Livewell Southwest

Falls prevention and management Protocol for in-patient, community and outpatient teams.

Version No. 3.1

Review: July 2017

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

Author: **Deputy Director of Governance / Professional Lead**

Asset Number: **530**

Reader Information

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References/sources of information	Barnett K (2002) Reducing patient falls in an acute general hospital in Shaw T& Sanders K (eds) Foundation of Nursing Studies dissemination Series. Vol 1 No1 Close J (2001) Interdisciplinary practice in the prevention of falls: a review of working models of care. Age and Ageing 30 Commodore D (1995) Falls in the elderly population: a look at incidence, risks, healthcare costs, and preventative strategies Rehabilitation nursing 20. Kinn S, Hood K (2001) a falls risk-assessment in an elderly care environment. BJN 10 Morse J (1997) Preventing patient Falls Sage Publications NHS Confederation: Ambulance Services Network Community

	Health Services Forum (April 2012): Briefing Paper NICE 2013 falls The assessment and prevention of falls in Older People. Clinical guideline 21 NICE 2012: Osteoporosis: Assessing the Risk of Fragility Fracture NHSLA (2008) Standard 3. 1.3.5 NPSA 2007 Slips trips and falls in Hospital NSF for Older People (DoH 2001) Plymouth's Strategy for Falls prevention 2002 RCN November 2004: Clinical Practice Guideline for the Prevention of Falls in Older People Savage T, Mathies-Kraft C (2001) Fall occurrence in a geriatric psychiatry setting before and after a fall prevention program. Journal of Gerontological Nursing 27 Swansea NHS Trust. Falls prevention management ; - Woolf A, Akesson K (2003) Preventing fractures in elderly people. BMJ 327 <u>LSW related Policies:</u> Manual Handling Health & Safety Incident Reporting Serious Incidents Requiring Investigation Record-Keeping
Supersedes document	Falls protocol Version 2:6
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
V 1.0	New Policy	10/2/2006	Sue Goodman S Edmunds	Prepared for publication
V 2.0	Reviewed and update	03/1/2008	S Goodman D Reid	Complete revision of protocol in light of recent national guidance.
V 2.1	Reviewed and update	02/5/2008	S Goodman J Barton	Addition of multi factorial care plan
V2.2	Reviewed and update	20/06/2008	Sue Goodman	Amendments following submission to Policy Ratification Group
V2:3	Reviewed	30/06/2010	S Goodman	Reviewed, no changes made.
V2:4	Reviewed	9/01/2012	D Slater	Significant changes made
V2:5	Amendment	26/06/2012	D Slater	Minor amendment made.

V2:6	Amendment	30/07/2012	L. O'Neill	Amendment made to appendix 6
V2:7	Extended	14/03/2014	Professional Lead.	Extended no changes
V2:8	Extended	13/10/2014	Professional Lead.	Extended no changes
V3	Amendment	August 2015	G Mills	Supersedes previous document "Falls Prevention and Management Protocol for Inpatient Areas": minor amendments to inpatient section; community section now added.
V3.1	Minor amend	May 2016	G Mills	Minor addition p8 – addition of lying and standing blood pressures upon admission. Updated to Livewell.

Falls prevention and management Protocol for in-patient, community and outpatient teams.

1 Background

A fall is defined as an event whereby an individual comes to rest on the ground or another lower level, with or without loss of consciousness (NPSA 2007). A fall maybe accidental, syncopal, a drop attack, epileptic, metabolic or psychogenic.

The prevention and management of falls is a significant issue for all healthcare professionals. (NHS Confederation 2012, NPSA 2007). Once a person has fallen, they are more likely to fall again. Falls cause death, fracture and reduced life expectancy following fracture. Falls also cause pain, loss of confidence and independence. Evidence and statistics suggest that patients in hospital are at greater risk of falling than those in the community. Inpatient teams have to balance the patients' safety with the right to make their own decisions about risk, and privacy and dignity.

NICE Guidance "The Assessment and Prevention of Falls in Older People" (2013) states that all older people in contact with a healthcare professional should be routinely be asked if they have fallen in the last year and about the "frequency, context and characteristics of the fall". The Guidance recommends that all people 65 or older who are admitted to hospital should be considered for a multifactorial assessment for their risk of falling during their hospital stay. They should also be offered a multifactorial assessment of their community-based falls risk, if appropriate. (People aged 50-64 who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition are also covered by the guideline).

2 Purpose

The guidance from the National Patient Safety Agency (2007), National Institute for Clinical Excellence (NICE) Clinical Guideline 21 (2004), Clinical Guideline 146 (2012) and Clinical Guideline 161 (2013) make falls and fracture prevention a priority for all healthcare environments and all healthcare professionals. Version 2.7 of this policy includes for the first time guidance for community staff.

3 Duties

- The Chief Executive is ultimately responsible for contents of policies and their implementation.

- Locality Managers are responsible for identifying, producing and implementing policies.

- Managers Matrons and Community Managers will support and enable operational clinical team leads to fulfil their responsibilities and ensure the effective implementation of this Policy.

- Ward / team managers are responsible for ensuring that all staff has access to the policy and a working knowledge of its contents.

- All clinical staff is responsible for ensuring they adhere to this policy.

4 Definitions

Syncope	-	A temporary loss of consciousness followed by the return to full wakefulness (fainting or blacking out).
FRAT		Falls Risk Assessment Tool
NPSA	-	National Patient Safety Agency
NICE	-	National Institute for Health and Care Excellence
MHRA	-	Medicines and Healthcare products Regulatory Agency
SIRI	-	Serious Incidents Requiring Investigation
Morse	-	A Falls Risk Assessment Tool
CPA	-	Care Programme Approach

5 Procedure for preventing / reducing risk of falls for inpatient areas

Assessment:

- All inpatients over the age of 65 and those between 50-64 with a perceived risk of falls will receive a multifactorial risk assessment – e.g. Morse – within 24 hours of admission. Any risks identified will require a documented plan for management. This can be completed by whoever administers the assessment and does not necessarily require a therapist in first instance, although they may review and add to the plan.
- Inpatients will be assessed using the Morse tool unless the ward uses CPA and a clinically reasoned decision can be made and documented that assessment is not necessary.
- Inpatients over the age of 65 and those between 50-64 with a perceived risk of falls will all receive an assessment of lying/standing blood pressure as part of admission
- If the service user is independently mobile then the clinician can document the rationale for not proceeding with assessment.
- Morse should be completed within 24 hours of admission unless clinically indicated. It is the responsibility of all members of the Multidisciplinary Team. Results should be shared with the patient and others where consent is given.
- Identified risks should be carried forward into a multifactorial care plan in collaboration with the patient/service user – multifactorial care plan to be completed within 24 hours of admission. Ideally this will form part of a holistic and integrated care plan and should include any agreed positive risk taking.
- Those at high risk should be monitored regularly according to individual need, using local protocols and clinical evidence. Observations should be recorded according to local procedure.
- Frequency of reassessment will be determined in relation to the patient's level of risk and following a fall. The care plan should reflect any changes.

