Title: **FALLS PREVENTION**

Ref No: 1749 Version 2
Classification: Protocol

Directorate: Operations

Due for Review: 21-10-2018
Document Control

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Ratified by: Jane Viner, Chief Nurse
Care and Clinical Policies Committee

Applicability: As indicated

Contents

1 Purpose

1.1 This policy aims to address how the Trust will work to prevent falls and harm from falls and heighten awareness of falls prevention across the health and social care locality; including patients, carers, the public, and staff

2 Introduction

Falls and fall related injuries are a common and serious problem for older people, families and carers of these people, health and social care organisations. With 30% of people older than 65 and 50% of people older than 80 falling at least once a year.

Injurious falls, including over 70,000 hip fractures annually, are the leading cause of accident – related mortality in older people. Falls often lead to reduced functional ability and thus increase dependency on families, carers and services. An ageing population means that the rate of falls and fractures are increasing.

Estimated national costs to the NHS at £2.3 billion a year; as falls are associated with extended length of stay, fracture and increased mortality. Locally estimated yearly costs of falls admissions are a minimum are £10,129,050.00(1)

2.1 The objective: To develop, implement and maintain a fully integrated falls care pathway, across primary, acute and community care. This document covers falls prevention across Torbay and the South Devon NHS Foundation Trust. Offering the best care possible, positive patient experience and evidence based services to reduce fall prevalence and injury from falls through pro-active prevention, timely and robust intervention and treatment. Please see Hyperlink to Falls Strategy document appendix 1

3. Roles and Responsibilities

3.1 The Chief Executive

The Chief Executive Officer has overall responsibility for maintaining staff and patient safety and is responsible for the governance and patient safety programmes within the organisation.

3.2 Senior Managers/Team Leaders/Matrons/Senior Sisters

Managers and service leads must ensure that:

A system is in place within the services they are responsible for, for the implementation of this policy and for monitoring its effectiveness

Serious incidents related to falls are reported, investigated and lessons learnt to improve service delivery and to avoid reoccurrence. Staff should follow the incident reporting system and where relevant undertake a Root Cause Analysis.

Staff have received appropriate levels of falls prevention training, appropriate to their level of involvement with those who fall and that staff have appropriate equipment resource available to support at risk patients.

That staff are fully aware of the relevant post fall protocol for their area.

Defects/ hazards that may increase any risk of falls reported by staff are promptly resolved

Clinical staff are competent in completing falls assessments, appropriate to the specific area of work and care plans through supervision, appraisal and documentation.

Falls and harm rates are monitored ensuring all actions noted post fall are actively managed

Appropriate falls assessments/interventions audits are fulfilled as required by the Trust for example Multifactorial falls assessments, Safety thermometer, National Institute for Clinical Evidence (NICE) quality standard, Royal College of Physicians FallSafe audit, and the National Royal College of Physician inpatient falls audit.

3.3 Falls prevention leads

Should ensure that:

Staff/patients and the public are kept up to date with current falls prevention evidence and legislation using training, meetings, websites, leaflets, etc.

Quarterly falls steering group and special interest groups are facilitated. See terms of reference on Trust website, falls pages

Falls champion and falls link nurse roles are promoted and professionally developed

They contribute and/or speak at relevant local and national events linked with falls prevention.

Falls prevention is kept on the Trust(s) agenda and the work is aligned with the DoH systematic approach to falls and fracture care in all stages of the patient care pathway and lifespan

Falls prevention programmes are flexible enough to accommodate participant's needs and preferences and should promote the social value of such programmes

3.4 Moving and handling team

Are responsible for instructing staff in moving and handling patients, use of beds and hoists to appropriate levels for staff, including advice on guiding falling patients to the floor, and getting up from the floor. (Post fall guidance appropriate to the area of work should be adhered to) Appendix 1

3.4.1 The Falling Patient

The Moving and handling team teach the following:

At all times DO NOT RESIST OR STOP a patient from falling if you are at risk of injuring yourself. Allow the patient to go to the floor as safely as possible, for both parties.

3.5 All Clinical Staff

NICE recommend that every patient over 65 receiving NHS treatment be asked about their history of falls in the last year.

All clinical staff must ensure that they:

Ask about frequency, context and characteristics of fall(s) and determine the need for further falls and bone health assessment and instigate interventions and refer on as appropriate

Forward a patient's falls history on transfer between any facilities, with relevant interventions clearly documented.

Offer all individuals at risk of falling, and their carers, falls prevention advice and interventions verbally and in writing (in appropriate formats/language depending on patient's nationality and ability) see Appendix 1 page to easy read and use relevant leaflets and written documents to reinforce and reiterate information or education given to patient/carer

Work within their professional codes of conduct (where applicable) and maintain professional competencies when completing falls assessments and providing interventions to reduce falls risks

Are aware of their work setting and implement relevant assessment and appropriate falls assessment and care plan documentation

Adhere to the Trust's moving and handling policy

Request, attend and complete Falls Prevention training depending on level of involvement with those who fall with regular updates, as required, for CPD purposes

Report any inpatient falls as incidents and ensure line managers, (GPs/families where relevant) are aware

Follow the post fall guidance relevant to their area see Appendix 1

That all patients know how to cope if they have a fall; are able to raise the alarm, get up from the floor, where possible and therefore avoid a long lie see video: Appendix 1

Report hazards and defects promptly, and make areas safe where it is necessary to do so. Where the area is not Trust property to document clearly and undertake risk assessments to reduce risks of falls.

That environmental falls risks for both patients and staff are systematically identified and addressed where feasible and resources allow

Where patients recurrently fall, have injurious falls or have gait and balance difficulties to consider the need to carry out a multifactorial falls assessment, either in situ or by referring on to local rehabilitation

teams; when interventions will be put in place to reduce falls risks and a plan agreed to deal with the falls and post fall, to avoid the long lie and that the patient has access to the appropriate care/equipment/support post fall.

NB the interventions with the strongest evidence base for reducing falls are:

- Medication review withdrawal and modification where appropriate
- Vision assessment and intervention
- Home hazard assessment
- Strength and balance exercise classes

That Telecare is considered for those at risk of falling, assessed and installed as part of the falls assessment and interventions. (e.g. Bed, chair exit sensors- to alert staff to patient movement when not safely independently mobile, community alarms - for summoning help in the case of emergencies)
Multi-factorial falls assessments are completed on patients according to NICE CG 161. Unless clinical judgement indicates otherwise and is documented accordingly

3.6 Your responsibility:

This protocol does not override the individual responsibility of health and social care professionals to make decisions appropriate to the individual patient, in consultation with the multidisciplinary team, patient and /or guardian or carer. Please ensure all falls are reported on the incident reporting system.

4. Prevention and Management of Slips, Trips and Falls (including falls from height) to inpatients

In addition to the above all hospital staff are to ensure:

That the Patient Handling, falls and bedrails assessment (Appendix 1) is completed for all adult admissions, ensuring that bed rails are not used indiscriminately for inpatients, within 6 hours of face to face contact and interventions put into place to address identified risks. This will be reassessed on any change (including any transfer to other facilities), deterioration, or further fall.

