NHS FORTH VALLEY
In-patient Falls Resource Pack

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Author / Contact: Lesley Yarrow
Group Committee – Final Approval: Falls Implementation Group

This document can, on request, be made available in alternative formats
## Management of Policies Procedure control sheet

(Non clinical documents only)

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### Consultation and Change Record – for ALL documents

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**Consultation Process:**

NHS Forth Valley Falls Strategy Implementation Group  
NHS Forth Valley Joint Clinical Governance Working Group

**Distribution:**

Quality Improvement Website  
Falls Champions

**Change Record**

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<td>14/01/2014</td>
<td>Lesley Yarrow</td>
<td>Update to relevant documents in line with national guidance and local best practice. Adddition of Falls Sense Gudiance</td>
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1 Acknowledgements

Forth Valley Falls Prevention Implementation Group would like to acknowledge the Ipswich Hospital NHS trust team who produced and implemented a resource pack for staff which some of this work has been based on. We would also like to acknowledge the contributions made by Physiotherapy, Nursing and Practice development staff in Forth Valley who trialled and helped develop some of these resources.

2 Introduction

Patient falls are the highest reported incident in hospital settings. Each year around 282,000 patient falls are reported to the National Patient Safety Agency (NPSA) from hospitals and mental health units. A significant number of these falls result in death, severe or moderate injury; including around 840 fractured hips, 550 other types of fracture, and 30 intracranial injuries.

This creates a significant financial burden to the organisation for immediate healthcare, but also can generate ongoing costs for rehabilitation and social care. The cost to the patient and carers is more difficult to quantify, but, can be measured in terms of distress, pain, injury loss of confidence, reduced self esteem, fear of further falls and loss of independence.

The causes of falls in the older population are complex and often multi-factorial. While people of all ages can fall, older people are particularly vulnerable due to increased risk factors such as: cognitive problems; previous falls; continence problems; polypharmacy; visual problems and co-morbid conditions such as stroke or muscular-skeletal problems. They can also be more vulnerable to serious injury resulting from a fall as a consequence of poor bone health.

With this in mind, it is important that any measures or interventions put in place to reduce falls are person centred and tailored to the individual. The interventions also need to have a strong evidence base to support implementation.

In addition to the individual risk factors, the hospital environment poses a challenge. This is in terms of observation, unfamiliar surroundings, specialist equipment and ever changing hazards.

Addressing the problem of inpatient falls and fall-related injury is complex and challenging for all healthcare professionals in the organisation. Patient safety is a priority. However, it should be balanced with the patients right to choice, rehabilitation, independence, privacy and dignity.

The purpose of the resources in this pack is, to give staff the tools to help improve patient safety in their ward area. Falls prevention in hospital is everyone’s business. Therefore the tools are designed to help staff from any of the professions involved in direct patient care to reduce avoidable falls in their area and where a fall does occur that there is a consistent approach to managing that fall in accordance with best practice. The resource pack will not stand alone, but will be part of a complete improvement programme, which will include ‘Falls Sense’ online training programme and ongoing support from the AHP and Nurse Consultant for Older People’s services.
3 Scope

This resource pack is intended for use for all in-patients in acute services and community hospitals within NHS Forth Valley to prevent and manage falls, this pack could also be used by the Care Home sector if they so wish. Exclusions are paediatrics, neonatal and obstetrics. The evidence base for falls prevention interventions is generally applicable to older people of 65 years and over. Older people will be the focus of this improvement work, however, staff may find the resources can also be applied to a younger in-patient population.
4 Introduction to Resources

Protocols, Pathways and Policies

Falls Care Plan Bundle and Trigger Tool Quick Reference Guide

This flow chart provides simple guidance and describes the process by which staff should use the falls trigger and falls bundles tools provided in your bundle booklets. The flowchart also includes guidance on when the post fall protocol should be implemented.

Falls Assessment Protocol

The Falls Assessment Protocol is a guide to comprehensive assessment for the older person who is at risk, or has experienced a fall. This is based on evidence from both the British and American Geriatric Society.

