

Falls Prevention and Management Policy

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VERSION CONTROL SUMMARY

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1.0	Dec 2008	Annette Lumb, Occupational Therapy Lead	Policy developed to comply with NHSLA requirements. Ratified by Quality & Healthcare Governance Committee.
2.0	Dec 2010	Anwar Maderbocus/ Kate Brown, Physiotherapy Team Lead	Policy updated to reflect new standards and Trust governance structure. Incorporates Protocol for the Prevention of Falls from Height (Appendix E.1) and Protocol for the Safe Use of Bed Rails/Cot Sides (Appendix F).
2.1	April 2011	Anwar Maderbocus/ Kate Brown, Physiotherapy Team Lead	Addition of Post Falls Protocol as Appendix G following NSPA's rapid response report 'Essential Care After an Inpatient Fall'
2.2	August 2013	Kate Brown, Physiotherapy Team Lead	Updated with information regarding the reporting of Serious Untoward Incidents and Safeguarding Vulnerable Adults in relation to falls. Amendments to post falls protocol detailing additional observations required Amendments to falls leadership structure Amendments to information on training Changes to appendices for incorporation into main body of policy
2.3	January 2017	Jackie Riglin, Falls Prevention Clinical Lead Kate Brown, Physiotherapy Team Lead	Major review including amalgamation of physical and mental health services
2.4	January 2017	Falls Prevention Clinical Lead Physiotherapy Team Lead	Changes to assessment process for all older adults within OPAC
2.5	April 2022	Annami Palmer, Falls Prevention Clinical Lead	Updated to reflect new guidance.
2.6	December 2024	Annami Palmer Falls Prevention Clinical Lead Karen Hurst Inpatient Falls Education and Training Lead	Updated to reflect new guidance and standardised assessment process.

FORMAL RATIFICATION RECORD

Version	Date	Author	Details of Previous Version:	Oversight Group	Approval Group	Ratifying Committee	Date:
V2.6	05/01/2025	Falls Prevention Clinical Lead, Falls Lead (Community)	As to current document available Updated into new format and national updates included	PSE	QSC		

MINOR CHANGE RECORD

Version	Date	Author	Description of Change/s Made:	Authorising Executive	Date:

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1.0 INTRODUCTION

The purpose of this policy is to provide guidance on:

- All elements of falls prevention and management.
- Providing safe, quality care in accordance with national and local falls guidance.
- Identifying the risks of falling.
- Implementing effective interventions to reduce the risks.
- Staff duties and responsibilities related to falls prevention.

1.1 Introduction

Falls and fall-related injuries are a common and serious problem for older people and is the leading cause of accident-related death in people over 75 years. It is the most common patient safety incident reported to the National Commissioning Board Special Health Authority and is estimated to cost the NHS more than £2.3 billion per year. Falling has an impact on quality of life, health and healthcare costs. However, preventing falls must be balanced with patients' rights to dignity, privacy, independence, rehabilitation and their choices about the risks they are prepared to take.

Falls also account for approximately 30% of all accidents to employees leading to time off work. Many of these accidents can be avoided by simple measures and ensuring that defects are promptly reported and dealt with.

The Trust premises are also used by many people including contractors and employees from other NHS Trusts. The Trust owes the same duty to these people as it does to its own employees. Cambridgeshire and Peterborough NHS Foundation Trust (thereafter called CPFT or the Trust) is therefore committed to ensuring that appropriate and effective falls prevention measures are in place to reduce, and where possible, prevent the incidence of slips, trips and falls across the Trust amongst patients/service users, visitors and staff.

2.0 OBJECTIVES and AIMS

The Trust aims to minimise the risk of falling for all of those who receive care from its services. This policy will provide clinicians with a strategy to identify patients at risk of falling and target multi-disciplinary interventions, thereby influencing a reduction in fall rates achieved by dignified, safe, and proven methods that will have a beneficial effect on the patient's quality of life. It sets out the systems and processes that the Trust has put in place to achieve this and outlines the duties and responsibilities of staff.

The objectives of the policy are:

- to identify those at risk of falls using the relevant falls screen.
- to ensure those identified at risk are offered a Multi factorial falls risk assessment to identify risk factors for falling.
- to agree an appropriate action plan with the patient/service user to address risks identified.
- to implement Royal College of Physicians Falls Safe bundle for preventing falls for those admitted to in-patient settings.

- to ensure all clinical staff are trained in identifying those at risk of falls, and appropriate clinical staff trained to complete a Multi factorial falls risk assessment and agreed intervention plan.
- to ensure all staff are aware of the potential for falls prevention by raising awareness and providing appropriate training and information materials as required.

The policy promotes compliance with NICE Clinical Guideline 161: 'Falls in older people: assessing risk and prevention' (2013), NICE Clinical Guideline 232: 'Head injury: assessment and early management' 2023, RCP, recommendations from National Audit of inpatient Falls (NAIF) Fallsafe, and NICE Quality Standard 86: Falls in Older People (2015).