All adult patients admitted through the Emergency Department are risk assessed for falls using questions on the Symphony System, within 2 hours of admission; where possible side rooms are avoided for those at falls risk (with exception of, for example: infection control risks)

That falls prevention strategies are implemented where risks are identified, for example: Intentional rounding, emergency footwear, ultra low beds, bed/chair exit sensors, postural drop identified

That falls risk of a patient forms part of ward handover and/or safety briefing and that risk is communicated by use of signs in notes/above beds

That the Supportive Observation Guidance TSDFT is followed, when considering need for increased monitoring and observation of patients. (Appendix 1)

That they are fully aware of the post fall protocol for their area of work

That patients are provided with relevant information about any proposed intervention, for example the risk of harm to them, the severity and probability of that risk and why the proposed intervention is deemed necessary to protect them from harm, and their consent is sought to implement it

In circumstances where a person has been assessed as lacking the capacity (under the Mental Capacity Act 2005) to consent to the proposed intervention a Best Interest Decision is made and both the capacity assessment and the best interest decision are recorded within the patient's care plan or clinical notes.

Staff consider, within any proposed intervention, whether the intervention constitutes a restriction of movement or a restriction upon physical liberty, some examples will include the use of sensors, GPS tracker systems, bedrails, Telecare (not an exhaustive list)

In circumstances where a restrictive measure is proposed, staff must ensure the following before it is implemented:

- The intervention is absolutely necessary to protect the person from harm.
- The intervention is a proportionate response to the identified risk
- There is no less restrictive option available
- The intervention will be in place for the shortest possible time

4.1 Definition of a fall

A fall is an event whereby an individual unintentionally comes to rest on the ground, or another level (excluding intentional change in position to rest in furniture, wall or other objects
WHO 2007
A fall is distinguished from a collapse that occurs as a result of an acute medical problem such as acute arrhythmia, a transient ischaemic attack or vertigo.
Adapted from Falls risk assessment (NICE clinical knowledge summary)

4.2 The best evidence currently available:

- National Institute Clinical Evidence (NICE) (2013) Guidance of Falls. HMSO: Oxford
- National Patient Safety Agency (NPSA) (2007). Slips, trips and falls in hospital HMSO: Oxford
- Patient Safety First (2009) The 'How to Guide for Reducing harm from falls' HMSO: Oxford
- Falling Standards, broken promises. (2010) Report of the national audit of falls and one health in older people.
- Breaking Through: Building Better Falls and fracture Services in England (2012): Age UK
- Fit for Frailty (2014) British Geriatrics Society
- American and British Geriatric Society falls guidance 2010
- College of Occupational Therapy – Prevention and management of falls 2015

4.3 Inclusion and exclusion criteria.

Whilst the main body of evidence for reducing falls is for those aged 65 + (it should include inpatients aged 50 to 64 years who are judged by a clinician to be at risk of falling because of an underlying condition. NICE CG 161). This policy does not exclude the use of falls assessments for younger patients, however it may not be deemed clinically appropriate.

4.4 Expected outcomes

Improve quality of patient and staff care within available resources
Reduction of falls and harm from falls
Reduction of hospital admission
Reduction in patient's fear of falling
Improved confidence, independence and quality of life for falling
Staff will be trained in falls prevention to a level relative to their role
That web based resources will increase in their usage
Increased level of awareness of falls prevention

5 Training and Supervision

5.1 All new staff should attend mandatory corporate induction which includes falls prevention. There are 3 levels of training linked to a framework of falls prevention training. Appendix 1 to falls training grid/framework
All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.
There are links to falls prevention training eg: Royal College of Physicians Preventing falls in hospital, on the Trust's falls website pages. Appendix 1
Access to 7 falls prevention videos is available on the above pages and the public website which are suitable for a basic level of falls prevention awareness for all staff, carers, patients and service user

6. Monitoring and Auditing

6.1 This policy will be monitored on a regular basis and relevant areas audited as required ie RCP FallSafe audit/Symphony
A full review of this document will take place every two years unless legislative changes determine otherwise
Oversight of this policy is by the falls prevention leads and the falls strategy group
Falls prevention leads will monitor and feedback to the strategy group and clinical governance: falls trends, admissions to hospital where falls have contributed, falls rate and harm, training data and hits on websites will be fed back quarterly to the falls strategy group

7. References

- NICE Quality Standards 86 (2014)
- Delirium. NICE clinical guideline 103 (2010)
- Mental wellbeing and older people. NICE public health guidance 16 (2008)
- Stroke. NICE clinical guideline 68 (2008)
- Head injury NICE clinical guideline 56 (2014)
- Dementia. NICE clinical guideline 42 (2006)
- Parkinson's disease. NICE clinical guideline 35 (2006)
- 1 – Based on 4/12-7/12 549 admissions to Torbay hospital due to falls and local costs for minor falls admissions. Figures from TSDFT performance team 2010

8. Equality and Diversity

8.1 This document complies with the Torbay and South Devon NHS Foundation Trust's Equality and Diversity statement.

9. Further Information

Links to policies:
Manual handling policy TSDFT 24 leaflet re carer/family use of bed rails
Post fall TSDFT Appendix 2
Post fall TSDFT Appendix 1
Dementia & Delirium link to Dementia intranet pages
Falls prevention Alarm Protocol TSDFT 1507
Least restrictive Use of Equipment TSDFT 1403
Warfarin, 0050
Intentional Rounding TSDFT 1382
Hi lo beds
Postural Stability Strength and Balance groups SOP (Appendix 1)
Supportive observation guidance TSDFT 1570

Appendix A

Affix Patient Id Label

Surname:

Forename:

Hospital / NHS Number:

Date of Birth:

Torbay and South Devon NHS
NHS Foundation Trust

Patient Handling, Falls and Bed Rail Assessment

To be completed within 6 hours of admission, if patients condition deteriorates, on transfer or post fall

Ward/Area……

Weight……kg

Height……cm

BMI $\frac{\text{weight (kg)}}{\text{height (cm}^2\text{)}}$……

Width at waist/widest point……cm
(Obese/bariatric patients – due max width capacity of MRI, CT & other equipment)

Patient History – tick appropriate column	Yes	No	Details
Is the patient uncooperative/have inadequate comprehension?			
Is the patient receiving medication which affects movement?			
Is the patient's centre of gravity altered, e.g. stroke?			
Does the patient have fixed/swollen/flaccid limbs?			
Does the patient have attachments e.g. catheters/IV?			
Does the patient use mobility aids and require assistance?			
Does the patient fear falling?			
Falls History – tick appropriate column	**Yes**	**No**	**Details**
Is the patient confused/disorientated?			Yes? Intentionally round
Is the patient unsteady of his/her feet?			Yes? Intentionally round
Is there a history of falls one year prior to this admission?			Yes? Intentionally round
Has the patient fallen since admission?			Yes? Intentionally round
Record of falls since admission: please circle. 1 2 3 4 5 More (Nº)			
Patient ability – tick the appropriate column	**No**	**Yes**	**Assistance req^d**
Can the patient turn over in bed?			
Can the patient sit up in bed?			
Can the patient move back up the bed?			
Is the patient able to maintain a sitting balance?			
Can the patient get into/out of bed?			
Is the patient able to weight bear/stand?			
Is the patient able to walk?			

