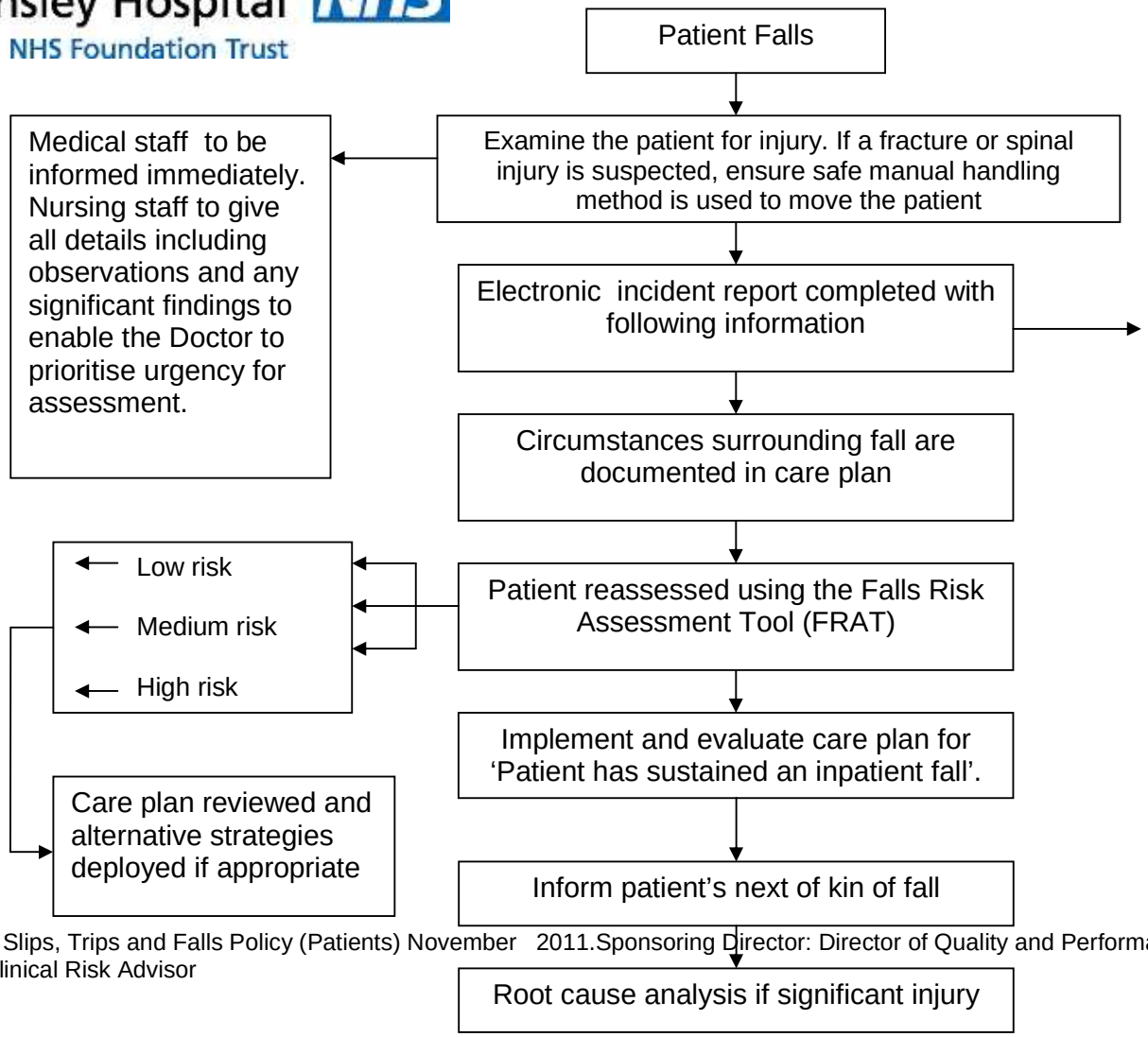
Please note:-If the patient is confused and suffered an unobserved fall or the patient is known to have hit their head, neurological observations should be performed as per recommendation in the 'Slip, trips & falls Policy'.