Medication Which May Increase the Risk of Falls

Information has been produced with regard to Medication Which May Increase the Risk of Falls. The document details common drug names and identifies in what way they can increase the risk of falls. Each group of drugs has been assigned with a risk category ‘moderate’ or ‘high’, in terms of the likelihood of increasing the risk of falling.

In-patient Post Fall Protocol

The NPSA issued a rapid response report in January 2011. This report was based upon the analysis of patient safety incidents reported to the National Reporting and Learning System, which indicated that after a fall in hospital some patients experienced some failure of aftercare.

When a serious injury occurs as a result of an inpatient fall, safe manual handling and prompt assessment and treatment is critical to the patient’s chances of making a full recovery. The In-Patient Post Fall Protocol aims to ensure that systems are in place to help staff to consistently achieve this in Forth Valley Royal and all Community Hospitals (NPSA /2011/RRR001).

Footwear Assessment Guidance

The Footwear Assessment Guidance aims to assist staff in decision making regarding the appropriateness of patients footwear. It acts as a guide only but may help staff to provide appropriate advice to carers and patients on safe, suitable footwear to wear in the ward.
Bedrails Policy

Patients in hospital may be at risk of falling from bed for many reasons such as poor mobility, cognitive impairment, or delirium, visual impairment, and the effects of their treatment or medication. Bed rails may reduce the risk of a person accidentally slipping, sliding, falling or rolling out of bed, however they may also increase the risk of someone falling if that person tries to climb over or around them. Bed rails should only be used after a considered risk assessment using the NHS Forth Valley Tool highlighted in the policy below.


Tools

The Falls Challenge Poster

The falls challenge poster is designed to provide, patients, visitors and staff with information on NHS Forth Valley’s approach to reducing falls in hospital and therefore needs to be visible to all. It also outlines what patients and their carers, families and friends can do to minimise risks on hospital wards. The poster displays a chart, which shows the national falls rate. This chart should be populated with the falls rate for the particular ward by the SCN/Falls Champion each month. This information will be sent retrospectively by email to SCN’s to share with Falls Champions.

Falls Care Plan Bundle including Trigger Tool

The NICE Guideline CG161 (NICE 2013) for the assessment and prevention of falls in older people states that the purpose of assessment is not only to identify those at risk of falling but to target interventions which are effective. The purpose of the Falls Care Plan Bundle and Trigger Tool is to identify those at risk and then to prioritise and target appropriate evidence based interventions specific to the individual, which aim to reduce the risk of falls. At the same time the bundle will help to maximise the person’s independence while they are an in-patient in hospital.

Care and Comfort Rounds

The purpose of the care and comfort rounds is to ensure that each patient is asked whether they have any requirements or if they need something. During the care and comfort round the staff member will be checking that the area is uncluttered, appropriate walking aids are available as required and that the patient can use the call bell appropriately and that it is within reach of the patient.
Information Leaflets

Reducing Falls in Hospital Leaflet

The *Reducing Falls in Hospital Leaflet* will be made available to all older people who are inpatients and their carers. It will provide information on maintaining their own safety in hospital. Staff will be expected to ensure that patients and carers receive this leaflet **within 24 hours of admission to the ward**.


Education

Falls Sense

*Falls Sense* is an e-Learning resource which provides training to increase awareness about falls; their impact and prevention. It contains educational material and resources for staff and members of the public to access. The content of the training covers the possible causes of falls and guidance on how to; recognise risks, screen and assess individuals. It also outlines methods for intervening and taking action in order to resolve, address or manage the risks.

Your Resources

The Falls Pathway

*The Falls Pathway* describes the path followed in the wider context of NHS Forth Valley to access appropriate services, when an older person is identified as a falls risk or having had a fall. It is intended that this will ensure consistency, equity and simplify access to falls services

This section is also for you to add your own resources relevant to falls
Section 3

Protocols, Pathways and Policies
Falls Care Plan Bundle and Trigger Tool Quick Reference Guide

**Aim**

To reduce the number of falls and impact of falls that occur in in-patient areas in NHS Forth Valley

**Screening and Assessment**

Trigger Bundle
All patients of 65 years and over will be screened for falls risk within 24 hours of admission