Overall Assessment based upon answers & clinical judgement - review if any changes	⇩		Initial Ass^t Date 1	Review Date 2	Review Date3
Follow Falls & Patient Manual Handling Assessment Plan	**HIGH RISK**	⇩			
Follow Low Risk Strategies & Basic Falls Advice Follow Patient Manual Handling Assessment Plan if req^d		**LOW RISK**			

Low Risk Strategies & Basic Falls Advice ⇩	**Tick**
Introduce patient to ward environment, washing & toilet facilities	
Remind patient to request assistance as required	
Check environment for slip/trip hazards & other obstacles	
Ensure that hearing aids are working & spectacles clean & within reach	
Teach patient to use bed controls and call bell (leave within reach)	
Check that patient has supportive, well fitted footwear with a non-slip sole	
If no one is available to bring in footwear use 'top-up' slippers	
Ensure that walking aids are kept within patient's reach, where appropriate	
Keep bed at lowest height. Consider use of Hi-Lo bed for shorter patient Yes/No	

Assessor……**Sign**……

Designation……**Date/Time**……

Affix Patient Id Label

Surname:

Forename:

Hospital / NHS Number:

Date of Birth:

Torbay and South Devon NHS
NHS Foundation Trust

HIGH RISK STRATEGIES & INTERVENTIONS **Complete Manual Handling Plan & Falls Assessment** **N.B. Ensure that patient is included in safety brief/handover as high falls risk**	**Yes**	**No**	**Comments**
Is Patient being observed? (Tick as appropriate) Intentional Rounding ☐ Cohorting ☐ 1 to 1 nursing ☐			
Should patient be moved to observable area? N.B. High priority for patients with evidence of confusion			
Is Falls Symbol above bed & on Nurse Information Board?			
Is night lighting required for patient?			
ECG required?			
Is patient on >4 medications, anti-hypertensives, sedatives or anti-psychotics? N.B. If Yes, arrange review by Medical staff or Pharmacist.			
If evidence of /risk of fragility fracture, refer Osteoporosis/bone health team, consider calcium & vitamin D3			
Has a lying/standing BP been recorded? Postural Hypotension Leaflet ☐ N.B. If Systolic differential is >20 mm Hg arrange review by Medical staff.			
Consider use of bed/chair sensor pads ☐ & Hi-Lo bed ☐			
Leaflets given to patient (Tick as appropriate) In-patient falls ☐ "Staying Steady" ☐ Intentional Rounding ☐			
Is patient incontinent? (If yes consider referring to Continence Advisory Service) If patient is symptomatic, take urinalysis to exclude UTI?			
Any visual difficulties?			Date of last eye test
Joint therapy assessment required?			N/A – if end of life/clinically inappropriate

MANUAL HANDLING PLAN

Complete relevant activities ONLY - AVOID UNDERARM LIFTING - Review if any changes

Activity	**Assessment N°**	**N° of Staff req^d**	**Equipment required**	**Additional Information**
Moving in bed/movement up bed	1			
	2			
	3			
Sit up on side of bed	1			
	2			
	3			
Sit to stand	1			
	2			
	3			

Assessor……**Sign**……
Designation……**Date/Time**……

Affix Patient Id Label

Surname:

Forename:

Hospital / NHS Number:

Date of Birth:

Torbay and South Devon NHS
NHS Foundation Trust

MANUAL HANDLING PLAN

Complete relevant activities ONLY – AVOID UNDERARM LIFTING – Review any chang

Barcode

SDHFCT 5027 1.3 05/15

Activity	Assessment N°	N° of Staff req^d	Equipment required	Additional In
Walking	1			
	2			
	3			
Transfers bed to chair chair to chair etc.	1			
	2			
	3			
Other transfers (detail)	1			
	2			
	3			
Lateral transfer A Patslide & slide sheet should be used	1	Min 3 staff req^d		
	2			
	3			
Hoisting Detail hoist used & sling size/type	1	Min 2 staff req^d		
	2			
	3			
	1			
	2			
	3			

BARIATRIC EQUIPMENT REQ^D?

Bed	Chair	Commode	Hoist & sling (size?)	Walking aid	Other

Assessor.....Sign.....

Designation.....Date/Time.....

Affix Patient Id Label

Surname:

Forename:

Hospital / NHS Number:

Date of Birth:

Torbay and South Devon NHS
NHS Foundation Trust

BED RAIL ASSESSMENT

			Mobility		
			Patient is very immobile (bedfast or hoist dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
			1	2	3
Mental State	Patient is confused & disorientated	A	Use bed rails with care	Bed rails not recommended	Bed rails not recommended
	Patient is drowsy	B	Bed rails recommended	Use bed rails with care	Bed rails not recommended
	Patient is alert & orientated	C	Bed rails recommended	*Bed rails recommended	Bed rails not recommended
	Patient is unconscious	D	Bed rails recommended	N/A	N/A

Please use the risk matrix above in conjunction with nursing judgement, remembering:-

- To assess, consider **Mental State in combination with Mobility,** e.g. A1, C3, etc.
- Patients with capacity can make their own decisions about bed rail use – but always document
- Patients with visual impairment may be more vulnerable to falling from bed.
- Patients with involuntary movements (e.g. spasm) may be more vulnerable to falling from bed, and if bed rails are used, may need additional support systems or protection.

* Consider rehabilitation aims- bed rails may not be appropriate. Document accordingly

Assessment Score & Date		Additional Information
1		
2		
3		

Physio/OT/S&LT/Dietitian referral req^{d}?	Yes/No	Details
Dementia awareness	Yes/No	Details

Further information:

Assessor……**Sign**……

Designation……**Date/Time**……

Appendix 1

Guidance, Training and Leaflet links

	Title of document	Link
1)	TSDFT Post Fall guidance	See below pending Integrated Care Organisation post fall guidance due out by 12/16 Existing post fall guidance for community hospitals extended until new ICO wide guidance published
2)	Inpatient Falls Prevention leaflet	https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Documents/falls-prevention-in-hospital.pdf Easy Read version: https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Documents/Easy%20Read%20falls%20prevention%20leaflet.pdf Last accessed 7/9/16
3)	Intentional Rounding leaflet	Easy Read version: https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Documents/Easy%20Read%20observation%20leaflet.pdf Last accessed 7/9/16
4)	NICE CG 161	https://www.nice.org.uk/guidance/cg161 Last accessed 7/9/16
5)	Falls training flowchart	https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Pages/falls-training.aspx Last accessed 7/9/16
6)	Falls training needs analysis	https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Pages/falls-training.aspx Last accessed 7/9/16
7)	Falls Strategy	https://icon.torbayandsouthdevon.nhs.uk/areas/falls/Pages/policies-procedures.aspx Last accessed 7/9/16
8)	Postural Stability Strength & Balance groups SOP	https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt/Clinical%20Effectiveness/G1837.pdf Last accessed 7/9/16
9)	Supportive observation policy	https://icon.torbayandsouthdevon.nhs.uk/corp_doc_mgmt Due for upload by 1/10/16

Guidance on What to Do When an inpatient Falls Torbay Hospital only (Appendix I of G1303 Inpatient Falls)

The immediate priority post fall is to ensure the patient's safety by identifying obvious injuries and preventing the worsening of any injury sustained when they fell. Therefore certain injuries need to be excluded before moving any patient and these include fractures, particularly hip and spinal fractures as well as head injury.

