



CLINICAL GUIDELINE

Guidelines for the Prevention and Management of Falls Adults Aged 16 and Over

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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Section 1 – Governance

1. Introduction

A fall is a symptom, not a diagnosis. It can be a marker for the onset of frailty, the first indication of a new or worsening health problem and/or can represent a tipping point in a person's life, triggering a decline in independence. For the patient, the consequences of falling can include fracture, soft tissue or head injury, fear of falling, anxiety and depression, which may all lead to a loss of confidence and more limited participation in everyday activities.

Falls are commonly associated with frailty, but it is not only frail people who fall. Falls are not an inevitable consequence of old age, and many falls can be prevented by well organised services and organisations working in partnership with the person and their carers. Falls prevention and management is not the preserve of one profession, service or organisation (National Framework 2014/16; AGS, BGS, AAOS 2011; Cameron 2010). The consequences of a fall cut across all agencies working with people at risk of falling. Adverse outcomes for patients which impact on the NHS include increased morbidity, longer stays in hospital and higher rates of discharge to institutional care (Oliver 2000; Oliver D, Connelly J, Victor C et al 2006). An economic evaluation published in 2013 estimated that the annual cost to health and social care services in Scotland of managing the consequences of falls was in excess of £470 million (Craig, Murray et al 2013)

All agencies working with people at risk of falling can be part of the solution. Effective falls prevention and management can make a significant contribution to achieving the proposed National Outcomes for Integration, specifically, supporting people to look after and improve their own health and wellbeing, live in good health for longer, live independently at home and maintain or improve the quality of their lives.

1.1 Drivers for Change

Because falls are so important the Scottish Government has outlined national standards and targets for improvement. For acute settings, the Scottish Patient Safety Programme identifies and describes key indicators for improvement. (Scottish Patient Safety Programme 2012). In the community there is the Framework for Action: the prevention and management of falls in the community (National Framework 2014/16). This framework identifies and describes key actions to be developed by health and social care services. These actions represent the minimum standard of care an older person should expect to receive, regardless of where and when they present to statutory services. There is also a National Delivery Plan (2012/15) for Allied Health professionals which include directives relating to falls.

1.2 Definitions

Definition of a fall - "A sudden unintentional change in position, causing one to land on a lower level, or on an object, the floor, or the ground" (Tinetti 1987)

Definition of a fall with harm – "Any instance where a fall with harm is identified. Harm will be where another secondary care intervention is necessary (steri-strip, suture, and/or management of dislocation, fracture, head injury, death), and/or a patient has fallen and received harm or injury requiring radiological investigation (x-ray, ultrasound, MRI or CT) with a confirmed harm (SPSP 2012)" NB occurrence of a radiological investigation should not lead to an automatic categorisation of 'harm' (harm must be confirmed by the investigation). Minor harms (e.g. grazes, light bruising, small cuts) would be excluded.

Definition of a serious fall – A fall resulting in a fracture or head injury or a fall resulting in death.

Note – if a person deliberately places themselves on the ground, this is not classified as a fall.

1.3 Governance Structures

There are defined groups to support the strategic development and operational management of falls services across the whole of NHSGGC.

Group Name	Group Purpose
Falls Strategic Steering Group Reports to Board Clinical Governance Forum and to local governance groups	To provide strategic and clinical leadership in ensuring a systematic and equitable approach to the implementation and monitoring of falls initiatives across the organisation.
Inpatient Falls Improvement Group Reports to Falls Strategic Steering Group and to local governance groups	To provide operational and clinical leadership in ensuring a systematic and equitable approach to the implementation and monitoring of falls initiatives across inpatient settings.
Partnership Falls Improvement Group Reports to Falls Strategic Steering Group and to local governance groups	To provide operational and clinical leadership in ensuring a systematic and equitable approach to the implementation and monitoring of falls initiatives across community settings.
Falls and Ortho-Geriatric Specialist Advisory Group Reports to Falls Strategic Steering Group	To provide expert advice and opinion on the evidence base for falls prevention and management including the operation of Falls Clinics and the Ortho-Geriatric Liaison and Rehabilitation Service across NHSGGC.

Section 2 – Prevention and Management of Falls

The prevention and management of falls is outlined in detail in the NHS GGC policy. Please refer to sections 5, 6, 7 and 8 of the policy for additional information.

In addition, more detailed guidance on the Glasgow Coma Scale, blood pressure measurement, suspected hip fractures and suspected head and neck injury follows.