Document to be stored in Nursing Records

APPENDIX I

Barnsley Hospital NHS
NHS Foundation Trust

PATIENT FALLS CARE PATHWAY



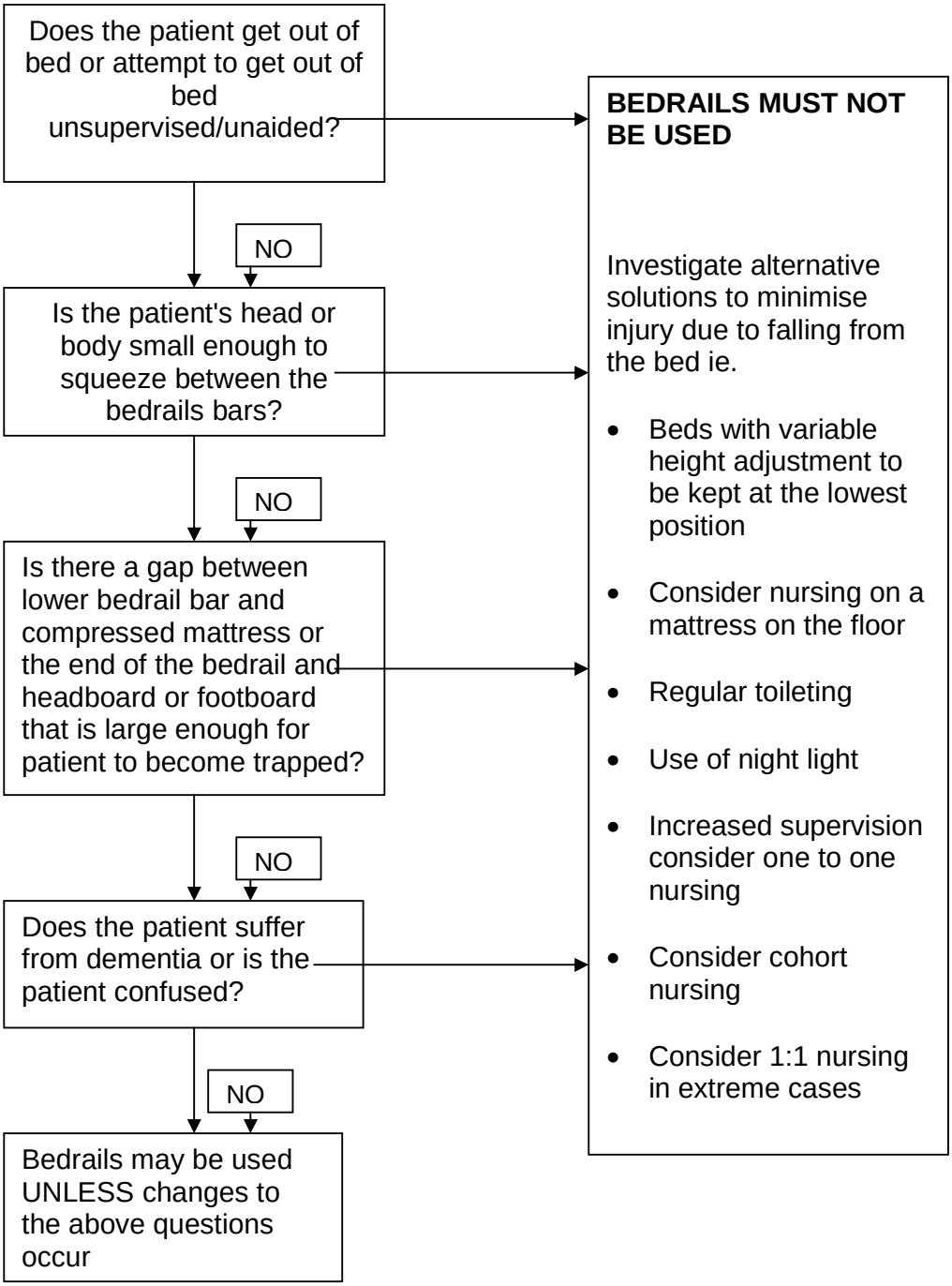
Details of incident report: -

- Time of incident
- Where the fall occurred
- Circumstances surrounding fall
- FRAT score prior to fall
- If at risk was the problem on the care plan
- Prevention strategies in place prior to fall
- Staffing levels
- Was the patient confused or disorientated
- Was the fall as a result of lack of equipment
- Were bedrails in situ
- Was the bed at the lowest height
- Strategies initiated to prevent further falls occurring
- Has the patient had another FRAT completed
- Consider use of observation charts