If the patient is experiencing cervical / neck pain, spinal pain, loss of sensation in arms legs and has suffered any bony protrusion, especially of the spine, please seek medical advice before moving them. A cervical collar may need to be fitted and these are available from Accident and Emergency.

Where a spinal injury is suspected the patient must be log rolled at all times. A scope stretcher is available from the Porters lodge and must be used to transfer patients from the floor**.**
Awaiting guidance to be published on log rolling.

For suspected head injury please carry out the following neurological observations

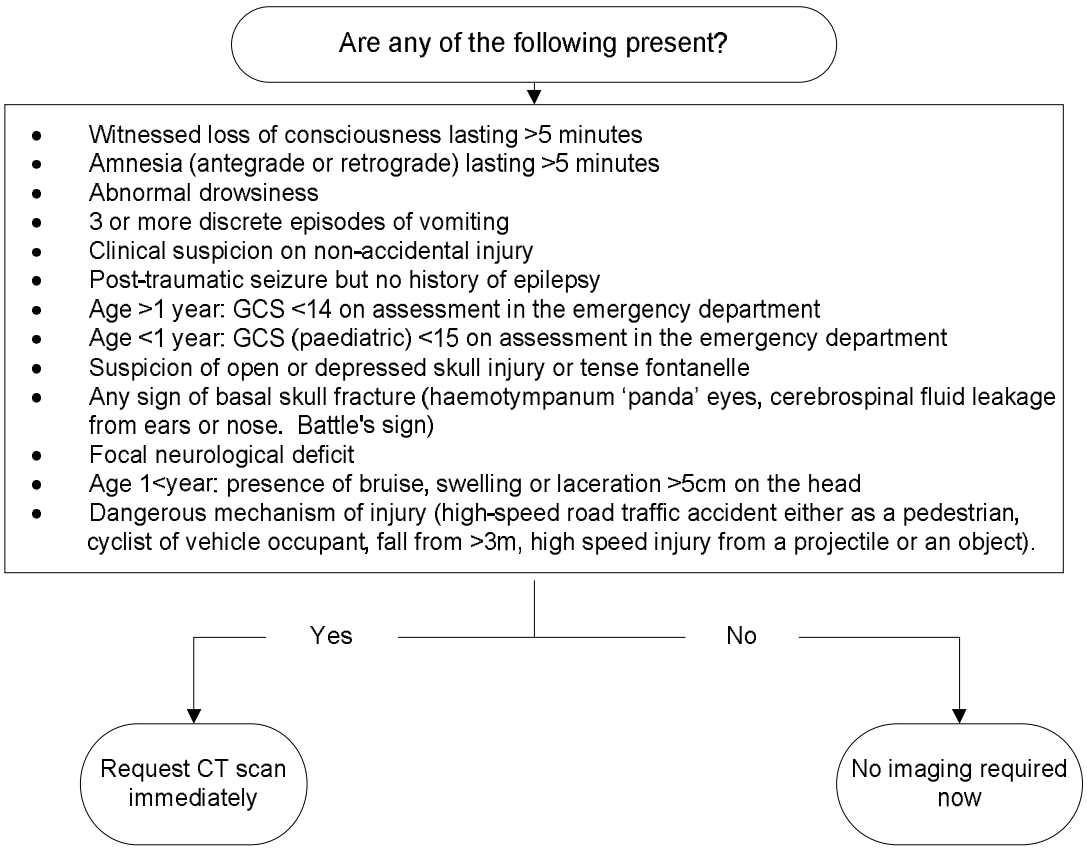
Frequency and duration of neuro observations:
• Perform and record observations on a half-hourly basis until GCS = 15
• When GCS = 15, minimum frequency of observation is:
Half - hourly for 2 hours
then 1-hourly for 4 hours
then 2 - hourly thereafter
• If the patient deteriorates to GCS <15 after initial 2-hour period, revert to half-hourly observations and follow the schedule as above as well as informing the Medical Staff.

Criteria for CT Head / Brain Scanning In General Hospitals

CT Scan / report completed within one hour of fall for the following:
• GCS <13 at any point since injury
• GCS <13 or 14 two hours after injury
• Definite focal neurological deficit
• Multiple injuries with head injury component (especially if ventilated)
• Unstable systemic state precluding transfer to neurosurgery
• Diagnosis uncertain
• Compound or penetrating injury; suspected open or depressed skull fracture
• Fully conscious but with base of skull fracture (CSF otorhinorrhoea; bleeding or new deafness in one or
both ears; post-auricular bruising - Battle's sign; non-traumatic peri-orbital haematoma)
• More than one episode of vomiting in adult (clinical judgement for children<16 years regarding cause but repeated episodes of vomiting mandates CT)
• Following any convulsion or fit
• Deteriorating neurological status
• Bleeding disorders and anticoagulant therapy if associated with amnesia or unconsciousness

Please also see Guideline 0050 on the Trust's intranet site for the NICE Head Injury Guidance