2. Glasgow Coma Scale

Ideally, following a head injury or suspected head injury, the Glasgow Coma Scale should be measured.

The Glasgow Coma Scale (GCS) provides a framework for describing the state of a patient in terms of three aspects of responsiveness: eye opening, verbal response, and the best motor response, each stratified according to increasing impairment. Patients with a head injury can be assessed and monitored using information from the GCS, see section 9 of the Falls Policy. The GCS is calculated by giving a score for each section and then totalling together. A fully functioning and conscious person should therefore score 15/15, with any lesser score indicating impairment. If the GCS is falling on repeated measurements, this is a serious and concerning sign that needs medical intervention, see section 9 of the Falls Policy.

Feature	Scale Responses	Score Notation
Eye Opening	Spontaneous	4
	To Speech	3
	To Pain	2
	None	1
Verbal Response	Orientated	5
	Confused conversation	4
	Words (inappropriate)	3
	Sounds (incomprehensible)	2
	None	1
Best motor response	Obey commands	6
	Localise pain	5
	Flexion - normal	4
	- abnormal	3
	Extend	2
	None	1
TOTAL COMA 'SCORE'		3/15 – 15/15

The Glasgow Coma Scale must be recorded until the GCS is equal to 15 or equal to the patient's pre-fall score (if known). Any deterioration must be reported to medical staff. The minimum frequency for these observations must be:

- half hourly for 2 hours,
- then 1 hourly for four hours,
- then 2 hourly thereafter until stable.

2.1 Advice on Undertaking a Lying and Standing Blood Pressure Measurement

Orthostatic hypotension (where blood pressure drops after standing up from a lying or sitting position) is a recognised risk factor for falling.

Patients with this condition may describe upon rising up and/or moving, symptoms of light-headedness, unsteadiness, nausea, blurring or tunnelling of their vision and sometimes an ache across their neck and upper back. If a significant drop in blood pressure on standing is confirmed, modification of the patient's lifestyle factors and prescribed medications can improve symptoms and reduce falls risk (European Society of Cardiology, 2009).

2.1.1 How to Measure Lying and Standing Blood Pressure (BP):

The following method must be used to accurately measure postural BP changes:

- Have the patient lying flat for at least 5 minutes and then take a BP measurement. Record this as the 'Lying BP'
- Stand the patient up as briskly as possible and take a BP measurement immediately. Record this as 'BP standing 0mins'
- Keep the patient standing and take repeated BP measurements at 1, 2 and 3 minutes. Record these measurements as 'BP standing 1min', 'BP standing 2mins' and 'BP standing 3 mins'

Any symptoms experienced by the patient must be recorded. If the patient remains symptomatic or the BP continues to fall at 3 minutes, then further BP measurements whilst standing should be attempted until BP normalises.

2.1.2 Definition of a Significant Blood Pressure Drop:

Orthostatic Hypotension is present when following a postural change there is:

- a ≥ 20 mmHg drop in systolic BP levels,
- or ≥ 10 mmHg drop in diastolic BP levels,
- or a drop of the systolic BP to <90 mmHg.

Lesser drops in BP, particularly from low baseline measurements, may also be significant especially when symptoms or signs are present. In older people orthostatic hypotension is often an intermittent finding and tests may need to be repeated.

2.2 Recognising a Hip Fracture

The possibility of a fractured hip should be considered for any patient with -

- a recent fall, and/or
- presence of hip pain, and/or
- shortening or external rotation of the lower limb, see figures 1 & 2 and/or
- change in mobility / function

If there is clinical doubt regarding the diagnosis, an x-ray must be considered, see section 9 of the Falls Policy.

Figures 1 & 2 - Shortening and external rotation of the lower limb



The left foot is externally rotated



The left leg is shortened

SIGN 111 guidelines (2009) suggest that in the event of a suspected hip fracture post fall - transfer to general hospital from the site of the injury must be undertaken as quickly as possible.

2.3 Responding to a Person who has fallen

2.3.1 In a Hospital Setting:

Please refer to section 9 of the NHS GGC Policy for the Prevention and Management of Falls.