**Actions**

Complete the falls screen using the Falls Trigger Bundle

**Falls risk identified**
Care bundle completed within 24 hours of admission

- Complete the Care Bundle
  - Complete Care Bundle and document all planned interventions
  - Refer to other members of MDT for further assessment/intervention as required by bundle – see Falls Assessment Protocol
  - Ensure patient has appropriate footwear, glasses, hearing aid etc
  - Source falls prevention equipment; low rise bed if required
  - Agree the plan with patient/carer
  - Provide patient/carer with Reducing Falls from Hospital leaflet
  - Ensure relevant documentation in unified note

**Fall event occurs on ward**

- Follow Post Fall Protocol
  - Complete Safe Guard (P1)
  - Review and update Care Bundle
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Rationale</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of falling</td>
<td>In half of all cases of falling, the falls are recurrent</td>
<td>Full assessment</td>
</tr>
<tr>
<td>Gait and balance</td>
<td>Abnormality of gait and balance is a recognised risk factor for falling</td>
<td>Refer to Physiotherapist</td>
</tr>
<tr>
<td>Lower limb function</td>
<td>Abnormality of gait and balance is a recognised risk factor for falling</td>
<td>Refer to Physiotherapist</td>
</tr>
<tr>
<td>Medication Review (including prescribed and over the counter medicines)</td>
<td>Polypharmacy is a recognised risk factor for falling. Of particular importance is the use of benzodiazepines, diuretics, tranquilisers, laxatives, antidepressants and neuroleptics</td>
<td>Refer to community/hospital pharmacist for medication review</td>
</tr>
<tr>
<td>Ability to perform activities of daily living</td>
<td>Poor functional performance is a recognised risk factor for falling</td>
<td>Refer to Occupational Therapist</td>
</tr>
<tr>
<td>Medical Problems e.g. postural hypotension, cardiovascular problems, neurological problems, dizziness, dementia</td>
<td>All of the aforementioned are a recognised risk factor for falling</td>
<td>Refer to GP/Hospital doctor for review Refer to Physiotherapy Department for Dix Hallpike testing and Epley Manoeuvre for BPPV and for Vestibular Rehabilitation Exercises for vestibular deficits.</td>
</tr>
<tr>
<td>Incontinence and Lower Urinary Tract Symptoms</td>
<td>Continence problems especially urgency are recognised risk factors for falling</td>
<td>Refer to District Nurse for continence assessment (if in-patient ward nurse to undertake assessment)</td>
</tr>
<tr>
<td>Osteoporosis risk, includes 75+, previous fracture, family history of fracture, early menopause, behavioural risk factors, female, underweight</td>
<td>Osteoporosis is a risk factor for falling and fracture</td>
<td>Refer to GP/hospital doctor for review</td>
</tr>
<tr>
<td>Use of assistive devices e.g. zimmer frames</td>
<td>Incorrect use of assistive devices are a risk factor for falling. People who use assistive devices are likely to have gait and balance problems</td>
<td>Educate the person re use of devices. Refer to appropriate professional e.g. physiotherapist, OT</td>
</tr>
<tr>
<td>Sedentary Lifestyle</td>
<td>Lack of exercise can reduce muscle strength and increase risk of falling</td>
<td>Encourage participation in physical activity</td>
</tr>
<tr>
<td>Assessment</td>
<td>Rationale</td>
<td>Action</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Environmental factors e.g. poor lighting, loose carpets/rugs, lack of safety equipment, slippery floor surfaces, unsafe stairway</td>
<td>Environmental factors especially within the home are responsible for a high proportion of falls</td>
<td>Advice on home safety. Refer to Occupational Therapist for advice on modification of home environment</td>
</tr>
<tr>
<td>Foot problems e.g. neuropathy, ill fitting shoes</td>
<td>Foot problems are a recognised risk factor for falling</td>
<td>Refer to podiatrist for advice</td>
</tr>
<tr>
<td>Vision e.g. acuity, long/short sightedness, tunnel vision</td>
<td>Visual Problems are a recognised risk factor for falling</td>
<td>Refer to optician or ophthalmologist</td>
</tr>
<tr>
<td>Use of alcohol</td>
<td>Alcohol use is associated with falling</td>
<td>Refer to GP, give advice on safe drinking Refer to dietitian if nutritional intake compromised by excess alcohol consumption</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutritional insufficiency is a risk factor for falling and fracture</td>
<td>Use MUST tool and take appropriate action</td>
</tr>
<tr>
<td>Mental Health Depression Anxiety Dementia type illness</td>
<td>Inability to understand risk of falling is a risk factor for falling</td>
<td>Advice on home safety. Refer to Occupational Therapist for advice on modification of home environment Refer to memory clinic if necessary Refer to community mental health team for specialist advice Discussion with family, carers re risks Complete individual risk assessment if person needs more observation than staffing allows</td>
</tr>
<tr>
<td>Pain</td>
<td>People in pain may have stiff gait/mobility</td>
<td>Assess pain and analgesia Refer to GP if analgesia not effective</td>
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### Medication Which May Increase the Risk of Falls