Selection of children (under 16) for CT scanning of head



Investigation for Injuries to the Cervical Spine

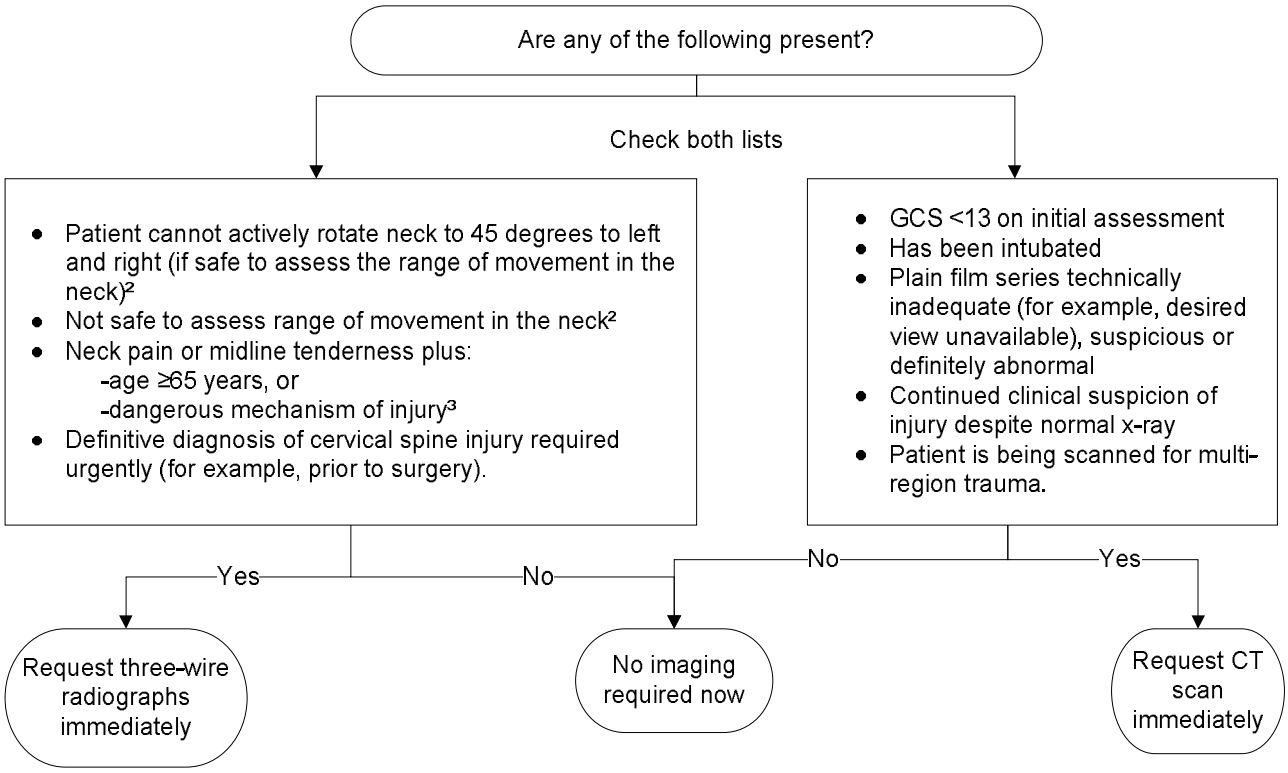
- In most circumstances, plain radiographs are the initial investigation of choice to detect cervical spine injuries – three views of sufficient quality for reliable interpretation (two views for children under 10 years of age).

Children under 10 years

- Use anterior/posterior and lateral radiographs without an anterior/posterior peg view
- Use CT imaging to clarify abnormalities or uncertainties

CT imaging is recommended in some circumstances (see algorithm over page)

Selection of adults and children (age 10+) for imaging of the cervical spine



- Children under 10 have increased risk from irradiation, so restrict CT imaging of cervical spine to children with indicators of more serious injury in circumstances such as:
  - severe head injury (GCS <8)
  - strong suspicion of injury despite normal plain films
  - plain films are inadequate

Please also see Guideline 0050 on the Trust's intranet site for the NICE Head Injury Guidance

For Community Staff Only **Appendix 2**

Client name: DoB NHS no

Multi-factorial Falls Assessment

Contact details	
Name	NHS number
Address	Date of Birth
	Telephone
	Referral Date
Postcode	Initial Assessment date
GP and surgery	GP Tel:
Referred by	Referrer's Tel:

Multi factorial falls Assessment Checklist	**Done** ✓	**Results/comments** ***If medical treatment commenced please detail below***	**Possible contributory factor**
Lying /standing BP			
Recent hearing test			
Vision. Any concerns?			
Home hazard Ax			
Confidence/fear of falls			
Cognitive Ax (AMT)			
Fracture Risk			
Gait & Balance Ax			
Osteoporosis screen			
Medication review			
Bloods			
Continence Ax + MSU			
Nutrition & Fluid intake			
Heart rate ECG/rhythm			

Therapy Plan		
Type of intervention/follow up	**Date referred/started/details**	**Initials**
Strength and balance rehabilitation class (Lower level)		
Strength and balance postural stability class (Higher level)		
1:1 Therapy/rehab		
Other action (specify)		

Signatures of staff completing assessment					
Name **Please print**	**Date completed**	**Profession**	**Contact Number**	**Signature**	**Initials**

GP Practice: Please Read Code 16D for every fall
Once Multi-factorial Falls Assessment complete: Please Read Code 38A1

Signature Date
Client name: DoB NHS no

Falls History					
Date/time of last fall:		Where occurred:			
Falls history over last 12 months: *Include frequency, characteristics, injury, place and activity at time of fall(s)* Were you able to get up off the floor? If not, how long did you spend on the floor?					
Have you changed what you do due to loss of confidence or fear of falling? Give details.					
Do you have an action plan if you do fall again (i.e. how you will get up again)?					
Any of the following signs/symptoms experienced/witnessed:					
None		Feeling faint		**Injuries incurred:**	
SOBOE		Dizziness		Soft tissue injury	
Incontinence		LOC		Fracture - *if low trauma screen for Osteoporosis/refer to Fracture Liaison*	
Tongue biting		Palpitations			
Blurred vision		Chest pain		Head injury	
Slurred speech		Acute illness/infection		Other:	

Past Medical History and any previous investigations for falls		

Medication (including over the counter medications)			
Drug	**Dose**	**Frequency**	**Relevant side effects**
Are there any difficulties taking medication as prescribed e.g. dexterity, memory problems? Y/N Please describe issues:-			

Signature Date

Client name: DoB NHS no

Routine Investigations			
Bloods:		**Abbreviated Mental Test**	
FBC		Age	
U&E		Place	
LFT		Year	
TSH/T4		Your job	
Glucose		Time (to nearest hour)	
Vitamin B12 (if postural hypotension)		DOB	
Other:		Recall address (42 West St)	
		Current Monarch	
MUST nutritional score & comment (if appropriate)		Count back 20-1	
		Year WW2 ended (1945)	
		Total (<8=cognitive impairment)	

Postural Hypotension		
Any symptoms of postural hypotension reported? What made the patient dizzy? How long did the dizziness last? **Consider benign paroxysmal postural vertigo – refer to specialist clinic/physio**		
Evaluation criteria	**Blood pressure**	**Pulse (? Regular)**
Supine for 5 minutes (in silence)		
Standing immediately (sitting safely if unable to stand)		
Standing after 3 minutes		
Comments:		
Standard Blood pressure and comments		

Routine investigations			
Investigation		**Observe for**	
Height		Height loss	
Weight		Weight loss	
BMI		<19 or >30	
Temperature		<35 or >37.5	
Respirations		<12 or >25	
CBS		<4 or >7	
Urinalysis		MSU sent	Yes/No
ECG shows		Date done	

Visual impairments		
1. Wears glasses Y/N Label near & distance glasses	Concerns re bifocals/varifocals Ensure wearing most recent glasses	Refer to optician
2. Do you take medication?	Ensure drops administered correctly	Pharmacy advice if problematic
3. Difficulties reading or seeing clearly for near activities eg eating meals/ doing hobbies with glasses on?		If yes refer to optician