2.3.2 In a Community Setting:

Assess person's risk of serious injury:-

- Do not move initially
- Check ABC, airway, breathing, circulation
- Check for signs of injury (red flag indicators)
 - Obvious bone deformity or bone protrusion.
 - Cervical Spine or spinal bony tenderness.
 - Rotational deformity of limb (e.g. fractured hip).
 - Rapid swelling.
 - Compromised skin integrity.
 - Head injury with stepping/bogginess or large haematoma.
 - Focal neurological deficit.
 - Paraesthesia of lower extremities.
 - Reduced/altered Glasgow Coma Score.

If there are signs of physical injury, red flag indicators or any other doubt about the person's condition

DO NOT MOVE THE PERSON. Dial 999 and ask for the ambulance service.

Contact base to inform them of situation.

- Contact next of kin/family/carer/appropriate other agencies and await arrival of ambulance

If there are no red flag indicators or physical injuries:-

- Assess reason for fall e.g. environmental factor (make area safe) or medical, dizzy, unwell, collapse (requires medical review)

- Assess for safe moving and handling up from the floor - Transfer patient to comfortable setting using appropriate handling techniques [Moving & Handling StaffNet pages](#).
- Non-urgent medical concerns - advise person regarding a review at GP/Minor Injuries.
- Contact next of kin/family/carer/appropriate other agencies.

Section 3 – Equipment to Assist with Individual Care

3. Specialist Equipment

Specialist equipment can be used to assist in providing individual care to people who have fallen, or are at risk of falling. Equipment is available for patients within inpatient and community settings. The use of this equipment – specialist seating, lap straps, bed and chair alarms, and bedrails is classified as a form of mechanical restraint and as such, must be individually assessed and continually reviewed by the multi-disciplinary team. Restraint must be carefully considered in the context of patient safety and the human rights and dignity of the individual (Mental Welfare Commission, 2007, 2013; NHSGGC Restraint Policy, 2014).

3.1 Staff Responsibilities

Staff involved in delivering patient care utilising mechanical restraint equipment must:

- Have had prior training, and understand the safe use and fitting of that particular piece of equipment and any accessories.
- Have documented the rationale for the use of mechanical restraint equipment.
- Ensure that the continuing use of mechanical restraint equipment is regularly assessed by the multi-disciplinary team and all decisions taken are documented
- Ensure that carers and next of kin, where appropriate, understand the rationale for using the equipment and accessories.
- Ensure equipment and accessories are in good working order and are checked regularly.
- Ensure equipment and accessories are clean.
- Report any incident involving equipment and accessories.
- Remove and report faulty equipment.
- Report and discuss any shortfall in equipment availability with senior staff.

3.2 Decision Making

Patients must be assessed individually to ensure that the most appropriate form of equipment or accessory is chosen. Staff should use their professional judgement to assess the risks and benefits for individual patients, and patients should be involved in decision making when they have the capacity to do so. When patients do not have the capacity to participate in these decisions, staff must attempt to involve the welfare Power Of Attorney or welfare guardian. It is also good practice to involve relatives/carers in these decisions.

The decision to use specialist equipment for an individual, and the reasons for doing so, must be agreed and reviewed regularly by the multi-disciplinary team. All decisions taken must be recorded in the patient record and the care plan updated accordingly. This information must be easily accessible to all relevant staff caring for the patient.

3.3 Seating

All patients must be assessed for suitable seating as part of their falls risk assessment and care planning. The initial assessment can be done by any member of the multi-disciplinary team. The following must be considered when selecting an appropriate seat:

- Seat should be wide enough to support body mass but not too wide that it might cause the patient to lean to one side of the chair, thereby disrupting spinal alignment.

- Seat depth and height are correct when the patient's bottom is at the back of the chair and their feet are flat on the floor. The patient's knees and ankles should be at 90 degrees. The seat should fully support the patient's thighs but not touch the back of the knees.
- The patient should be able to support their head and neck themselves or the chair back should be high enough to support the head and neck when required.
- Shoulders should not be hunched when arms are on the armrests.
- The base of the chair should be firm.
- The patient should feel comfortable.
- Drinks, personal belongings and call buttons, where used, must be accessible to the patient.

Care must be taken when additional pressure relieving cushions are used. Re-assessment of the suitability of the patient's seat with cushion in situ must take place. Pillows must not be used to sit on.

3.3.1 Specialist Seating

Patients must have a multidisciplinary review by Occupational Therapy and/or Physiotherapy to consider the use of specialist seating when:

- The available standard chairs do not fit the patient according to the above recommendations.
- The patient cannot maintain their own posture in the chair.
- The patient frequently slips out of the chair.
- The patient complains of discomfort related to the chair.