**Key**
- High Risk
- Moderate Risk

#### Medication Which May Increase the Risk of Falls

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<tr>
<th>Group</th>
<th>Common Drug Names</th>
<th>Contributing Factors</th>
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<tbody>
<tr>
<td><strong>Antidepressants</strong></td>
<td>Amitriptyline, dosulepin (Dothiepin), imipramine, lofepramine, citalopram, fluoxetine, trazadone, mirtazepine, venlafaxine.</td>
<td>Drowsiness, blurred vision, dizziness, postural hypotension, constipation, retention of urine.</td>
</tr>
<tr>
<td><strong>Antipsychotics</strong></td>
<td>Chlorpromazine, haloperidol, lithium, promazine, trifluoperazine, quetiapine, olanzapine, risperidone.</td>
<td>Postural hypotension, confusion, drowsiness, Parkinsonian symptoms.</td>
</tr>
<tr>
<td><strong>Sedatives and hypnotics</strong></td>
<td>Temazepam, diazepam, lorazepam, nitrazepam, zopiclone, clordiazepoxide, chloral betaine (Welldorm), clomethiazole.</td>
<td>Drowsiness which can last into the next day, lightheadedness, confusion, loss of memory.</td>
</tr>
<tr>
<td><strong>Drugs for Parkinson’s Disease</strong></td>
<td>Co-beneldopa, co-careldopa, rotigotine, amantadine, entacapone, selegiline, rivastigmine.</td>
<td>Sudden daytime sleepiness, dizziness, insomnia, confusion, low blood pressure, blurred vision.</td>
</tr>
<tr>
<td><strong>Drugs with anti-cholinergic side effects</strong></td>
<td>Procyclidine, trihexyphenidyl (Benzhexol), procloprerazene, oxybutynin, tolterodine.</td>
<td>Dizziness, blurred vision, retention of urine, confusion, drowsiness, hallucinations.</td>
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<td><strong>Cardiovascular drugs</strong></td>
<td>ACE inhibitors / Angiotensin-II antagonists: Ramipril, lisinopril, captopril / irbesartan, candesartan.</td>
<td>Low blood pressure, postural hypotension, dizziness, tiredness, sleepiness, confusion.</td>
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<td></td>
<td><strong>Vasodilators:</strong> Hydralazine</td>
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<td></td>
<td><strong>Diuretics:</strong> bendaflumethiazide, bumetanide, indapamide, furosemide, amiloride, spironolactone, metolazone.</td>
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<tr>
<td></td>
<td><strong>Beta-blockers:</strong> Atenolol, bisoprolol, carvedilol, propranolol, sotalol.</td>
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<tr>
<td></td>
<td><strong>Alpha-blockers:</strong> Doxazosin, alfuzosin, terazosin, (also used for benign prostatic hyperplasia).</td>
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<tr>
<td><strong>Analgesics</strong></td>
<td>Codeine, tramadol. Opiates – morphine, oxycodone.</td>
<td>Drowsiness, confusion, hallucinations, postural hypotension.</td>
</tr>
<tr>
<td><strong>Anti-epileptics</strong></td>
<td>Lamotrigine, clonazepam, phenytoin, phenobarbitone, carbamazepine, sodium valproate, gabapentin primidone.</td>
<td>Tiredness, unsteadiness, sedation.</td>
</tr>
<tr>
<td><strong>Hypoglycaemic Agents</strong></td>
<td><strong>Anti-diabetics:</strong> Insulin, glibenclamide, gliclazide, glimepiride, metformin, pioglitazone, rosiglitazone.</td>
<td>Dizziness and light-headedness</td>
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<tr>
<td></td>
<td><strong>Masking of hypoglycaemia:</strong> Beta-blockers, thiazide diuretics</td>
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Inpatient Post Fall Protocol

