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The falls leaf is used to represent patients at risk of falling

FALLS PREVENTION

A Fall - " An event whereby an individual comes to rest on the ground or other lower level 'with' or 'without' loss of consciousness"

The Northern Care Alliance falls prevention agenda has been adapted from the Royal College of Physicians FallSafe Resources

Includes:

1. Falls Risk Assessment
2. Bed Rail Risk Assessment
3. Moving and Handling Risk Assessment
4. Falls Care Plan (if identified at risk of falls)

Royal College of Physicians

Complete a detailed risk assessment within 6 hours:

- Of admission
- Of transfer to another ward or department
- Of a condition change e.g. patient becomes confused, deterioration in condition, post-operatively, post fall or if a patients condition improves

If none of the above triggers an earlier review a detailed risk assessment must be completed a maximum of every 7 days.

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Patient Risks

- **Age – 30% of people over the age of 65 fall at least once a year.**
- **Is your patient taking risk medications?**

Avoid new night sedation

Diuretics: cause hypotension

Beta blockers: cause bradycardia/ hypotension

Anti-Anginals: Cause Hypotension

Consider Doctor or pharmacy review!

- **Please refer to Medicines Guidance sheet .**
- **Communicate any new medication and its effects to patients and staff.**
- **Has your patient got any conditions that may increase the risk of falling?**

stroke / neurological / cardiac / respiratory / balance problems / cognitive impairment / acute confusion / postural hypotension / dizziness / drug and alcohol misuse / learning disabilities / mental health illness

Consider referrals to specialist teams for further support

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Assessing Patient Risks

Lying & Standing Blood Pressure (L&S BP)

- All patients require a L&S BP on admission to the ward.
- Document recordings on the Falls Risk Assessment.
- If unable to take a reading for a valid reason then please document this clearly on the risk assessment and take the reading at the earliest opportunity.

N/A, not needed or not requested are NOT valid reasons if unable to take reading

Is my patient cognitively impaired?

Dementia /delerium

Does my patient have learning disabilities?

Reasonable adjustments

Has my patient got capacity to maintain their own safety?

MCA

Can my patient see/hear clearly?

Have they got glasses/ hearing aid?

Moving patient closer to nurse station/bay tagging!

Have you considered Enhanced Patient Observation?

Have they fallen whilst in hospital?

Have I communicated all previous falls to staff?

Has my patient fallen at home?

Think patient anxiety and confidence when mobilising

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Environmental Risk Factors

- Is my environment clutter free?

Intentional rounding

- Is my patient wearing appropriate footwear?
- Ask family members to bring in suitable footwear

Grip socks ?

- Have you explained the environmental risks to your patient?
- Have you orientated the patient to the ward area?
- Have you given the patient a falls risk leaflet?
- Is the nurse call bell within reach/can they use it?
- Are the patients possessions within reach?
- Are their walking aids within easy reach? Have they brought this in with them?

Have we explained how to use the call bell?

Do we need to supply a walking aid whilst in hospital?

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Essential Care Post Fall

1. Assess your patient for injuries – top to toe assessment before moving patient
2. Commence Neurological Observations if fall unwitnessed by staff/head injury.
3. Request a medical review.
4. If harm injury suspected use Emergency Lifting Equipment
5. Duty of candour – Inform relatives.
6. Complete a Datix report – Provide as much detail as possible.
7. Senior nurse to complete a post falls checklist and return to falls team.

Ferno Scoop

Mangar Elk

For more information on falls please click **here** or contact: sally.Hulmes@nca.nhs.uk
For more information on the Mental Capacity Act and assessing Capacity click **here.**

Please help us to improve our Take 5 presentations by taking 1 minute to answer 5 feedback questions Click Here
If you are interested in developing a Take 5 presentation please email **Take5@nca.nhs.uk**

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Falls Web Page

Please go to the Falls Web Page on the Intranet or contact a member of the Falls Prevention Team for more information on:

Helpful videos for: Lying and Standing Blood Pressure, Neuro Observations, Emergency Lifting Equipment

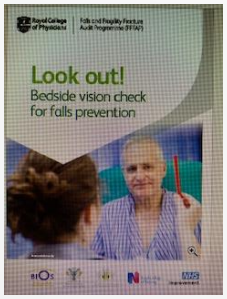
And handouts you can print for:

Falls Leaflet

Lying & Standing BP

Neuro Observations

Vision Assessment



Medicines Guidance Sheet