Do not use pressure relieving cushions in conjunction with specialist seating as the cushion may alter the seat height, and make the seat unsuitable for the person.

3.4 Lap Straps

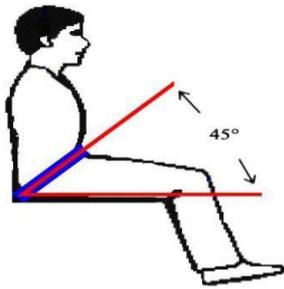
To promote patient safety it may be necessary to manage the patient's care through the use of specialist seating with personalised adaptations, which may involve the application of a pelvic, lap, seat or waist belt and also straps or harnesses.

Patients must be assessed individually to ensure that the use of lap straps is the most appropriate method of preventing potential falls from a chair.

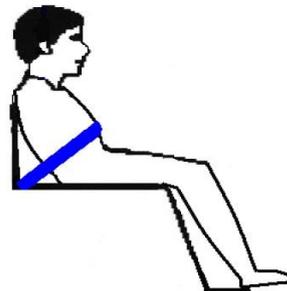
Patient safety may be compromised if lap straps or seating accessories are used improperly. For safe use of a lap strap, patients must be able to sit at or near to a 90 degree angle (see Figure 1). A poorly fitted or poorly adjusted belt may lead to the patient slipping down and possibly out of the seat (see figure 2). Users or carers with poor co-ordination or limited strength in their hands may find it difficult to operate some types of fastening/release or adjustment mechanism.

Figure 1. Correct belt position

Occupant in or near a 90° position. Strap must fit snugly over the pelvis. Do not trap arms under seat belt

**Figure 2. Incorrect belt position**

Belt positioned above the pelvis. Patient in a reclined posture. Patient in danger of entrapment by belt.

**3.5 Bed and Chair Alarms**

To promote patient safety it may be necessary to manage the patient's care through the use of a bed and/or chair alarm. These alarms are usually a pressure sensitive mechanism encased in a plastic pad that detects patient movement as the individual attempts to rise up off the pad. This action triggers an alarm noise.

Bed and chair alarms are thought to have a part to play within the multifaceted approach to falls prevention, although there is no evidence base for their use, or recently published studies on their efficacy. However, they can serve as an "early warning system" alerting nursing staff when patients attempt to leave their bed or chair unassisted. To be effective, they need to be implemented with care and with a clear understanding of their limitations.

Alarms can be considered for patients:	Alarms are not considered suitable:
<ul style="list-style-type: none"> • With cognitive impairment (e.g. dementia, delirium) which affects their judgement and awareness of the difference between safe and hazardous bed or chair transfers. • Who do not ask staff for assistance despite having poor bed and /or chair mobility. 	<ul style="list-style-type: none"> • For patients in acute settings who weigh less than six stones (38kg) as they may not be able to apply sufficient force to activate the pressure sensitive system. However, movement sensors in community settings are not weight specific for activation. • For patients nursed on a pressure relieving mattress or pressure relieving overlay mattress. • Where the patient is distressed, causing them to frequently leave their bed / chair unsafely or interfere with the device.

When using a bed or chair alarm, consideration must be given to the following:

- To prevent a potential fall
 - In acute settings, patients allocated a bed or chair alarm should be nursed close to the nurse's station, in order to allow staff to hear the alarm and respond as quickly as possible.

- In community settings, patients allocated a bed or chair alarm should sleep in a room close enough to allow their relatives/carers to hear the alarm and respond as quickly as possible.
- Whether the repeated sounding of the alarm is likely to increase agitation and distress for the patient.
 - In acute settings, some alarms, if available and appropriate, offer a pager mode system, with the ability to turn the alarm sound off at the bedside so this does not disturb patients.
 - In community settings, use of the vibration mode can be considered. The relative/carer can have the alarm positioned under their pillow with the vibrations alerting them to patient movement from the bed. (This may also be helpful for a relative/carer who is hard of hearing).
- The welfare of other patients sharing the same bed or day area. An alarm is likely to disturb these patients, especially overnight.
- The ongoing indication for the use of a bed or chair alarm is assessed and documented daily. Behavioural monitoring charts are available for this purpose.
- Alarms must be kept clean and in good working order.
- Alarms should be checked during all care interventions to ensure that they are undamaged and power supplies are patent. If the alarm is not working or staff suspect that it is not functioning properly, remove it from use immediately and review the patient's level of supervision.