**Signs of life**

Ensure safety of responder; initial assessment; ABC; EWS (Acute), or routine observations* (CH)

**No signs of life**

Follow Resuscitation Policy as per patient status

**Fall**

- **No apparent or minor injury**
  - Repeat EWS/obs and follow escalation policy

- **Major injury or illness e.g.**
  - fracture
  - EWS = 4
  - GCS = 13
  - significantly abnormal obs (CH)

- **Suspected spinal injury or suspected fracture NOF – straight lifting technique must be implemented**

**Apparent injury**

- **Head injury**
  - ½ hourly obs until GCS 15 or 14 if pre-existing condition
  - Then: ½ hourly for 2 hours; 1 hourly for 4 hours; 2 hourly until further review
  - Consider head CT (see SIGN 110); discuss with consultant or GP if indications present

**Patient changes requiring review:**

- new agitation or changed behaviour
- GCS drop of 1 in 30 mins
- GCS drop of 3 in eye score
- GCS drop of 2 in motor score
- New severe or persisting headache
- Persistent vomiting
- New or evolving neuro signs

**Confirm changes with a colleague, then request immediate medical review**

**Actions and Interventions**

**Nursing:**

- Reassess care bundle and actions
- Update care bundle
- Consider low bed, rails, telecare
- Continence assessment if appropriate
- Complete IR1 form (any discipline)
- Inform family, doctor and wider MDT including pharmacist
- Lying and standing BP (adhering to guideline)
- Ensure falls leaflet has been provided to family at admission
- Document all actions and interventions

**Physiotherapy:**

- Assess fully including: gait; walking aid; muscle strength and balance
- Document and communicate findings to nursing staff
- Update care bundle as appropriate
- Issue ‘Keeping Mobile and Avoiding Falls’ leaflet

**Occupational Therapy**

- Complete appropriate functional and cognitive assessments

**Pharmacy:**

- Medication review

**Doctors:**

- Establish cause of fall (mechanical is not a diagnosis)
- ECG if LOC chest pain or SOB
- Medication review
- Consider bone health; prescribe appropriate medication
- Consider referral to Ageing and Health if unexplained falls
- Urgent check INR if patient on Warfarin or coagulopathy and no result within therapeutic range or lower in the last 36 hours

**Links:**


EWS is a requirement for acute hospital only.

*routine observations in community hospitals (CH) will include: BP, resps, pulse, oxygen saturations, and temp. 12 lead ECG will be at the discretion of the senior nurse.
Footwear Assessment Guidance

Guidance for assessing in-patient footwear

Consider the following questions:

- Does the patient have their own slippers or shoes?
- Do they appear to fit?
- Can the patient put on their own footwear?
- Is the footwear in good condition e.g. not worn down or flattened and are all fastenings, laces in good order?
- Is the footwear likely to require to be washed and if so does the patient have alternative suitable footwear?
- If they have dressings on their feet or oedema, does this prevent them from wearing commercially available shoes or slippers?
- In your opinion does the patient’s footwear contribute to their instability?