Medicines:

Staff should be aware that a list of medications deemed to increase a patient's risk of falls

can be found on LSW-net under Medicines Management.

Falls or “near misses”:

- If a patient does fall or a ‘near miss’ occurs, an incident form must be completed promptly and fully and the appropriate guidance followed.
- The incident number and circumstances must be recorded within the patient record. If the patient has cognitive impairment or dementia, this should be indicated on the incident form.
- If the fall results in harm classified as ‘moderate’, ‘severe’ or ‘death’ (see http://www.npsa.nhs.uk/corporate/news/npsa-releases-organisation-patient-safety-incident-reporting-data-england/ for definitions) then it must be investigated in accordance with LSW’s Serious Incident Requiring Investigation (SIRI) Policy. The principles of the Duty of Candour must be followed. For any other harm caused by falls, a Root Cause Analysis should be instigated.

6. Guidance on the safe use of bedrails

see Appendix 6.

Note: Privacy/dignity shields in place on some Hi-Lo beds are not to be used as bedrails. Consideration must be given to the ligature risk of the bed rails. This will need to be documented within the care plan.

7. Intervention following a fall as an inpatient

see Appendix 4 and 5

For all patients where head injury has occurred or cannot be excluded e.g. un-witnessed falls, NICE guidance must be followed. The flowchart can be found as Appendix 4 and 5

Following a fall the patient should be assessed and examined by a medical practitioner according to the following timescales:

- Syncope: within 5-10 minutes. If medical staff are not available then consider contacting emergency services.
- No syncope but pain: within 1 hour.
- None of the above and no fracture: within 24 hours.

All patients must have their physiological condition monitored using the ABCDE approach at least four hourly following a fall at least until medical review has taken place.

Where the patient has consented to share information, their next-of-kin (or other person identified by the patient) must be informed of the fall, at the earliest opportunity. Where a patient is unable to consent staff must use their clinical judgement as to what is in the patient’s best interest. All such decisions must be recorded.

8. Procedure for preventing / reducing risk of falls for community patients and outpatients

This guidance also includes patients in twenty four hour care settings in the community and is the responsibility of all healthcare professionals.

- All patients over the age of 65 and those between 50-64 with a perceived risk of falls referred to Livewell Southwest community services will be assessed for their potential to fall, using the Falls Risk Assessment Tools FRAT1 (and FRAT2 as applicable) on initial assessment – see Appendix 13.
- In some teams where CPA is used, the FRAT 1 would be required where a risk is perceived or identified by a CPA assessment.
- If the service user is independently and safely mobile the assessor can document and sign to state assessment not required.
- Following completion of FRAT 1 and where other risks are identified a multifactorial intervention programme should be considered (as per NICE 2013) (see Appendix 8 for an example) and completed in collaboration with the patient/service user.
- This should be reviewed within an agreed timescale. Frequency of reassessment must be determined according to the patient's level of risk, following any relevant changes to treatment plan and following a fall. This should be documented in the holistic care plan, alongside any agreement regarding positive risk taking...
- Staff should be aware that a list of medications deemed to increase a patient's risk of falls can be found on LSWnet under Medicines Management.

9. Intervention following a fall in the community

see Appendix 5 (Flowchart)

- Any patient who is discovered having fallen or falls in the presence of a professional must not be moved until they have been checked by staff for signs or symptoms of fracture or potential for spinal / head injury with or without loss of consciousness.
- Emergency services must be called to attend if staff suspect any lower limb fracture, spinal injury, head injury or acute onset medical problems.
- If the patient is able to help themselves up and it is safe and appropriate to do so, consider guiding them through the process of rising from the floor. The professional should remain with the patient until support arrives or they are confident they are safe to be left. The patient should be encouraged to report their fall to their General Practitioner and carers.
- Consider referring the patient for input from health and social care input if appropriate and the patient consents.
- The circumstances surrounding the fall must be documented in the patient record on the incident form and the incident number identified in the patient record (see Appendix 12). The record should be completed as soon as possible following the fall.
- If a fall has occurred in the interim since a patient was last seen by a professional, a comprehensive history of the fall should be taken including:
    - Time and place of incident (including location).
    - Activity being undertaken at time of fall; circumstances surrounding the fall (e.g. patient hurrying to the toilet).
    - Any symptoms prior to the fall – dizziness, loss of consciousness, palpitations, pain, headache.

- Injuries sustained; details of medical advice sought and outcome if appropriate.
- State whether a ‘fall’, ‘slip’ or ‘near miss’.
- Any change in functional abilities.
- If confidence has been affected.
- Strategies in place prior to fall and non-compliance to strategies already in place.
- Strategies to be put in place following the fall, in order to reduce the chance of further falls.

10. The role of the Falls Team

- The Falls Therapy Team consists of Physiotherapists, Occupational Therapist and Therapy Support Workers.
- Based at Mount Gould Hospital site and is part of an integrated multidisciplinary falls service. Referrals are received following assessment at the Falls and Syncope Clinic for medical investigations into unexplained falls.
- Falls groups are also delivered in Ivybridge, Kingsbridge and Tavistock by therapy staff covering those areas.
- Falls Team Therapists carry out assessments on people either in their own homes or as outpatients.
- A treatment plan is agreed and interventions could include home exercise, Balance & Safety Group, enabling safety and confidence, healthy bones, falls prevention advice and information about community services.
- The Team are involved in raising public awareness of falls and ways of reducing the risks of falls, and act as a specialist resource for other professionals and services.

11. Training and Knowledge

- All staff must have a working knowledge of this policy.
- Training appropriate to role and practice area will be offered to all clinical staff. This will include a competency assessment. Managers may agree with individual staff where it is appropriate for this to be in the form of a self-declaration of competency.
- Community staff will be required to attend sessions which will include gaining a working knowledge of contributory factors and actions to take if a patient falls. Training for mental health staff will reflect their specific training needs.
- Session times and dates for all training / knowledge sessions will be available via LSW training and development department.

12. Monitoring Compliance and Effectiveness

- Monitoring compliance of this policy will take place following each fall with managers using the checklist as guidance for assuring accurate completion of incident forms using the Post Fall manager’s checklist (Appendix 11). There will also be an audit tool based on the standards in this policy, and this will be available to managers. The Quality Improvement Facilitator will coordinate

audit of compliance with the protocol, across in-patient areas, with a minimum of one audit being conducted annually.