APPENDIX J

FLOWCHART FOR SUITABILITY OF BEDRAILS

Care4u



APPENDIX K

MONITORING MATRIX

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible person/group/ committee	Frequency of monitoring	Responsible person/group/ Committee for review of results	Responsible person/group/ Committee for development of action plan	Responsible person/group / Committee for monitoring of action plan
a. Duties	Training reports Falls reports	HR ESR staff Clinical Risk Staff	Monthly Monthly	Divisional Governance	Divisional Governance	QSIEB
b. requirement to undertake appropriate risk assessments for the management of slips, trips and falls involving patients (including falls from height)	Monthly reports of falls and multiple falls	Clinical Risk Department	Monthly	Lead Nurses	Quality Safety Improvement and Effectiveness Board (QSIEB) In-Patient Falls Prevention Group	QSIEB
c. organisation's expectations in relation to staff training, as identified in the *training needs analysis*	Report from the Electronic Staff Record (ESR)	HR ESR staff	Monthly	Lead Nurses Therapy Manager	Divisional Governance Committees In-Patient Falls Prevention Group	Clinical Governance Committee
d. process for raising awareness about preventing and reducing the number of slips, trips and falls involving patients	Spot audits on randomly selected wards	Senior Nursing Staff	Weekly	QSIEB	Chief Nurse	QSIEB/Clinical Governance

Equality Impact Assessment (EQIA)
Pro-Forma

The purpose of an Equality Impact Assessment (EQIA) is to ensure that we do not discriminate against any of the Equality Groups (Age, Disability, Gender, Sexual Orientation, Race, Religion or Belief) and ensure that we promote equality in the provision and take up of our services and employment practices at Barnsley NHS Foundation Trust.

Div/ Dept	Risk Management
Policy/ Service	Patient Slips, Trips and falls Policy
Is this policy service New/Existing	New. Previously Staff, visitors slips, trips and falls and Inpatient falls.
Assessor(s)	Angie Clark
Date of Assessment.	August 2011
Aims/Objectives/Purpose Of Policy/Service	To reduce the number of patient slips, trips and falls and the resulting severity of possible injury arising from them through staff having a greater awareness of how to deal with such situations.
Associated Objectives for this Service e.g. NSF's National Targets, References	To minimise the number of patient slips, trips and falls and to manage identified risks proactively. National Patient Safety Agency (NPSA) Slips, trips and falls in hospital report 2007. Monitored through the Trust Clinical Dashboard and the Quality Account
Who Does this policy Affect?	Patients. All staff
What outcomes do you want to achieve from this service delivery?	To reduce the number of patient slips, trips and falls occurring within the Trust by having a robust Patient Slips, Trips and Falls Policy
What factors could contribute/detract from effective delivery of this service?	Training for all members of staff is a contributory factor to the implementation and effective delivery of the policy
Could this service/policy have a different impact on different groups	If Yes please circle which groups Race……No Age ……..Yes Disability ……Yes

	Gender …….No Religion ……No Class……No Sexual Orientation ……..No
Explain any reasons/evidence to support the above question relevant to this impact (e.g. language barriers, consultation, complaints, surveys, mystery shopper, evaluations)	Research (National Service Framework for Older People DoH 2001) shows that older people are more likely to fall. The age and any disabilities of an individual are taken into consideration when completing a falls risk assessment. Staff should be aware of the increased risk of the potential for slips, trips and falls occurring for service users with mobility problems.
If you have answered yes to the above, please describe any current/planned actions, (**SMART**), agreed workstreams relevant to your EIA which will: • **Eliminate discrimination** • **Promote equal opportunities** • **Promote good race relations**	Slip resistant flooring is placed on all floors with a contrasting border in corridors to identify where the wall ends and an opening exists ie. Doorway. To comply with the DDA Disability Discrimination Act Regulations Signs with a visual display placed on wet floors to identify a hazard for non English reading persons. Slips, trips and falls training delivered by the Falls and Syncope Nurse Specialist regularly for all nursing staff. Falls reports are produced monthly and distributed to the members of the Inpatient falls steering group to identify any common themes. Each Divisional Governance meeting has monthly reports for falls trends within their area.
Following the above actions, will there be a need for a further impact assessment?	No
How will this EQIA be communicated/shared?	Sent to Trust Equality and Diversity Advisor for sign off. Uploaded on Trusts public webpage. HR intranet. Communicated to relevant Div/Dept at Falls Meeting.
When is the next review (please note review should be immediate on any amendments to your policy etc.)	4 years in line with the Slips, Trips and Falls Policy