Staff must ensure that patients have safe and comfortable footwear prior to walking or transferring. To achieve this:

- Patients should be encouraged to bring in or have brought in, suitable footwear
- Patients with long term medical foot problems, which cannot be accommodated by ‘off the shelf’ foot wear, should have an appliance request form completed, requesting an assessment by the Orthotist for suitable footwear. BeneFoot shoes may be considered in these circumstances.
- ‘Pillow Paws’ foam slippers must not be used for patients at risk of falls as they do not provide the necessary support and damage easily, contributing further to the falls risk.
- After other avenues are explored for carers/ relatives to bring in patients own slippers/footwear and this has failed then consider supplying patient with ward stock which is held by ward A11, B21, A32 and B23, ensuring the appropriate documentation is completed
Section 4

Tools
The Falls Challenge

Our Approach to Patient Safety in Forth Valley

- **What do we do on admission?**
  - Moving and Handling Assessment
  - Identify Risks
  - Reducing Falls in Hospital Leaflet
  - Fall prevention Care Plan Filed!
  - Observation Tool/Patient Comfort Rounds

- **What can we ALL do to help prevent falls?**
  - Provide you with a means of attracting assistance
  - Keep your walking aids close to hand
  - Make sure you have appropriate footwear
  - Make sure you are wearing your own glasses and they are clean
  - Make sure the environment is uncluttered
  - Make sure you have a suitable height chair
  - ASK for help to mobilise around the ward

---

**Cost to the Patient...**
Loss of confidence
Loss of independence
Longer hospital stay
Potential injury or loss of life

**People who are at risk?**
- History of previous fall
- Impaired walking
- Poor strength and balance
- Multiple medical problems
- Over 4 medications
- Medication effects
- Cognitive impairment

---

Example
<table>
<thead>
<tr>
<th>Date:</th>
<th>Criteria</th>
<th>Time Band</th>
<th>Actual Time</th>
</tr>
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<tbody>
<tr>
<td>Date:</td>
<td></td>
<td>8-10am</td>
<td>10-12am</td>
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<td></td>
<td></td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td></td>
<td>1. Introduce yourself to the patient and relatives if present.</td>
<td></td>
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</tbody>
</table>
# Falls Care Plan Bundle and Trigger Tool

**Active Stand to determine postural hypotension**

- **Method:** Using a continuous blood flow pressure monitor, measurements are recommended after 10 minutes of lying supine, followed by measurements every 30 seconds standing for 3 minutes. Measurements may be continued for longer if blood pressure is still falling after 3 minutes. If the patient does not tolerate standing for this period the lowest systolic blood pressure during upright posture should be recorded. A decrease in systolic blood pressure ≥20mmHg or a decrease in systolic blood pressure to ≤50mmHg is defined as postural hypotension regardless whether or not symptoms occur.

<table>
<thead>
<tr>
<th>Time</th>
<th>Heart rate</th>
<th>Blood Pressure</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supine 10 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supine 20 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous PB recording</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand 30 sec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand 1 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand 3 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand 2 min 30 sec</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand 5 min</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If YES to any question above complete falls care plan bundle (unless clinically inappropriate) and state care to be undertaken below. Review care to be undertaken if situation changes i.e. a fall, changing mobility.

<table>
<thead>
<tr>
<th>Care Plan Bundle</th>
<th>State Care to be Undertaken</th>
<th>Sign and Date</th>
<th>Care Evaluated</th>
<th>Sign and Date</th>
<th>Care Evaluated</th>
<th>Sign and Date</th>
</tr>
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<tbody>
<tr>
<td>Call Ensure call bell explained and in reach.</td>
<td>Consider alternatives for patients unable to recall use of call bell e.g. move bed in sight of nurse/staff, telehealth care e.g. movement alarms.</td>
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<td>Medication Request a review of medication if patient is on 4 medications or more or if the patient is on specific medications associated with heightened falls risk. Avoid unnecessary antidepressants, sleeping tablets, sedation, anti-psychotics.</td>
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<td>Footwear Check footwear is safe. Refer to NHO North Valley Footwear assessment guidance and if required supply ward stock – see Footwear Allocation Form.</td>
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<tr>
<td>Mobility Ensure patient has correct, appropriate walking aid and appropriate supervision/physical assistance when mobilising; ensure mobility issues are documented; request physio assessment.</td>
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<td>Environment Patient in most appropriate place on ward for their needs e.g. close to nurses' station, close to toilet, quietest area. Consider wider aspects e.g. lighting, seating at referral; Appropriate use of bed rails (see guidance).</td>
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<tr>
<td>Unconsciousness Ensure patient is conscious wearing glasses if worn; also to identify patients from bed length away? If patient too poor to identify objects, ask doctor to review. Ensure glasses are worn or within reach. Advise patients relatives on accessible options. Ensure hearing aid is good working order. If required ask audiologist to check, access amplifiers.</td>
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<td>Continue Perform analgesc if there are signs of UTI. (UTIs should only be treated if symptomatic). Consider if there are signs of urgency. Does this risk of falls appear to be associated with patients need to use toilet? If so, a routine of frequent toilet visits may be helpful in preventing falls.</td>
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<td>LSS BP check, lying &amp; standing BP and record. If deficit exists inform doctor, advise patient on slow movement from sitting to standing, consider anti-embolism/compresion stockings.</td>
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<td>Cognition If AMT≤9 consider a CAM (confusion assessment method) Document and report results and refer as appropriate.</td>
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<tr>
<td>Inform Provide falls leaflet to patient/family, engage them in care plan; check contact wishes in event of fall.</td>
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Section 6