- Incidents of falls are collated on a monthly basis and provide part of a quality report for the organisation.
- Recommendations and action plans from SIRI's and other investigations relating to falls will be shared across the organisation.
- All suspected or actual falls and near misses will be reported on the organisation Incident Reporting System. Any fall which results in injury or where concerns have been highlighted, will be subject to root cause analysis investigation.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Professional Practice Safety and Quality

Date: 3rd August 2015

Appendix 1

Morse Falls Risk Assessment

Please note Morse is being used to gather information on how best to manage a patient's mobility needs and not as a predictor of likelihood of falling (NICE 2013).

The tool must be completed within 24 hours of admission.
The six categories of assessment are:

- History of falling; Secondary diagnosis; Mobility Aids; Attachment to equipment; Gait; Mental Status

1. History of falling

This is scored as 25 if the patient has fallen during or during the seven days before the present hospital admission (including falls following seizures or impaired gait). If the patient had not fallen then score 0.

2. Secondary diagnosis

This is scored as 15 if the patient has more than 1 medical diagnosis recorded. The diagnosis must be relevant and causing ongoing problems in order to be included. A diagnosis is relevant if the patient is taking prescribed medication for the condition (even if they appear to be stable on the medication) e.g.

- Diuretics
- Benzodiazepines
- Antihypertensives
- Corticosteroids
- Drugs treating Diabetes Mellitus
- Polypharmacy (4 or more drugs)

For further information see section 5.3.

3. Mobility Aids

This is scored as 0 if the patient walks unaided, with a nurse / physiotherapist or helper, uses a wheelchair, or is on bed rest and does not get out of bed at all. If the patient uses crutches, a stick or any kind of walking frame, then score 15. If the patient uses furniture or walls for support whilst walking then score 30.

4. Attachment to equipment

If a patient is attached to IV / sc fluids, a syringe driver or similar device, score 20.
If a patient has a urinary catheter and uses a stand rather than a leg bag, score 20
If not attached to equipment, score 0.

5. Gait

Assessment of gait is made using the terms normal, weak, impaired.
Normal gait (score 0) Patient walks with head erect, arms swinging freely at the side, striding unhesitantly.

Weak gait (score 10) Patient is stooped but able to lift head whilst walking without losing balance. If support from furniture is required, it is for reassurance only rather than grabbing to remain upright. Patient may shuffle.

Impaired gait (score 20) Patient may have difficulty rising from a chair and/or bouncing (i.e. making several attempts). The patient's head is down and s/he watches the ground. Patient takes short steps and shuffles. Due to poor balance the patient grasps on to furniture, a support person or a walking aid and cannot mobilise without this assistance.

6. Mental status

Using this scale, mental status is scored using the patient's own assessment of their ability to mobilise. Ask the patient "are you able to get to the bathroom alone or do you need assistance?"

If the patient's answer is consistent with your assessment of mobility then they score 0.

If the patient's answer is inconsistent with your assessment, then they are considered to overestimate their abilities and be forgetful of limitations, scoring 15.

The scores must then be added to produce a total, relating to a high/medium/low risk of falling.

High risk =>55 ;- Medium risk =30-55; - Low risk =0-25

Appendix 2

Place patient ID label here
Name

DOB

NHS No

Falls Risk Assessment (Morse)

Category	Scoring	1	2	3	4	5
1. History of falling						
No	0					
Yes	25					
2. Secondary diagnosis (include meds risk)						
No	0					
Yes	15					
3. Ambulatory aids						
None/bed rest/nurse assist	0					
Crutches/stick/frame	15					
Furniture/walls	30					
4. IV Therapy						
No	0					
Yes	20					
5. Gait						
Normal/bed rest/wheelchair	0					
Weak	10					
Impaired	20					
6. Mental status						
Oriented to own ability	0					
Overestimates/forgets limitations	15					
Total score						
High risk (>55)						
Medium risk (30-55)						
Low risk (0-25)						

Date:		Time:	
Printed Name:		Designation:	

Appendix 3

Assessment guidance for fracture / spinal injury / head injury

Listed below are possible signs of injury. The list is not exhaustive: there may be other signs or the patient may only have one or none of the following signs.

1. Possible symptoms lower limb fracture:
    - new deformity of the limb
    - pain in the limb
    - obvious bruising
    - shortening of the limb
    - the limb appearing to turn outwards.

2. Possible signs of spinal injury:
    - back or neck pain
    - altered sensation in the limbs such as numbness or tingling
    - inability to move the limbs
    - un-coordination / paralysis of part of the body
    - loss of bladder / bowel control
    - twisted head/ neck / back position

If you suspect fracture or spinal injury:

- do not move patient.
- Call 9/999 to summon emergency ambulance
- state clearly to ambulance control that spinal injury or lower limb fracture suspected.
- Commence observations: - respiratory rate, temperature, oxygen saturations, blood glucose, pulse, blood pressure
- Take measures to maintain privacy and dignity
- Proceed to check for head injury as in post falls protocol

3. If head injury has occurred, fall unwitnessed or patient presenting with
    - vomiting
    - headache
    - altered consciousness
    - dizziness
    - head pain
    - tenderness

If you suspect head injury:

- do not move the patient
- In community, call 999 and request ambulance. Commence neurological observations.

- For inpatients, call (or if out of hours, inform) the doctor on duty and commence neurological observations (15 point Glasgow coma scale and pupil size and

reactivity).

- Continue neurological observations every 30 minutes for 2 hours. Do not leave the patient unattended
- If stable, hourly for 4 hours
- Then 2 hourly for a further 4 hours

- If there is any deterioration within these times, the on duty doctor must be immediately notified and observations must revert to 30 minute intervals and progressed according to patient condition.

- Should the patient go to Emergency Department information regarding these timings must be handed over to the receiving (ambulance) team. Should the patient return within the period where observations are still needed then continue according to the timings stated.
- If GCS less than 15, or pupil size and/or reactivity abnormal initially (unless 12-15 is within the patient's normal parameters) then call emergency ambulance - call 9/999 to summon emergency ambulance and do not move patient.
- Continue all observations. If GCS continues to deteriorate then keep ambulance control informed whilst providing an appropriate level of medical support.

- Ensure immediate medical review (at Emergency Department if needed) for all patients with head injury or unwitnessed fall if they have history of bleeding, clotting disorder or on current treatment with Warfarin or other anticoagulant therapy.

- If loss of consciousness occurred the patient should immediately be moved to the Emergency Department for assessment.

Appendix 4

Fall in the Community

Fall

Summon help if available

Check Danger Responsiveness Airway, Breathing, Circulation and Disability, Exposure/Environment (DR ABCDE)

Cardiac / respiratory arrest

CALL 999
Commence Basic Life Support
UNLESS TEP STATES OTHERWISE.