Client name: DoB NHS no

4. When did you last have your eyes checked?	No check in last 2 years If **diabetic** ensure annual screening contact:	Advise / refer to optician Failsafe Co-ordinator 01803 656096
5. Does your vision make you feel unsafe? If answer is YES, after considering all above options: Double vision Binocular: Double vision Monocular: Suspected tunnel vision / visual field loss:		 Referral letter to eye clinic Refer orthoptist 01803 655122 Refer to optician Refer to hospital eye clinic
Sudden visual/field loss, painful red eye or recent history of flashing lights		**Urgent** referral On Call eye doctor 07818 562917
Hearing impairments	Difficulty using hearing aids/wax	

Fracture Risk Assessment			
Question		**Point Value**	
Age < 65		0	
65-69		1	
70-74		2	
75-79		3	
80-84		4	
>85		5	
Fractures since age 50		1	
Did your mother or father have a hip fracture?		1	
Weighs <57kg/9 stone		1	
Current smoker		1	
Unable to get out of chair without using arms		2	
Low risk = 0-3	**Moderate risk = 4-6**	**High risk = 7+**	**Total score**
Suggest further assessment or calcium and Vitamin D supplementation for those at moderate or high risk **Yes/No**			

Short Falls Efficacy Scale – International (Short FES-I)

We would like to ask about how concerned you are about the possibility of falling. Reply thinking how you usually do the activity. If you don't currently do the activity answer how concerned you would be if you did the activity.	Not at all concerned 1	Somewhat concerned 2	Fairly concerned 3	Very concerned 4
1 Getting dressed and undressed				
2 taking a bath or shower				
3 Getting in or out of a chair				
4 Going up or down stairs				
5 Reaching for something above your head or on the ground				
6 Walking up or down a slope				
7 Going out to a social event (e.g. religious service, family gathering, club)				
			Total	**/28**

Signature Date

Client name: DoB NHS no

Functional assessment				
Home hazard assessment				
House	Bungalow	Flat (which floor)	RH	NH
Alone	Partner	Warden Controlled	Family	Other
Access (front and back):				
Heating (type, adequacy):				
Stairs/Steps/Rails:				
Phone/Lifeline:				
Environmental hazards (trailing wires, rugs, floor coverings, thresholds, clutter, pets, lighting):				
Hazardous tasks (pulling curtains, accessing switches and windows, putting rubbish out, carrying, climbing, reaching):				
Mobility (indoors/outdoors/distance)				
Transfers (bed/chair/toilet/bath/shower)				
Personal ADL				
Toileting (access, managing clothing, equipment, continence, nocturia)				
Cooking/meals/nutrition/fluids				

Signature Date

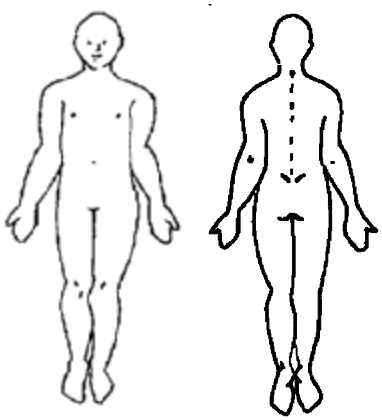
Client name: DoB NHS no

Shopping
Housework
Gardening
Support services
Cognition
Leisure activities

Alcohol consumption

For some fallers alcohol may be a reason for the fall. Do you think alcohol could have played a part in your falling? NO ☐ YES ☐ (if yes complete an alcohol screening tool)

Body chart relates to physical assessment



Key: P = pain; A = altered sensation

Signature Date

Client name: DoB NHS no

Physical assessment	
Range of Movement	
Strength and Power	
Posture	
Co-ordination	
Proprioception	
Sensation	
Gait	
Walking aids	
Ability to get up from the floor	Verbal/observed
Ability to move around on the floor	Verbal/observed
Feet (nail condition, corns, bunions/pain)	
Footwear (indoors/outdoors/orthotics)	

Signature Date

Client name: DoB NHS no

Berg Balance Scale

1	Sitting to standing	4 – able to stand without using hands and stabilize independently;3 – able to stand independently using hands; 2 – able to stand using hands after several tries; 1 – needs minimal aid to stand or stabilize; 0 – needs moderate or maximal assistance to stand	
2	Standing unsupported	4 – able to stand safely for 2 minutes; 3 – able to stand for 2 minutes with supervision; 2 – able to stand for 30 seconds unsupported; 1 – needs several tries to stand 30 seconds unsupported; 0 – unable to stand for 30 seconds unsupported	
3	Sitting unsupported	4 – able to sit safely and securely for 2 minutes; 3 – able to sit for 2 minutes with supervision; 2 – able to sit for 30 seconds ; 1 – able to sit for 10 seconds; 0 – unable to sit for 10 seconds without support	
4	Standing to sitting	4 – sits safely with minimal use of hands; 3 – controls descent using hands; 2 – uses back of legs against chair to control descent; 1 – sits independently but has uncontrolled descent; 0 – needs assistance to sit	
5	Transfers	4 – able to transfer safely with minor use of hands; 3 – able to transfer safely with definite need for hands; 2 – able to transfer with verbal cueing and/or supervision; 1 – needs 1 person to assist; 0 – needs 2 people to assist or supervise to be safe	
6	Standing unsupported with eyes closed	4 – able to stand for 10 seconds safely; 3 – able to stand for 10 seconds with supervision; 2 – able to stand for 3 seconds; 1 – unable to keep eyes closed for 3 seconds but stands safely; 0 – needs help to keep from falling	
7	Standing unsupported with feet together	4 – able to place feet together indep and stand for 1 min safely; 3 – able to place feet together indep and stand for 1 min with supervision; 2 – able to place feet together indep but unable to hold for 30 seconds; 1 – needs help to attain position but able to stand for 15 seconds with feet together; 0 – needs help to attain position but unable to hold for 15 seconds	
8	Reaching forward with outstretched arm	4 – can reach forward confidently 25cm; 3 – can each forward 12cm; 2 – can reach forward 5cm; 1 – reaches forward but needs supervision; 0 – loses balance when trying/requires external support	
9	Pick up object from floor from a standing position	4 – able to pick up slipper safely; 3 – able to pick up slipper but needs supervision; 2 – unable to pick up but reaches 2-5cm from slipper and keeps balance independently; 1 – unable to pick up and needs supervision when trying; 0 – unable to try/needs assistance to keep from losing balance	
10	Turning to look over shoulders while standing	4 – looks behind from both sides and shifts weight well; 3 – looks behind one side only, other side shows less weight shift; 2 – turns sideways only but maintains balance; 1 – needs supervision when turning; 0 – needs assistance to keep from losing balance	
11	Turn 360 degrees	4 – able to turn safely in 4 seconds or less; 3 – able to turn one way only in 4 seconds or less; 2 – able to turn safely but slowly; 1 – needs supervision when turning; 0 – needs assistance when turning	
12	Placing alternate foot on step	4 – able to stand indep and safely and complete 8 steps in 20 sec; 3 – able to stand indep and safely and complete 8 steps in >20 sec; 2 – able to compete 4 steps without aid or supervision; 1 – able to complete >2 steps needing min assistance; 0 – needs assistance to keep from falling/unable to try	
13	Standing unsupported one foot in front	4 - Able to place foot in tandem indep and hold for 30 seconds; 3 – able to place foot ahead of other indep and hold for 30 seconds; 2 – able to take small step indep and hold for 30 seconds; 1 – needs help to step but can hold for 15 seconds; 0 – loses balance when stepping or standing	
14	Standing on one leg	4 – able to lift leg indep and hold for >10 seconds; 3 – able to lift leg indep and hold for 5-10 seconds; 2 – able to lift leg and hold for = or >3 seconds; 1 – tries to lift leg unable to hold for 3 seconds but remains standing indep; 0 – unable to try or needs assistance to prevent fall	
		Score	/56