3.0 SCOPE

This policy applies to all adult patient/service users in the care of the Trust either admitted to an in-patient facility, using an out-patient facility, or during a home visit from staff in the community. In this policy the terms 'patient' and 'service user' can be used interchangeably to mean a person receiving services from the Trust.

This policy applies to all staff who are involved in the care of patients to ensure that each individual has an appropriate risk assessment undertaken, and an appropriate management plan initiated and actioned. The Policy outlines the responsibility for staff whilst at work.

4.0 DUTIES, ROLES and RESPONSIBILITIES

All Trusts should have a board-level falls steering group that has representation from, and reports to, the organisation's board. This group should regularly review their data on falls and moderate harm, severe harm, and deaths per 1,000 occupied bed days and assess the success of their practice against trends in these figures.

To support the implementation of a successful falls prevention and management process, staff have the following duties and responsibilities:

Chief Executive

- Has overall responsibility for the prevention and management of falls in the Trust

Directorate Senior Leadership Teams

- Should review the capacity and makeup of falls prevention services and influence relevant parties to support the development of local services, ensuring that falls prevention is a local health priority.

Service managers

- All managers should support their teams in the implementation of this policy and monitor compliance against the required practice.
- All managers should be considering the role of their services in primary falls prevention, and the messages given out about health behaviours.
- All managers are responsible for ensuring staff have appropriate training in Falls Prevention and Management.
- Risk assessments in clinical areas are the responsibility of the local clinical manager.

- All managers are responsible for ensuring that a system is in place to clean up spillages between scheduled floor cleaning times.
- All managers are responsible for ensuring reports of any flooring or environmental defects are acted upon.
- All managers are responsible for ensuring that following a fall the incident is recorded, and where appropriate, considered under the safeguarding of vulnerable adults procedures.

In addition, service managers of in-patient areas are responsible for ensuring:

- Clinical post-falls procedures are followed as appropriate.
- Slips, trips and falls are monitored, reviewed and action taken as appropriate.
- Datix falls incident reports with the outcome of the fall (i.e. diagnosis from A&E stated fractured neck of femur) are completed.
- Ensure RIDDOR reports are submitted as required.
- Managers will ensure that inpatient care is in line with national falls and fracture guidelines, and quality standards.

All clinical staff have a responsibility to:

- When working with older people, routinely ask about falls, observing for deficits in gait and balance.
- Undertake relevant training to recognise the signs of potential risk, and assess for potential risks, including medical conditions which might predispose a person to fall.
- Ensure the care plan is implemented, detailing the falls risks and risk management being utilised to help reduce risk of falls (Assistive technology, etc.).
- Understand the referral pathway to local services, that reduce fall risks and should be able to provide up-to-date patient information on falls (See Appendix 4).
- Ensure that staff and patient areas are without slip and trip hazards that any issues are dealt with or reported in a timely way.
- Ensure individuals complete a Datix incident/near miss report form where appropriate in line with Trust policy (See section 7).
- Ensure, if staff have a fall at work, that the fall is reported via the Datix system and a RIDDOR report completed if applicable.

In addition, in-patient clinical staff have a responsibility to:

- Understand, and carry out their role in initiating, carrying out, and reviewing observations due to falls risk, in line with policy.
- Inform each patient of the level of observation they are subject to and the reasons for this.
- Review the level of observation based on recorded clinical need and risks of falls.
- Ensure that observations are viewed and used as opportunities to build a therapeutic relationship. Ensure the legal status of the patient is considered and the appropriate process followed. Consent is required for informal patients however patients nursed under the mental health act can have these prescribed without consent if the risk of fall is caused by their mental health condition.
- Ensure the People Handling Risk assessment is adhered to.

Facilities/Estates

In patient areas:

- Ensure that the guidelines given in the Department of Health's (DoH) Health Building Note 00-10 Part A; Flooring are considered when introducing new or refurbished floor surfaces.

- Ensure an appropriate cleaning regime is chosen for the type of floor, when it is used and the contaminants present.
- Ensure the floor cleaning is scheduled to take place at suitable times to reduce the risk of slips, trips, and falls.
- Ensure that cleaning contractor displays suitable warning signs during floor cleaning and that access is prevented to wet floors or contaminated areas.
- Monitor and review cleaning regimes at regular intervals.

OPAC Falls Prevention Service (Community only)

- Raise awareness of Falls Prevention and management and the role all community staff have to reduce falls risks.
- Facilitate the development and delivery of a rolling programme of training on both prevention and management of falls for community teams.
- Ensure clinical practice is based on best evidence.
- Develop a co-ordinated and integrated approach to falls management and prevention, working closely with commissioners and other provider organisations, as well as with other local statutory and voluntary agencies.