Not in cardiac or respiratory arrest

Check for signs of lower limb fracture and / or spinal injury

Signs of, or suspicion of, lower limb fracture or spinal injury present

1. **Do not move patient.**
2. **Call 999** state to ambulance control that spinal injury or lower limb fracture suspected
3. **Commence observations if possible**:- temp, oxygen saturations, blood sugars, pulse, blood pressure, respiratory rate.
4. **Check for signs of head injury**. If signs present **or if fall unwitnessed** then commence neuro obs (15 point Glasgow coma scale; pupil size and reactivity, limb movements)
5. Communicate neuro obs to ambulance crew.

No lower limb fracture or spinal injury suspected

Commence obs as possible– resp rate (RR), pulse (P), blood pressure (BP), temp (T), oxygen sats, blood glucose (BG), AVPU

Signs of head injury present or fall unwitnessed

Call 999 state to ambulance control that head injury suspected/fall unwitnessed. Start neuro obs(15 point Glasgow coma scale; pupil size and reactivity, limb movements)

No signs of head injury present and/or fall witnessed

GCS less than 15, or pupil size and/or reactivity abnormal:- do not move patient. Update ambulance control.

Can the patient move him/herself?
Consider if it is safe to move patient and if so safest method of doing so.
Consider first aid, pressure relief, pain-relief, hydration.

If less serious injury sustained but still one requiring emergency dept attendance arrange for attendance at ED

If uninjured or very minor injury then encourage patient/family members to consult GP at earliest opportunity

Document in patient notes. Complete incident report that day/shift. Inform team leader/ matron at next opportunity.
Contact Next of Kin if patient consents or in best interests if unable to consent. Share information with Multidisciplinary Team and consider relevant onward referral

Appendix 5

Inpatient Fall

FALL

Summon help using emergency alarm, check for hazards

Check Danger Responsiveness Airway, Breathing, Circulation Disability, Exposure/environment (DR ABCDE)

Cardiac / respiratory arrest

Commence basic life support order in place.(TEP form)
CALL (9)999 & 2222

Not in cardiac or respiratory arrest

Check for signs of lower limb fracture and / or spinal injury See Appendix??

No lower limb fracture or spinal injury suspected

Signs of, or suspicion of, lower limb fracture or spinal injury present

1. <u>Do not move patient.</u> Inform doctor / out of hours coordinator

2. Reassess if fracture still suspected

3. **Call 9999** ensure team calling ambulance state to ambulance control that spinal injury or lower limb fracture suspected

4. **Commence observations**:- temp, oxygen saturations, blood sugars, pulse, blood pressure, respiratory rate.

5. Check for signs of head injury. If signs present **or if fall unwitnessed** then commence neuro obs (15 point Glasgow coma scale; pupil size and reactivity, limb movements)

6.Continue neuro obs every 30 minutes for 2 hours, then hourly for 4 hours and then 2 hourly for a further 4 hours. Communicate neuro obs to ambulance crew.

7. Should the patient go to emergency department and return within the period where neuro obs are needed then continue the obs according to the timings stated above.

Commence obs – resp rate (RR), pulse (P), blood pressure (BP), temp (T), oxygen sats, blood glucose (BG), AVPU

Signs of head injury present or fall unwitnessed

Start neuro obs – 15 point GCS, pupil size and reactivity and limb movements continue with BP, P, T, RR and BG

All observations normal and GCS 15 :
1. Notify doctor immediately. Full medical review to be completed asap – not later than next working weekday or if clinically indicated

2. Continue neuro obs every 30 minutes for 2 hours, then every 1 hour for 4 hours, then 2 hourly for a further 4 hours.
If GCS drops to 13 or below call ambulance if this is not the patient's normal GCS reading.

Any deterioration in neuro obs must be reported immediately and timings recommenced at 30 minute intervals.

No signs of head injury present and fall witnessed

GCS less than 15, or pupil size and/or reactivity abnormal:- call ambulance do not move patient. Continue all obs'

Complete appropriate first aid / and reassess

Consider if it is safe to move patient and if so safest method of doing so.
Consider first aid, pressure relief, pain-relief, hydration.

If less serious injury sustained but still one requiring emergency dept. attendance arrange for attendance at ED

If uninjured or very minor injury then ensure medical review completed within 24 hours

Document in patient notes. Complete incident report (same shift) inform ward manager / matron for the unit at next opportunity. Contact Next of Kin

NHS number:

Date of Birth:

Location:

Appendix 6

Bedrail risk assessment

This guidance is designed to clinically support **staff** in identifying patients who may require bedrails. When healthcare staff are considering using bedrails or when patients / carers have requested that bedrails are used this form must be completed.

Note: Privacy/dignity shields in place on some Hi-Lo beds are not to be used as bedrails. Consideration must be given to the ligature risk of the bed rails. This will need to be documented within the care plan.

Does the patient normally use a bed rail?	Yes	No	
Is the person likely to fall from their bed?	Yes	No	
If so, is a bedrail the most appropriate solution?	Yes	No	
Can an alternative method of bed management be used?	Yes	No	
If a disabled person requires some sort of body positioning device on the bed, can this be used instead of a bedrail?	Yes	No	
Could the use of a bedrail increase risk? e.g. a) Would an active but disorientated patient try to climb over or round it? b) Does the patient have any cognitive impairment?	Yes	No	
Does the patient need to get out of bed regularly or urgently during the night and is not usually assisted with transfers?	Yes	No	
Is the bed fitted with integral bed rails or are they separate to the bed?	Yes	No	
Does the patient have the capacity to consent to the use of bedrails? Record outcome on this form	Yes	No	
If patient has capacity Does the patient agree to the use of bedrails?	Yes	No	
If patient does not have capacity. Have the family/carer/advocate been consulted about the risks and benefits?	Yes	No	
After consultation, are family/carer/advocate in favour of using bedrails?	Yes	No	
Considering the factors above, as well as the person's wishes, is it in the person's best interest to use bedrails? (please record reasons)	Yes	No	

Name……Signature…….
Designation…… Date…….

Appendix 7: -

Use of Bed Rails (Cot-Sides)

This guidance is designed to support managers to ensure correct fitting and positioning and the maintenance of side rails.

These guidelines are taken from the Guidelines issued by the Medical Devices Agency (MDA) DB2006 (06) December 2006.

"Healthcare organisations are placing greater emphasis on delivering patient care within a framework of risk management and clinical governance. The purpose is to ensure that the best possible care is provided, particularly when using medical devices. Assessments by healthcare professionals are increasingly being used as a method of identifying, quantifying and addressing risks associated with the use of medical devices. The MDA recommends that organisations operate risk management procedures."

Where healthcare staff are considering using bed rails or when patients / carers have requested that bed rails are used, then a detailed documented risk assessment must be carried out.