Education
Falls Sense Guidance

Go to [http://www.fallssenseforthvalley.scot.nhs.uk](http://www.fallssenseforthvalley.scot.nhs.uk) to access the home page.

Use the tabs at the top left of the page titled About Falls Sense and Why is Training Important to read through why this training has been put together and how to get the most out of the e-Learning Resource.

The training is structured in such a way as to allow you to access subject matter according to your interest, need or experience. You may wish to initially explore the areas that are most relevant to your role. However, with each of the different modules playing a part in the prevention and management of falls, you should aim to complete them all in time.

Ideally, start with the Introduction Module from left hand side menu and navigate through the module using the arrows at the bottom on the right hand side.

The resource covers a broad spectrum of topics relating to falls and each module takes the same format in considering three aspects of falls:

- **Risk**
- **Assessment**
- **Intervention**

A Links and Resources section features on the left hand side of each training module – here you will find useful resources, links to other relevant modules and links to national and local guidance.

When reading through the text you may come across words which are underscored and highlighted in blue – this is a glossary link – hover your cursor over the word and a box will appear with extra information.

Assessment & Certificate

At the end of each training module there will be an assessment which takes the form of True/False questions relating to the content of the module.

A score of 75% is needed in order to pass the assessment and achieve the module certificate – this certificate can be printed off and used towards your Continuing Professional Development along with any learning points you may have written down while working through the modules.

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**Example of a glossary link:**

A structured, critical examination of a patient's medicines with the objective of minimising the number of medication-related problems.
Section 7

Your Resources
NHS Forth Valley Falls Pathway

For inpatients follow NHS Forth Valley In-patient Falls Resource Pack

Assessment in A&E and community setting should include the following (where appropriate)

Falls risk factors:
- History of falls – 2 or more in the last year?
- Injurious fall or long lie on floor
- Single fall in last year with balance and gait problems
- Unexplained falls including syncope, loss of consciousness, blackouts, dizziness
- Relevant medical history; medication review; BP; neurological; cardiovascular
- Fracture risk
- Bone health risk factors
- Vision
- Gait/balance/lower limb strength
- Foot problems/footwear
- Cognition
- Environment
- Fear of falling
- Hydration
- Continence

Links:
- NHS Forth Valley Falls, Fracture Prevention and Bone Health Strategy

Multi-factorial intervention
- Medication review/modification
- Management of orthostatic hypotension
- Management of cardiac problems
- Individualised gait/balance/strengthening/provision of suitable walking aids (Fast-track physiotherapy or ReACH)
- Environmental hazard (OT, social work or Care and Repair)
- Telehealthcare/MECS
- Vitamin D supplementation for those who are deficient
- Visual problems (Optometrist)
- Foot problems impacting on gait/balance (Podiatrist)
- Vestibular assessment and rehabilitation
- DEXA
- Management of osteoporosis
- Social care assessment
Publications in Alternative Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print.

To request another language for a patient, please contact 01786 434784.

For other formats contact 01324 590886, text 07990 690605, fax 01324 590867 or e-mail nhsfv-alternativeformats@nhs.net