Patient/carer information leaflets are available to help facilitate discussion.

Movement sensors and other telecare equipment may be available in the community. These devices can provide important information on the patient's usual movements within the home, thereby aiding the monitoring of falls risk and the construction of an appropriate management plan.

3.6 Bedrails

Patients may be at risk of falling from bed for many reasons including impairments in physical, cognitive and functional abilities. Bedrails are designed to reduce the risk of patients accidentally slipping, sliding, falling or rolling out of bed. Bedrails will not prevent a patient leaving their bed and falling elsewhere, and should not be used for this purpose. Bedrails are not intended as an aid for a patient to manoeuvre him / herself e.g. sitting forwards in a bed, rolling over etc (unless specifically identified in the bed manufacturers user guide that this is an appropriate use of the bedrail).

There is some evidence to suggest that bedrail use may increase the risk of serious injury if patients attempt to climb over them to exit the bed, or become entrapped within the rails (Medicines and Healthcare Regulatory Agency, 2007; National Patient Safety Agency, 2007). Hence use of bedrails must be individually assessed and continually reviewed by the multi-disciplinary team, with decisions made always taking into account the benefits and risks for the individual patient (MHRA Safe Use of bedrails, 2013)

3.6.1 Definition of a Bedrail

Bedrails can be classified into two different types:

- Integral types - these are incorporated into the bed design and supplied with / or offered as an optional accessory by the bed manufacturer, to be fitted later.
- Third party types - these are not specific to any particular bed model. They are attachable and detachable and intended to fit a wide variety of metal framed beds from different suppliers.

3.6.2 Where to Use Bedrails?

Where to Use	Where NOT to use
<ul style="list-style-type: none"> • When prescribed as part of care planning to prevent slipping, sliding, falling or rolling from the bed. • If the patient is being transported on their bed or trolley. • In areas where a patient is under the influence of / recovering from anaesthetic or sedation and is under constant observation. 	<ul style="list-style-type: none"> • When not prescribed as part of care planning. • As an aid for a patient to manoeuvre him/her self in bed (<i>unless specifically identified in the bed manufacturers user guide that this is an appropriate use of the bedrail</i>). • Where there is a risk of the patient climbing over or through the bedrail. • As a method of restraint.

3.6.3 Bedrails Risk Assessment

Staff should use their professional judgement to consider the risks and benefits for individual patients by referring to the information on the back of the Bedrails Risk Assessment. A patient / carer information leaflet is also available to facilitate discussion.

The assessment of whether to use bedrails must be reviewed when the patient's:

- Physical condition changes and this change may affect risk of slipping, sliding, falling or rolling from the bed (e.g. new stroke).
- Behaviour changes and this change may affect the safe use of bedrails (e.g. increased agitation and attempts to climb over the bed rails).
- Care environment and or care provision changes.

As a minimum requirement, bedrails assessment must be reviewed:

- Daily in any acute medical, surgical, or assessment and rehabilitation area.
- Weekly in areas which provide less acute care.
- Monthly in long term care areas.
- If the care environment or care provision changes.

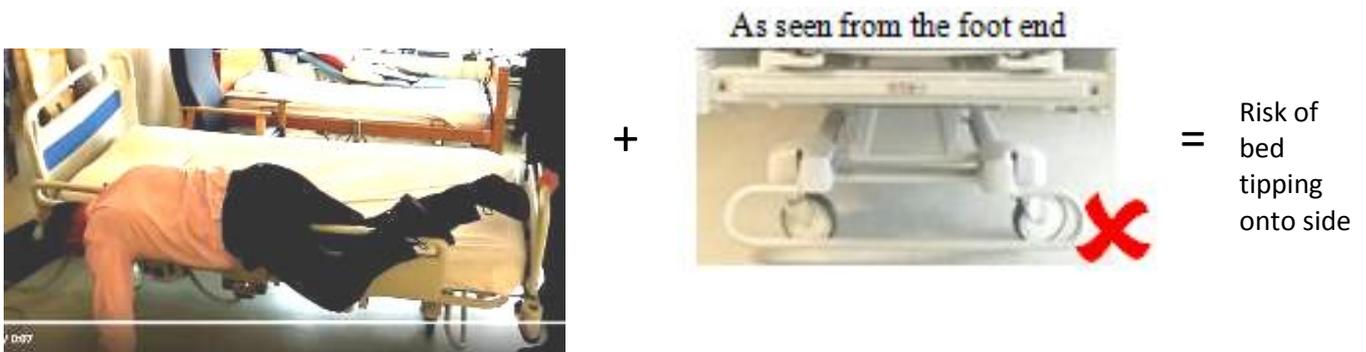
Bedrails can only be used without the need for formal risk assessment in the immediate pre and post operative period when sedative or anaesthetic medication has been administered, or when the patient is sedated / anaesthetised within an intensive care setting (Level 3) and one to one nursing care is provided. Formal assessment is not required when bedrails are used for the transportation of patients between areas. Informal assessments of bedrail use should continue until the patient is fully conscious.