1. Risk assessment

The first consideration should be whether side rails are actually required or whether alternative equipment might be more appropriate.

This should be considered as early as possible, well before the fitting stage. Often bed rails are used not because the individual needs them, but because of association with the environment, their condition or their age.

See Appendix 6.

If either the bed, mattress or bed rail is changed, the risk assessment should be carried out again.

2. Using air mattresses or overlays

Care is needed when using replacement mattresses such as alternating cell mattresses or mattress overlays with bed rails because:

- the reduction in the effective height of the bed rail relative to the top of the mattress may allow the occupant to roll over the top of it;
- the hazard of entrapment between the side face of the mattress and the bed rail may be exacerbated due to the soft, easily compressible nature of the mattress edge;
- if the standard mattress is replaced with an alternating cell mattress or lightweight foam mattress, the whole bed rail assembly including the mattress and bed occupant can tip off the

bed when the occupant rolls against the bed rail since many divan bed rails rely on the weight of a standard, traditional divan mattress to hold the assembly securely in place. The manufacturer should be consulted regarding securing systems, such as straps;
- if an alternating cell mattress is intended to be used with a bed rail then the mattress supplier should be contacted for advice. Extra height bed rails are available from several suppliers

3. Adjustable/profiling beds

Additional vigilance is required when using bed rails with adjustable/profiling beds.

- When the risk assessment indicates that bed rails should not be used but the patient is using a profiling bed with integral rails then these rails must be removed or the bed changed if unable to remove bed rails.
- Many beds have a single piece bed rail along each side of the bed; when the bed profile is adjusted entrapment hazards can be created which are not present when the bed is in the all-horizontal position.
- Many beds, particularly special care beds such as low air loss beds often have two pairs of bed rails fitted, one pair at the head end and one pair at the foot end. Again, additional vigilance is required when using these types of split bed rails because the space between the head and foot end rails varies according to the bed profile adjustment; therefore entrapment hazards maybe created when the bed is adjusted to particular profiles.
- Care should be taken to use the rails as instructed by the bed manufacturer e.g. both pairs (at each end of the bed) may be required to be used together when the bed occupant is left unattended.

4. Maintenance and Audit

MDA adverse incident investigations have shown many serious and fatal incidents with bed rails that have been caused by a simple lack of maintenance. Bed rails are rarely included in planned preventative maintenance (PPM) schemes, such as hospital beds would be. This is partly due to their use in residential and nursing home environments.

- Adjusters, clamps and fixings can wear, work loose or be missing completely.
- Telescopic components can also become jammed, discouraging correct adjustment. Unfortunately, these types of problem are often only discovered after an incident has occurred.
- It is also possible that material fatigue can occur. Plastic components need particular attention as they can degrade due to age, exposure to light and some cleaning chemicals.
- Bed rail assemblies must be **traceable**, for instance, by labelling with an in house number, and **inspected** on a regular basis to ensure that they are maintained in a satisfactory condition. Records should be kept of inspections and maintenance and suppliers of the bed rails should be contacted for advice and replacement parts.
- Auditing the condition and use of side-rails is extremely important and should be carried out on an annual basis, by Equipment and Health & Safety personnel.

Appendix 8

Example Inpatient Falls Management: Prompt sheet for use in Care Planning

Consultant/GP Ward/Unit Date	Place patient ID label here Name DOB NHS No

	No	Yes
Is there a history of falls prior to this admission?		
Has the patient fallen since admission?		
Does the individual try to walk alone but is unsteady / unsafe?		
If yes have you considered intentional rounding or 1:1 observations?		
Is the patient or relative anxious about falls?		

GOAL: To reduce the likelihood of falls whilst maintaining dignity and independence	State action taken:	Signature
Environment: • Consider nursing in the most appropriate place on the ward e.g. near to nurses' station, close to the toilet.		
• Identify any slip/trip hazards including IV line if in situ.		
• Is the lighting adequate? Does a bedside light need to be left on overnight or light left on in the toilet?		
▪ Risk assess the need for bed rails (refer to policy).		
• If likely to fall from bed ensure bed height at the lowest setting providing that this does not reduce mobility or independence (this approach should NOT be used to prevent an individual from getting out of bed)		
• Consider a low profiling bed or alternative low sleeping arrangements.		
• Has the call bell been explained and is it in easy reach?		
• What are the alternatives for individuals who will be unable to recall the use of the call bell?		
• Consider the position of any walking aid -is it close by/within reach? Or placed well out of reach?		
Medication/medical issues: • Check for medication associated with falls risk		

(antidepressants, sleeping tablets, sedatives, anti-psychotics). *See 'Drugs and Falls' list.* Request medication review.		
• Check lying and standing blood pressure and record. If deficit exists inform doctor.		
Continence: • Is the risk of falling associated with using the toilet? Consider a routine of frequent toilet visits. Consider patients needs during the night.		
• Is there a new continence problem?		
• Is there urgency of micturition?		
• Perform urinalysis. Consider MSU.		
• Consider continence assessment and referral		
Fracture risk & bone health: • Consider fracture risk assessment		
• Has a medical review included the need for bone modifying medication?		
• Has a nutritional screen MUST (Malnutrition Universal Screening Tool) been completed and treatment plan commenced?		
• Is fluid intake adequate? Has healthy diet and bone health information been provided to patients and their carers?		
• Ask relatives to supply safer replacements or supply new supportive slippers from ward store if there is one.		
• Consider slipper socks in bed for patients at risk of falling at night.		
• Regularly check foot condition and toenails and treat accordingly.		
• Check that garments fit well and all fastenings are fit for purpose		
Communication with others • Ensure medical staff, physiotherapist, OT, social worker etc aware of patient's risk, frequency, nature, seriousness of falls (expected actions by MDT members include mini-mental, osteoporosis check, mobility aid review).		
Information given to patient/carer: Please tick Staying Steady ☐ Healthy Eating ☐ Healthy Bones ☐ Others ☐		
Print Name and Designation: Date: Signature: Review Date:		

Appendix 9

1:1 Observation Chart

Patient's Name		NHS Number:		Ward:	
Date:		Reason for observation			

Person allocated	Location	Summary of presentation to be completed hourly by nurse undertaking observations.	Signatures
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:
Name:			Signature 1: Signature 2:

Insert Patient ID label
Name

DOB

NHS No

Appendix 10. Intentional Rounds Checklist V2

1 On each round the following should be checked:
- Does the patient have access to a drink?
- If walking aid/call bell used, is it within reach?
- If in hi-lo bed, is it at an appropriate setting?