Signature Date

Appendix 3

Short Form Triage Multifactorial Falls Risk Assessment (MFFA)		Torbay and South Devon NHS Foundation Trust
Assessor's Name	**Signature**	**Date**

Client details				**Referrer details**	
Name		Date of birth		Name	
Telephone		NHS number		Telephone	
Address		GP details		Address	
Ethnicity		Consent received to collect data & refer onward			

Past medical history (include medical conditions and hospital admissions)	**Medication** (include prescribed/over the counter/recreational/herbal/inc. eye drops - list all
	Any hypnotics, antidepressants, night sedatives or Anti-psychotics? Problems with taking medication? Any change or review?

Postural hypotension (more than 20mm Hg systolic drop between lying and standing BP)

Person has light-headedness on standing or sitting up, check lying/standing blood pressure.

Blood pressure	Lying (5 mins)	
	Standing	
	Standing (+3 mins)	

Bloods taken to rule out underlying medical conditions contributing to falls? Y/N

History of falls	
How many falls in the last 12 months?	
Activity at the time?	
When was the last fall?	
Is there a pattern?	
Why do you think you fell?	
Injuries sustained?	
Any sign of infection? (ear, chest, urine)	
Any blackouts/loss of consciousness prior to falling (this/previous falls)?	(If yes refer to Care Of The Elderly consultant for review, via GP)

Assessor's advice and interventions	
Managing your medicines leaflet given	Y/N
Medication review required	Y/N
Dosette/blister pack required (refer to Trust SOP & GP/Pharmacist)	Y/N
Advised safe measures when getting up and lying down (or from sitting to standing)	Y/N
Referred to Community Physiotherapist	Y/N
Referred to GP	Y/N

Any dizziness? If Yes, clarify type of dizziness below					
Lightheaded - as if going to faint		Unsteady - as if drunk		Vertigo - sensation of motion	
Lasts seconds/minutes/days?		Inner ear problems?		Labyrinthitis?	
When - you're lying down?		- turning over in bed?		- head movements?	

Assessor's advice and interventions	
Checked lying standing blood pressure	Y/N
Referred to Community Physiotherapist	Y/N

Osteoporosis			
Known diagnosis		**Unknown diagnosis**	
Is there a known diagnosis?	Y/N	Any low trauma fractures >50 years?	Y/N
Are bone-protection meds prescribed?	Y/N	Parental history of hip fracture?	Y/N
Are these being taken correctly?	Y/N	Premature untreated oestrogen deficiency?	Y/N
Pre-disposing factors (eg Malabsorption, inflammatory bowel disease, liver disease, transplantation, previous anorexia, prolonged immobility)?	Y/N indicate	(menopause/hysterectomy <45 years, pre-menopausal amenorrhea >6 months)	
		Oral steroids taken >3 months?	Y/N
		Rheumatoid Arthritis	Y/N
Excess alcohol >4 units per day?	Y/N	Low body weight (Body Mass Index <22)	
Housebound/Residential Home resident?	Y/N		
Taking Calcium/Vitamin D supplements?	Y/N		

Assessor's advice and interventions	
If Yes to 2 or more risk factors Refer to GP for further assessment	Y/N
Written lifestyle advice given (National Osteoporosis Society leaflet: Introduction to Osteoporosis)	Y/N
Bisphosphonate prescribing leaflet given`	Y/N

Client Name	Date of Birth	NHS Number
Assessor's Name	**Signature**	**Date**

Fear of falling and strategies following a fall			Assessor's advice and interventions	
Client concerned about falling or has poor confidence with mobility	Y/N	Falls Efficacy Scale International (short version) Score	Refer to OT for rehabilitation	Y/N
Loss of confidence going out?	Y/N		Refer to Physiotherapy for strength and balance assessment	Y/N
Fear of falling affecting activities?	Y/N	How?	Teach backward chaining method Demonstrated only?	Y/N Y/N
Able to move about and get up from the floor independently?	Y/N		Written information given about community alarm system	Y/N
Knows how to keep warm / relieve pressure and manage risks of being on floor for long time?	Y/N		Bed/chair exit sensors considered Other Telehealthcare solutions discussed	Y/N
Has Pendant alarm system and willing to use or means of summoning help?	Y/N		Refer to Teleheathcare team?	Y/N
Gait and balance			**Assessor's advice and interventions**	
Can the person get up from a chair without using arms?	Y/N	OTAGO 4 test balance scale: FTS: STS: TS: OLS:	Referred to Physiotherapy	Y/N
Can they stand unsupported and not lose balance for 30 secs?	Y/N			
Is there a problem with muscle strength / joint range?	Y/N		Refer to rehabilitation strength & balance gp	Y/N
Is there a problem with gait?	Y/N		Refer to PSI S & B group	Y/N
Is mobility aid appropriate and used safely?	Y/N	Ferrule check?		
Motivated to attend balance and stability class?	Y/N			
Any previous exercise class?	Y/N	Where/when?		
Is pain affecting mobility?	Y/N	Where is pain?		
Daily living and home hazards			**Assessor's advice and interventions**	
Problem with washing / dressing / toileting?	Y/N		Written information provided re:	
Problem with cooking / laundry / shopping / cleaning?	Y/N		Handy Person Scheme	Y/N
Home environment checked?	Y/N		Staying Steady (Age UK)	Y/N
Lighting in the home suitable / sufficient?	Y/N		Preventing accidents in the home (Age UK)	Y/N
Any problems with stairs?	Y/N		Home Safety Checker (Age UK)	Y/N
Access to community and social activities?	Y/N		Advice and strategies discussed	Y/N
What help are you receiving?			Refer to OT	Y/N
Feet / footwear			**Assessor's advice and interventions**	
Difficulty maintaining foot care?	Y/N		Advice given re suitable footwear	Y/N
Foot problem inhibiting gait / balance?	Y/N		Leaflets given - Podiatry falls prevention	Y/N
Unstable, loose or poorly fitting shoes / slippers worn?	Y/N		List of podiatrists given	Y/N
Appropriate compression hosiery worn?	Y/N		Refer to Podiatry services for assessment	Y/N
Numbness in limbs or sensation changes?	Y/N			
Orthotics worn?	Y/N			

Client Name	Date of birth	NHS number
Assessor's Name	**Signature**	**Date**

Alcohol			Assessor's advice and interventions	
Client is concerned about their alcohol intake?	Y/N	What do they drink (is this alcohol?) How much? (ask them to demonstrate if unsure)	Discussed falls risks associated with high intake	Y/N
Daily alcohol intake is above recommended units? (men 3 units per day / women 2 units per day)	Y/N		Provided written information re. alcohol abuse	Y/N