For Patients Pre and Post Surgery/ Procedure/ Transportation who are known / suspected to have ongoing personal safety needs i.e. patients with mobility or cognitive health issues – a Risk Assessment document MUST be completed and reviewed as per the bedrail policy.

3.6.4 Potential Hazards

Patient safety may be compromised if bedrails are used improperly. As such, careful consideration must be given as to the need for their use in addition to the many other possible interventions available to reduce falls risk.

Possible hazards include entrapment of a limb or body part, injury from falling over rails, or suffocation on padded accessories (eg. bumpers). In addition there is the risk of the bed tipping onto its side if a patient attempts to climb over the bedrails whilst the wheels of the bed are pointed sideways (see diagram below).

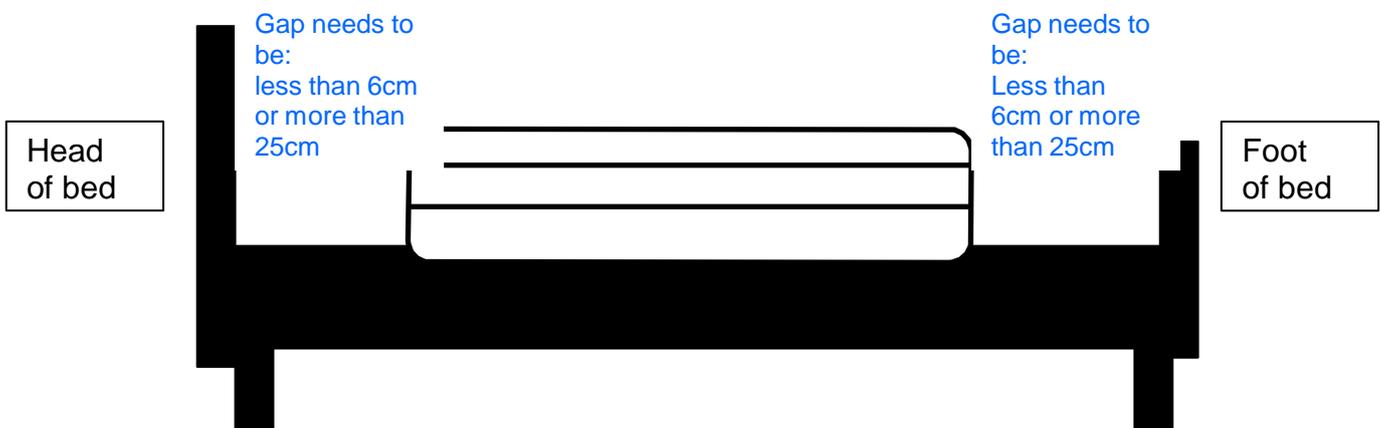


Repeat the risk assessment and update the care plan if any such hazards are present. Be aware that wires and cables attached to equipment can become damaged or disrupted by bedrail use (e.g. call buzzer detachment from socket).

To help avoid hazards, consideration must be given to the following:

1. Patient and Bed Size:

- The size and shape of the patient's head and body. Unusual patient head or body size or shape (e.g. wearing bulky dressing, head and neck braces) may lead to entrapment.
- The overall height of the mattress in relation to the bedrail height. Tall mattresses may lead to patients rolling over the bed rails. Extra height bedrails must be used.
- Bumpers may reduce the risk of the patient striking their limbs on the bedrail. However, there may be risk of suffocation if the face becomes compressed against the bumper.
- The gap between the head and foot of the bed in relation to the bedrail position must follow standard advice to avoid potential entrapment of the patient's head, body or limbs – see figure below.