Ward name:

Date:

2 Questions / prompts: ↓ Times: →												
1. Box 1 checks completed?												
2. Is patient awake (A) or sleeping (S)?												
3. Does patient need to go to the toilet?												
4. Is patient comfortable?												
5. Is there anything else patient needs?												
Initials:												
3 Questions / prompts: ↓ Times: →												
1. Box 1 checks completed?												
2. Is patient awake (A) or sleeping (S)?												
3. Does patient need to go to the toilet?												
4. Is patient comfortable?												
5. Is there anything else patient needs?												
Initials:												

In the event of a patient falling →	Time of fall:	Witnessed: Yes / No	Incident form no:

Insert Patient ID label
Name

DOB

NHS No

List of people completing this form:

Name:	Signature:	Initials:	Designation:

IR checklist C&R V.2. SG et al 2010

Appendix 11

Inpatient Post Fall Managers

Patient Name:			NHS Number:
	Please identify date, time and location of fall including brief description of fall.		
	Yes	Variance	Comments
1 Was a Risk assessment undertaken within six hours?			
2 Was a moving and handling plan undertaken within six hours?			
3 Was their fall management plan commenced on admission?			
4 Was their fall management plan completed within 24 hours?			
5 Following the fall were the appropriate actions undertaken? (Appendix 5)			
6 Following the fall was the risk assessment reviewed?			
7 Following the fall was the Moving and Handling plan reviewed?			
8 Following the fall was the FALLS management plan reviewed?			
9 Were the circumstances of the fall documented on the Incident form?			
10 Was the incident form number recorded within the notes?			*Please identify incident number*
11 Was the next of kin informed?			

Date:				
Ward Manager printed name:			Ward Manager signature:	

Checklist for Completion of Incident Forms where a fall is witnessed or a patient has been found on the floor

Appendix 12

Place this information visibly around workspaces and computers

A fall is defined as an event whereby an individual comes to rest on the ground or another lower level, with or without loss of consciousness (NPSA 2007). A fall maybe accidental, syncopal, a drop attack, epileptic, metabolic or psychogenic. Levels of harm are described here: http://npsa.nhs.uk/corporate/news/npsa-releases-organisation-patient-safety-incident-reporting-data-england/

Key information which must be recorded in the patient record:

a. Circumstances surrounding the fall
b. Action taken
c. Outcome of the incident
d. The incident form number

Key information which must be recorded on the incident form:

e. Time and place of incident (including exact location)
f. Activity being undertaken at time of fall; circumstances surrounding the fall (e.g. patient hurrying to the toilet)
g. Injuries sustained; details of medical advice sought and outcome if appropriate
h. State whether a 'fall', 'slip' or 'near miss'
i. Inpatient areas: Staffing levels and skill mix at time of fall
j. Strategies in place prior to fall and non-compliance to strategies already in place
k. Strategies to be put in place following the fall, in order to reduce the chance of further falls
l. If teams are using both paper and electronic record, this information should be recorded in both formats
m. Include information on cognitive impairment/dementia by checking the button if appropriate

Managers completing incident forms-

n. please include reference to staffing levels and skill mix
o. ensure all items on Managers Post Fall Checklist (Appendix 11) are discussed

Appendix 13

Falls Risk Assessment Tool (FRAT1)

Multi - professional guidance for use by the primary health care team, hospital staff, care home staff and social care workers.

Notes for users:

1) Complete assessment form below. The more positive factors, the higher the risk for falling.
2) If there is a **positive response to three or more of the questions on the form, then please see over** for guidance for further assessment, referral options and interventions for certain risk factors.
3) Some users of the guidance may feel able to undertake further assessment and appropriate interventions at the time of the assessment.
4) Consider which referral would be most appropriate given the patient's needs and local resources.

Name	**Date of birth**
NHS Number	**Date and time of assessment**
Name of assessor	**Designation**
Signature	**Date time completed**

		Yes	**No**
1	Is there a history of any fall in the previous year?		
2	Is the patient / client on four or more medications per day?		
3	Does the patient / client have a diagnosis of stroke or Parkinson's Disease?		
4	Does the patient / client report any problems with his/ her balance?		
5	Is the patient/client **unable** to rise from a chair of knee height?		

Suggestions for further assessment, referral options and interventions (Side 2)

Risk factor present	Further assessment	Referral Options	Interventions
1) History of falling in the previous year	Review incident(s), identifying precipitating factors.	Occupational Therapy Physiotherapy Falls Clinic/ICT (1)	Discuss fear of falling and realistic preventative measures.
2) Four or more medications per day	Identify types of medication prescribed. Ask about symptoms of dizziness.	General Practitioner Consider Falls Clinic/ Community Therapy/Intermediate Care Referral Form.	Review medications, particularly sleeping tablets (see www.bhps.org.uk/falls for more information on medication and falls Discuss changes in sleep patterns normal with ageing, and sleep promoting behavioural techniques.
3) Balance and gait problems	Can they talk while walking? Do they sway significantly on standing?(3)	Occupational Therapy Physiotherapy Falls Clinic/Intermediate Care/Community Therapy	Teach about risk. And how to manoeuvre safely, effectively and efficiently. Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises. Transfer exercises. Evaluate for assistive devices. Consider environmental modifications (a) to compensate for disability and to maximise safety, (b) so that daily activities do not require stooping or reaching overhead.
4) Postural hypotension (low blood pressure)	Two readings taken 1. After rest five minutes supine 2. 1 minutes later standing Drop in systolic BP ≥ 20mmHg and or drop in diastolic ≥ 10mmgHg or more	District Nurse Practice nurse General Practitioner	Offer extra pillows or consider raising head of bed if severe. Review medications. Teach to stabilise self after changing position and before walking. Avoid dehydration

Livewell Southwest

Appendix 13

Falls Risk Assessment Tool (FRAT 2)

Multi professional tool to target interventions and identify referral pathways for older people.

Surname:
First Name:
Hospital No:
NHS No:
Date of Birth:
Address:

Consultant/GP: ……
Assessor name: ……..
Designation: …….
Contact Telephone no: ……..
Signature: …….. Date: …….

	Risks	Yes	No
1a	History of Falls Has a history of 1 or more Falls in the last year? Where? When? Why?		
1b	History of blackout reported by patient or carer?		
2	Number of Medications Takes 4 or more different medications per day including those purchased?		
3	Central Nervous System Suppressants (e.g. drugs causing sedation/drowsiness). Use of 1 for more than 2 weeks? See 'Drugs and Falls' leaflet.		
4	Alcohol intake More than 1 unit of alcohol per day?		
5	Postural Hypotension Feeling light headed in last 6 months. Dizziness on sitting/standing up?		
6	Nutrition Recent loss of weight, poor fluid intake? Dental problems?		
7	Bone Health/Fracture risk Has information been provided re healthy diet and caring for your bones? Has a fracture risk assessment been completed? (see overleaf)		
8	Vision Difficulty reading a book/newspaper? Cannot recognise an object across the room? Recently started to wear bifocals? Difficulty judging depths of steps and kerbs?		
9	Hearing Has difficulty in hearing conversational speech?		