Vision and hearing			Assessor's advice and interventions	
1. Does client wear glasses?	Y/N	Ensure most recent worn and clean, label near and distance glasses.	Advise re separate reading distance glasses if still going out/ steps and stairs additional risk	Y/N
2. Does client take eye medication?	Y/N	Ensure drops taken correctly	Recommended bi-annual vision check (advise of Optician home visit service) If Diabetic annual screening required – Failsafe co-ordinator 01803 656096	Y/N
3. Difficulties reading or seeing clearly for near activities eg eating/hobbies	Y/N	Refer to optician. If feels vision unsafe, & have considered all above options, refer via letter to eye clinic Torbay Hospital. If symptoms of: Sudden visual/field loss Flashing lights/painful red eye **Urgent referral to On Call eye doctor 07818 562917**		
4. When was their last eye check?			Written info give: Better Sight (Age UK)	Y/N
5. Does their vision make them feel unsafe?	Y/N		Checked ear wax	Y/N
Wears hearing aid(s)? In good working order?	Y/N		Referred to Community Nurse	Y/N
Date of last vision check			Referred to Audiology / Hearing Services / GP	Y/N
Date of last hearing check			Referred to Sensory impairment team	Y/N

Continence and hydration			Assessor's advice and interventions	
Has overwhelming urgency to pass urine?	Y/N		Continence assessment needed	Y/N
Gets wet before reaching toilet?	Y/N		Baseline assessment refer to District Nurse	Y/N
Needs to go frequently by day?	Y/N			
Is woken up from sleep with desire to pass urine?	Y/N		Acute problem referred to GP / out of hours service / Community Matron	Y/N
Toileting is bothersome	Y/N	Would like some help?		
Any signs of dehydration?	Y/N		Recommend 6 - 8 glasses (250mls) of fluid per day (unless contra-indicated eg renal failure)	Y/N
Is there a history of recurrent urinary tract infections?	Y/N			
			Written info given: Bladder & bowel weakness	Y/N

Nursing observations				Assessor's advice and interventions	
Height	Height loss			Consider osteoporosis refer to Fracture Liaison	Y/N
Weight	Weight loss			Complete MUST?	Y/N
Temperature	Pulse Regular Y/N		Irregular ECG Y/N	MSU sent date:	Y/N
Respirations	Sats		Sats on mobilising?	Hypoxia noted include with request for medication review	
CBS	MUST score				

Cognitive impairment / mental capacity			Assessor's advice and interventions	
Forgetfulness, confusion or loss of confidence?	Y/N	Need to complete valid cognitive Test (AMT)	Referred to GP?	Y/N
Poor concentration?	Y/N		Referred to Memory Café	Y/N
During the last month, has the client been often bothered by feeling down, depressed or hopeless?	Y/N		Referred to Community Psychiatric Nurse	Y/N
During the last month, have you often been bothered by having little interest or pleasure in doing things?	Y/N		Referred to Occupational Therapist for further assessment of daily living	Y/N

Please review the problems you identified in this assessment					
Client name		**Date of birth**		**NHS number**	

MEDICAL	✓	FUNCTIONAL	✓	ENVIRONMENTAL	✓	ADDITIONAL FACTORS	✓
Continence		Gait and balance		Environmental hazards		Client's confidence	
Visual impairment		Muscle strength		Accommodation		Carer's confidence	
Physical wellbeing		Personal care		Stairs		Lifestyle and social activities	
Mental wellbeing		Daily living activities		Outdoor access		Community activities	
Medication review		Strategies following a fall		Toilet/bathroom			
Osteoporosis risk		Podiatry		Housing issues			
Medical investigation		Fear of falling		Heating issues			
ECG passed to GP							
Consider referral to GP, Practice / District Nurse, Community Matron, Optician		Consider referral to Zone Team		Consider referral to Zone Team, Handyperson scheme Housing team at the council		Consider referral to Lifestyles / public health / fitness teams and Zone Team	

- **Medical investigation required or medication review - refer to GP**
- **If fall caused by blackout, loss of consciousness - refer to Falls Consultant (Care of the Elderly) via GP (unless already under investigation)**

Action required	Referred to	Outcome	Date and Sign

Assessor's name	Assessor's signature	Initials	Designation	Date

If referring onto other services, gain consent and send copy of this Multifactorial Assessment with any other relevant documents and outcome measures.

11. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	1749		
Document title:	Falls Prevention Policy		
Purpose of document:	This policy aims to: Address how the Trust(s) will work to prevent falls and harm from falls within the area and heighten awareness of falls prevention across the health and social care locality; including patients, carers, the public, and staff		
Date of issue:	21 October 2016	**Next review date:**	21 October 2018
Version:	2	**Last review date:**	22 January 2016
Author:	Claire Burcham, Lead Falls Nurse for TSDFT Jane Reddaway, Falls Prevention Lead - Community		
Directorate:	Trustwide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Jane Viner, Chief Nurse Care and Clinical Policies Committee		
Date approved:	14 October 2016		
Links or overlaps with other policies:	All TSDFT Trust Strategies, policies and procedure documents 1507 - Falls prevention Alarm Protocol TSDFT 1403 - Least restrictive Use of Equipment TSDFT 0050 - Warfarin, Schedule for 1382 - Intentional Rounding TSDFT		

	Please select	
	Yes	*No*
Does this document have training implications? *If yes please state:*	☒	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☒

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
22 January 2016	1	New	Jane Viner, Chief Nurse Care and Clinical Policies Committee
21 October 2016	2	Revised	Jane Viner, Chief Nurse Care and Clinical Policies Committee

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

13.

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Details *(please state):*			

14.

NHS South Devon and Torbay Clinical Commissioning Group | Torbay and South Devon NHS NHS Foundation Trust

Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	1749 Falls Prevention	**Version and Date**	2 October 2016
Policy Author	Jane Reddaway, Falls Prevention Nurse - Community		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☒ No☐	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☒ No☐	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒

Please provide details for each protected group where you have indicated 'Yes'. Whilst the main body of evidence for reducing falls is for those aged 65+ (it should include inpatients aged 50 to 64 years who are judged by a clinician to be at risk of falling because of an underlying condition. NICE CG 161). This policy does not exclude the use of falls assessments for younger patients, however it may not be deemed clinically appropriate.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒

If 'Yes', how will you mitigate this risk to ensure fair and equal access?
See above restrictions those who do not meet the programmes criterion will be referred to a lower level service.

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

To outline the Trust's Falls Prevention Policy which supports NICE clinical guidelines 161 and to improve patient/service user experience and safety.

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Falls prevention leads. Manual Handling Team. Emergency Department Team. Care and Clinical Policy Group. Suggestions and recommedations incorporated.

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Jane Reddaway/Claire Burcham	**Signature**	
Validated by (line manager)	Jane Viner	**Signature**	