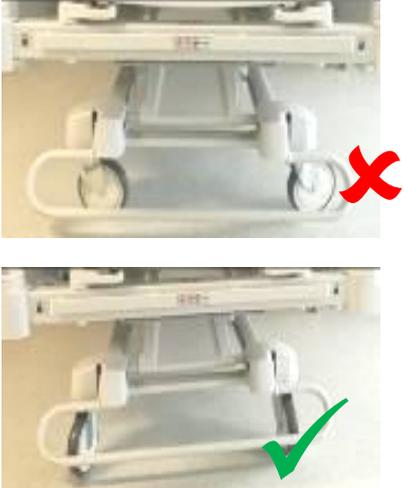


- After attending to a patient, ensure the bedrail is fully engaged to avoid the patient rolling over on top of it.
- Ensure the bed is returned to a height suitable for the patient after cleaning or care procedures.

2. Bed Wheel Position:

- After moving a bed, ensure the wheels are pointing to the head or foot end of the bed. The easiest way to do this is to finish moving the bed by pushing it towards **or** pulling it away from the wall at the head end of the bed.
- Prior to working with a patient on the bed, check the wheels are pointing to the head or foot end of the bed – see figure below.

Wheels as seen from the end of the bed



3. Using different bed types and trolleys:

- When using profile beds in different bed configurations, be aware of potential entrapment to limbs depending on the patient's body position.
- Bariatric beds must be used with a compatible extra-wide mattress.
- Trolleys are usually narrower and higher than standard beds and therefore can present additional hazards for the patient. Patients must not be left unattended on trolleys when bedrails are not in use.
- When patients are being transported on a trolley, bedrails must always be used.

Examples of Hazards:

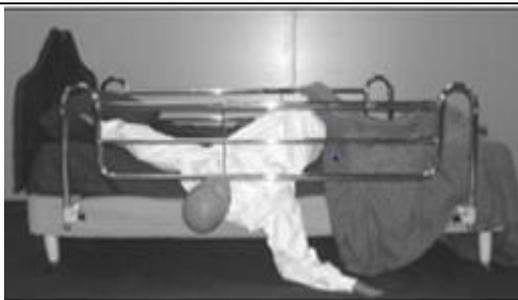
Head & body entrapment because insufficient gap left between head of bed and bedrails



Entrapment due to unusual head size



Head & body entrapment because bedrails applied inappropriately to the bed or not securely elevated



Patient rolling over bedrails because extra height mattress used with normal height bedrails (extra height bedrails should have been used)



3.7 Hi-Lo/Low Profile Beds

Some individuals are at risk of either slipping, sliding or rolling out of bed or getting up and walking unaided when it is not safe to do so. Others may become agitated if they feel restrained by the use of bedrails. Bed rails should not be used in these situations (refer to 3.6 above). Instead a Low Profile bed should be considered.

3.8 Placement of Mattress on the Floor

The decision to nurse a patient on a mattress on the floor should only be taken when all other interventions to keep them safe in bed (including the use of a low level bed) have been exhausted. Placing a mattress on the floor must be done for the least amount of time possible. Patients must be assessed individually to ensure that this is the most appropriate method of preventing potential falls from bed. Staff should use their professional judgement to assess the risks and benefits for individual patients. Patients should be involved in decision making when they have the capacity to do so.

The decision to place a mattress on the floor must be:

- Discussed and agreed with all relevant parties (eg. the patient, senior medical staff, senior nursing staff, and AHP) as soon as practicable. When patients do not have the capacity to participate in these discussions, staff must attempt to involve the welfare Power Of Attorney or welfare guardian. It is also good practice to involve relatives/carers in these decisions. The outcome of the discussions must be documented in the patient record.
- Documented in the nursing care plan.
- Reviewed daily.
- Accompanied by a Moving and Handling risk assessment. This must be reviewed daily.

The following must be taken into account when placing a mattress on the floor:

- The placement of the mattress on the floor must be done in a way which is not demeaning to the patient.
- The mattress must be placed in a bed space.
- The nurse call button, if in use, must be beside the patient at all times.
- Drinks and personal belongings must be accessible to the patient.
- A generic risk assessment should be completed to ensure the environment immediately around the patient is made safe for the patient and staff. Care must be taken when placing call buttons, personal belongings, drinks, equipment etc.

Section 4 – Recovering a Person from the Floor

4. Recovering a Person from the Floor

Guidance regarding the recovery of a person who has fallen can be found on the [Moving & Handling StaffNet pages](#). Prior to recovering a person from the floor you will be undertaking an assessment, considering the person's condition e.g. looking for signs of injury as a result of a fall including head injury, hip fracture or spinal injury.