Name: Hospital No: NHS No: Date of Birth:

10	Footwear/Foot care Difficulty with foot care affecting mobility? Inappropriate footwear?		
11	Balance Needs to hold on to furniture, requires a walking aid?		
12	Walking Unsteady on feet, shuffles or takes uneven steps/housebound?		
13	Transfers Lack of control when moving between surfaces, e.g. bed to chair?		
14	Environmental hazards Cluttered, slip/trip hazards e.g. flooring/thresholds? Problems with steps/stairs?		

	Risks	Yes	No
15	Reduced confidence Fears further falls, change/limitation in lifestyle due to falls?		
16	Coping Strategies Unable to get up from the floor / unable to summon help?		
17	Memory/Comprehension (understanding) Short term memory/comprehension difficulties that may affect ability to follow advice given? Finding it hard to remember things/think clearly? Presence of dysphasia (impairment of speech and/or comprehension of speech)?		
18	Continence • Difficulty getting to the toilet in time? • Do you leak before getting to the toilet? • Frequency of toilet visits, less than 3 hourly? • More than once during the night?		

Fracture Risk Screen

Please ✓ relevant box	No	Yes	Yes score
Client aged Less than 65			0
65 -69			1
70 - 74			2
75 - 79			3
80 - 84			4
85 or older			5
Have you broken a bone since age 50?			1
Did your mother ever break a hip?			1
Do you weigh 125 pounds / 9 stones / 57 kgs or less?			1
Do you smoke?			1
Have you taken oral steroids (e.g. Prednisolone) for longer than 3 months?			7
Are you able to get out of a chair without using your arms for support?			No score 2
Developed from Black et al (2001). Osteoporosis International 12: 519-528,2001 Total			

0 – 3 = low risk. 4 – 6 = moderate risk. Lifestyle advice, information on bone health and reducing falls risks.

7 and above = high risk. Refer for further medical assessment. Lifestyle advice, information on bone health and reducing falls risks.

Consent to share information sought: Yes ☐ No ☐

Date…… Signature……

Multifactorial Falls Risk Assessment Tool Part Two (FRAT 2)

Action Plan
(including onward referrals if appropriate)

Name:
Hospital No:
NHS No:
Date of Birth:

Contact Details

Call 24 Hour	0800 0850407	
Hearing and Sight Centre	01752 201766	
Podiatry service for advice	08451 558053	(based at Seventrees Clinic)
Orthotic Services	08451 558074	Mount Gould Local Care Centre
Community Therapy Team		
	0845 1558081	(Community Occupational Therapists, Physiotherapists, Speech and Language Therapists)
Tavistock Community Therapy Team	01392 386744	
Ivybridge/Yealm Community Team	01752 881934	
Devon Doctors:	01392 822344,	fax 01392 823564 for Therapy Referrals
Care and Repair	01752 856100	
Social Services, Customer Services	01752 668000	
Community Equipment Service	0845 2232454	Millbrook Healthcare
Continence Service	01752 434759	
Audiology	01752 763175	
Falls and Syncope Clinic	01752 439780	(Medical Lead: Dr Paul Hancock, Consultant Physician)
Health Professions Council	020 75820866	www.hpc-uk.org
Age UK	www.ageuk.org.uk	
Cosyfeet	www.cosyfeet.com	

Multifactorial Falls Risk Assessment Tool Part Two (FRAT 2)

Action Plan continued
(including onward referrals if appropriate)

Name:
Hospital No:
NHS No:
Date of Birth:

Risk Identified	Action	Date/Time	Signature

	FRAT 2 Interventions	Referral Options
1a	• Review incident(s), identify causes of falls. • Provide “Staying Steady” Age UK free advice leaflet. • Discuss emergency call alarms e.g. Call 24. • Discuss realistic preventative measures.	• GP if unexplained or repeated falls • Call 24
1b	• Discuss further medical review. • Discuss with GP referral to the Falls & Syncope Clinic.	• GP • Falls & Syncope Clinic
2.	• Identify medications being taken (including non prescribed over the counter medicines. • Identify falls risk (see leaflet Drugs and Falls) • Ask about symptoms of dizziness. • Check compliance with medications. Can the individual take the medication as prescribed? If necessary provide written instructions on what to take and when. • Identify date of last medication review (if greater than 1 year, request one)	• GP
3.	• Identify type of medication i.e. hypnotics, antidepressants, sleeping pills, anti psychotics (see leaflet Drugs and Falls) • Identify date of last medication review (if greater than 1 year, request one) • Discuss normal changes in sleep patterns with ageing if appropriate and advise sleep promoting behaviours.	• GP if medications involve falls risk
4.	• Remember alcohol when taken with some medicines can increase falls and confusion. • Education regarding immediate and long term risk consequences including dulling of neurological capacity from alcohol. Give sensible drinking advice • More than one small glass of wine/sherry/small measure of spirit/1/2 pint beer or lager per day increases falls risk. • Too much alcohol is toxic to bone tissue.	• District Nurse/Practice Nurse/GP

5.	• Check lying/standing blood pressure. • Advise to stabilise self after changing position and before walking. • Avoid dehydration. • Discuss referral for review of medication. • Consider extra pillows to raise head or raising bed if severe. A patient postural hypotension advice leaflet is available locally	• District/Practice Nurse • GP/Falls & Syncope Clinic

FRAT 2	Interventions	Referral Options
6.	• Check food and fluid intake. • Nutritional assessment. • Explain importance of a well balanced diet for health and well being. Provide “Maintaining a Healthy Diet” Age UK advice booklet. • Is assistance with shopping required?	• District/Practice Nurse • GP referral to dietician
7.	• Advise about the importance of regular meals, a balanced diet and adequate Calcium & Vitamin D • Provide Age UK booklet “Caring for your Bones, advice for older people”. • Complete fracture risk assessment (Blacks et al) • If established osteoporosis or high risk score on fracture risk assessment, are they having bone strengthening medication e.g. Bisphosphonates, Calcium & Vitamin D?	• GP • Nurse
8.	• Are spectacles clean? • Ensure vision test completed in the last year. • Ensure lighting is adequate and property uncluttered. • Bifocals/varifocals can cause falls (advise caution), consider advising separate glasses for reading/distance. • Advise to concentrate on walking especially in new situations/uneven surfaces. Advise contrasting colours to show risk areas e.g. top of stairs. • Advise diabetes/glaucoma/cataracts are monitored regularly.	• Optician (some can offer home assessments) • GP referral to Royal Eye Infirmary • Hearing and Sight Centre

9.	• Remove wax. • Has hearing been tested and corrected as much as possible? • Replace hearing aid batteries. Is it being worn and in working order?	• District Nurse • GP • Audiology at Derriford Hospital • Hearing and Sight Centre
10.	• Check & advise on well fitting/safe footwear. • Is further assessment needed for lower limb supports or therapeutic footwear? • Provide information – local leaflet, also Cosyfeet mail order catalogue is a useful resource. • Check person's ability to attend to foot care.	• Orthotic Services • Seek advice from Health Professions Council registered Chiropodist/podiatrist re treatment/referral
11.	• Advise re risk and how to manoeuvre safely. • Consider modifications to avoid stooping or stretching overhead. Advise changes to home environment, removal of obstacles to ensure safety. • Indication of significant balance problem or lower limb muscle weakness, consider referral for more detailed assessment and treatment. • Check walking aid and ferrule(s) is safe and not worn. Replace if necessary.	• Occupational Therapist • Physiotherapist (Therapy referrals via Devon Doctors) • If equipment has been issued via the Community Equipment Service then ferrules or replacement aid can be obtained from Millbrook

FRAT 2	Interventions	Referral Options
12.	• Is footwear safe; are there problems with the feet (see 10 above)? • Is the appropriate/assessed walking aid being used and in good condition? Replace if necessary. • If there has been a recent reduction in mobility and confidence to venture outdoors, consider a more detailed assessment Research shows that older people with gait instability and lower limb weakness are at increased risk of falling.	• Chiropodist/Podiatrist for advice • Social Services/ Community Equipment Service • Physiotherapist
13.	• Advise about risk • Consider a more detailed assessment of transfers, gait, balance, moving and handling and environmental modifications to increase safety.	• Physiotherapist • Occupational Therapist

14.	• Advise re safety in the home/adequate lighting, discuss reasonable preventative measures. • Advise re removal of clutter/obstacles/rugs. • Advise re personal/pendant alarms/home security. • Discuss any problems keeping the home warm. • Check whether minor repairs/modifications to increase safety are required. • Consider environmental safety assessment e.g. The Home Falls and Accidents Screening Tool (Home Fast)	• Occupational Therapist • Care and Repair • Social Services • Consider Telecare
15.	• Discuss emergency call alarms. • Further discuss fear of falling.	• Call 24 • Occupational Therapist
16.	• Discuss emergency call alarms. • Provide advice re coping strategies (local leaflet) • Teach how to rise from the floor.	• Call 24 • Occupational Therapist • Physiotherapist
17.	• Check for signs of memory loss using standardised tool e.g. Abbreviated Mental test score (AMTS) • Involve carer in the provision of falls prevention advice and information. • Refer for specialist assessment. • Consider underlying medical reason e.g. chest infection, urinary tract infection.	• GP/Community Psychiatric Nurse
18.	• If patient is housebound, further assessment indicated? • If patient can attend clinic consider referral for further assessment.	• Seek consent and liaise with District Nurse • Seek consent and liaise with Continence Service

Appendix 14

Falls Related Information Leaflets for clients

Booklets to be given to all clients at risk of falls include:

- Age UK - 'Staying Steady' Information about falls risks, prevention and coping strategies. Includes general activity, health and lifestyle advice.
  www.ageuk.org.uk
- NOS – 'Healthy Bones'
  www.nos.org.uk

Supplementary Leaflets – more detailed information / advice is available at request from the Falls Therapy Team (01752 434732) and includes the below:

Leaflet No	Name of Leaflet	Brief Description
1a	Falls	Coping Strategies following a fall. Advice about getting up from floor through kneeling.
1b	Falls	Coping Strategies following a fall Blank space for individual advice by therapist about getting up from floor.
2	Medicines Safety First	Advice about medication, side effects and management
3	Home Safety Check	Check points and safety tips for home. Useful for clients to work on themselves
4	Stay Safe	General safety tips to reduce falls risks
5	Exercises Other Exercise Sources:	General exercises for flexibility, strength and balance in lying, sitting and standing. a) AGILE Exercise programmes (White & Blue File) b) Later Life Training CD + file – FaME and Otago. c) Otago d) Help the Aged Preventing Falls: Strength & Balance Exercises for Healthy Ageing (blue and yellow book) e) Physio Tools
6	Falls Diary	For recording circumstances of falls
9	Wearing the Right Footwear	Advice about good shoes and buying tips
10	Basic Footcare Advice	Hygiene and general foot care advice
	A Good Relaxation Guide	Tips to deal with worry, difficult situations and

		physical tension
	A Good Sleep Guide	Tips to improve sleep
	Postural Hypotension	Information sheet about symptoms and improving control of postural hypotension
	Contacts for Exercise/Dance Classes	Information about some local activity groups

Other Useful Leaflets / Factsheets

Available from

Plymouth City Council 01752 668000
Customer services:

Call 24 Hour: 0800 085 0407
Age Concern : 01752 665424
Home Safe: 01752 720506
Healthy Homes: 0800 5120012

Meals Direct: 01752 305162
Oakhouse Foods: 0845 257 1132

Community Transport: 01752 600633

Hearing & Sight Centre: 01752 201766
DIAC 01752 201065
Carers Champions 01752 211348

Hotter Footwear 0800 525 893
Cosyfeet 01458 447275

National Osteoporosis Society: www.nos.org.uk
Tel: 01761 471771
Age UK: www.ageuk.org.uk
Tel: 0800 169 1819
Staying Steady, Healthy Bones, Healthy Eating
+ various Health, Housing, Home and Financial leaflets

Specific factsheets related to falls/balance:

Parkinson's disease Society: www.parkinsons.org.uk Tel: 020 7931 8080
Multiple Sclerosis Society: www.mssociety.org.uk Tel: 020 8438 0700
Multiple Sclerosis Trust: www.mstrust.org.uk Tel: 01462476700
The Stroke Association: www.stroke.org.uk Tel: 0303 3033 100

Appendix 15

Abbreviated Mental Test Score	
Age?	Correct = 1 Incorrect = 0
Time to nearest Hour?	Correct = 1 Incorrect = 0
Address to recall at end of test e.g. 42 West street (ask patient to repeat to ensure heard correctly)	-
Year	Correct = 1 Incorrect = 0
Name of this place?	Correct = 1 Incorrect = 0
Identification of two persons e.g. doctor, nurse, neighbour etc.	Correct = 1 Incorrect = 0
Date of birth	Correct = 1 Incorrect = 0
Year First World War ended	Correct = 1 Incorrect = 0
Name of present Monarch	Correct = 1 Incorrect = 0
Count backwards from 20-1	Correct = 1 Incorrect = 0
Address recall correct?	Correct = 1 Incorrect = 0
Total /10	

Please note this test has limited validity and should be used merely as an indicator for consideration of further detailed assessment.