If a hip fracture or spinal injury is suspected arrangements must be made to 'straight lift' the person from the floor. In acute settings, equipment such as hoverjack or spinal board should be used; a **hoist should not be used**.

In community settings, paramedic assistance should be requested.

Where no major injury is suspected, the patient should be assisted from the floor. Additional assistance or equipment may be required to achieve this safely.

Section 5 – Reporting a Fall

5. Datix and Significant Clinical Incidents

Across all NHSGGC settings slips, trips and falls must be recorded in Datix.

At all times NHSGGC aims to learn from any falls incident and encourages all staff to engage in the Datix system. It is never the intention of investigations to apportion blame to an individual but instead to understand how the incident arose and what to do to prevent similar incidents in the future.

An incident must be reported if it:

- results in injury or ill health.
- is contrary to the specified or expected standard of patient care or service.
- places patient(s) or staff member(s), or visitor(s), contractor(s) or member(s) of the public at unnecessary risk of harm.
- places NHSGGC in an adverse position with potential loss of reputation.
- places NHSGGC property or assets in an adverse position or at risk of loss or damage.

Falls should be considered for managerial review in accordance with Health and Safety / RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations) guidelines.

A fall must be reviewed to establish if it was avoidable. This review will identify if there were any deficiencies in care which may have contributed to the fall occurring, and from which learning can be identified.

If the fall resulted in a fracture, brain trauma or death, this is classed as a serious outcome. All fractures (excluding digits) and head injuries must be recorded in Datix as a category 4 incident. Deaths resulting from a fall must be recorded as a category 5 incident. Both category 4 and 5 incidents must then be escalated via the rapid alert template as a Significant Clinical Incident (SCI) and subject to appropriate review within directorate / HSCP processes (NHSGGC Incident Management Policy, 2011).

For category 1 to 3 incidents, the following questions will help identify if a significant clinical incident review is required. An answer of 'YES' to any of these questions requires the Lead / Senior Nurse to decide if an SCI is needed:

- Was there a problem with any equipment involved in this case?
- Has there been a breach of policy or procedure?
- Is there something you think should have been done differently in this case?
- Do you feel there is any learning to be gained from investigating this event? (Would something be done differently next time?)
- Are there any patient / family concerns regarding the treatment / care / outcome?
- Are there any management concerns related to the event or individuals involved?
- Is there currently any interest from the Procurator Fiscal?
- Do you believe this event was avoidable?

5.1 Staff Responsibilities When Reporting A Fall

The roles of each staff member or department responsible for reviewing a patient fall event are outlined in the tables below.

Table 1 - Inpatient settings

Staff member or Department	Roles and Responsibilities
Ward nursing staff	Carry out a post fall review and Datix findings, and complete safety cross front and back
Ward medical staff	Carry out a post fall medical review and insert a copy into the patient record
Ward Senior Charge Nurse and Senior Medical Staff	Review post fall information and update Datix regarding outcomes if necessary
Lead Nurse	Monitor fall reviews and investigations, ensuring learning is implemented and disseminated. Escalate category 4/5 SCIs to senior management team.
Hospital Falls Co-ordinators	Support staff in SCI process, highlight harm and any issues with Datix reporting
Clinical Risk	Provide advice and assistance with SCI process

Table 2 - Community settings

Staff member or Department	Roles and Responsibilities
Front line community staff	If the fall is witnessed, inform team lead and Datix the incident. If the fall is not witnessed, consider the five bullet points at the start of this section, inform team lead and Datix as required.
Reviewer	Review outcome and recommend a falls assessment by the appropriate service, dependent upon individual circumstances of the person who has fallen.
Clinical Risk	Provide advice and assistance with SCI process

5.2 Outcome of Falls Reporting

Falls data from Datix is collated to produce outcome reports for all clinical areas. These results provide necessary feedback to local teams to facilitate improvements in clinical care. The falls data is also escalated to departmental, sector and health board and HSCP clinical governance committees. In addition NHSGGC is required to report outcome data to the Scottish Government as part of the Scottish Patient Safety Programme and the Framework for Action: the prevention and management of falls in the community.

In hospital settings for local service improvement, the safety cross is a useful resource at ward / team level as a visual outcome monitoring tool.

In community settings, in addition to Datix information local data collection regarding falls can be used for local service improvement.

Section 6 – References

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