Trust Falls Steering Group

- Develop and review the Trust Falls Management and Prevention Strategy and Policy.
- Facilitate the development and delivery of a rolling programme of training on both prevention and management of falls.
- Review the capacity and makeup of falls prevention services.
- Ensure clinical practice is evidence based.
- Ensure lessons learned from adverse incidents both within, and external to, the Trust are shared, considered, and relevant actions taken.
- Regularly review data on slips, trips and falls, and related harm, and assess the success of their practice against trends in these figures.
- Implement a programme of audit of the delivery and effectiveness of falls prevention across the Trust.
- Raise awareness of issues associated with slips, trips, and falls.
- Develop a co-ordinated and integrated approach to falls management and prevention, working closely with commissioners, other local provider organisations, and local statutory and voluntary agencies.
- Prepare regular reports for the Patient Safety Executive.

5.0 TRAINING AND PROFICIENCY

All staff will have training applied to their Training Needs Analysis (TNA) as agreed by the Directorates, following a clinical pathway of learning and proficiency. Dependent on the clinical pathway this might be e-learning, face-to-face, or a hybrid model.

For community staff training is delivered by the Falls Prevention Service. For ward-based staff training is delivered by the 'Enhanced Therapeutic Handling and Falls Prevention Facilitator'.

Additional information and resources will be cascaded via the trust wide falls steering group, directorate falls groups and falls champions.

6.0 DEFINITION OF TERMS

SLIP: A slip is to slide accidentally causing the person to lose their balance; this is either corrected or causes a person to fall.

TRIP: A trip is to stumble accidentally often over an obstacle causing an individual to lose their balance, this is either corrected or causes an individual to fall.

FALL: A fall is an event which results in the person or a body part of the person coming to rest inadvertently on the ground floor or other surface lower than the person, whether or not an injury is sustained.

7.0 PROCESS and CONTENT

Falls risk assessments are completed in collaboration with patients/carers, they are supported to actively engage in decision making and treatment planning, and their views are considered as part of their Falls prevention plan.

7.1 Falls Risk Assessment

Community Settings:

Older People in contact with healthcare professionals should be asked routinely whether they have fallen in the past year and asked about the frequency, context, and characteristics of the falls. Older People reporting a fall, or considered at risk of falling, should be observed for balance and gait deficits and considered for their ability to benefit from interventions to improve strength and balance.

Older People who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance, should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience. This assessment should be part of an individualised, multi-factorial intervention (see Appendix 2 for access to the Falls Prevention Pathway Dashboard). People under the age of 65 who present as at risk of falling because of an underlying condition, should also be considered for a multi-factorial falls risk assessment and intervention. Where a patient would benefit from a multi-factorial falls risk assessment, onward referral should be discussed with the patient. Onward referral should take into consideration their ability to self-manage, and whether they are independent with activities of daily living. See Appendix 4 – Falls prevention pathway community and primary care.

In-patient settings:

- Regard all patients aged 65 years or older as at risk of falling in hospital. A fall screen need not be completed for these patients as falls risk is presumed, and a multi-factorial falls risk assessment is therefore required.
- Patients aged 50 to 64 who are admitted to hospital, and are judged by a clinician to be at higher risk of falling because of an underlying condition, are also covered by the guideline recommendations about assessing and preventing falls in older people during a hospital stay.

- For all other patients, a falls screen should be completed and further assessment carried out if indicated by the screen.
- Falls risk screens and multi-factorial falls risk assessments should be commenced on admission.

See Appendix 2 for further information.

7.2 Falls Interventions to reduce falls risk

- Appropriate intervention(s) for each risk factor should be agreed in conjunction with the patient, implemented and documented in the patient record.
- The patient should be provided with a patient held personalised care plan.
- Interventions may include medication review including bone protection, advice regarding footwear, strength, and balance exercise program, teaching how to get up off floor, replacing ferrules on walking aids, advice re community lifeline to prevent a long lie, onward referral for orthotic inserts, continence assessment, cognitive assessment, nutrition and fluid review, assistive equipment for activities of daily living, environmental adaptations.
- Relevant written information about preventing falls should be given to service users and relatives as part of the intervention plan as appropriate.
- Each ward should have a Falls Champion, and an information board to share information for staff, patients and visitors.
- Wards must have access to falls prevention equipment, and where identified as needed, this should be in place.
- Wards should consider line of sight where there it is identified that a patient has a falls risk.

7.3 Observations for falls management in inpatient setting

- There is a need for inpatient wards to have clear governance and process around decision making and practice when a person presents at risk of falls within our inpatient wards. This supports and works in tandem with the falls policy and practical guidance which is being produced to support staff in using bed rails, and low profiling beds.
- Assessing the need to use increased observations would draw upon factors assessed within the CPFT Falls Risk Assessment Tool and clinical judgement around an individual's risk factors. Risk factors may increase the risk of moderate to severe harm following a fall and should be factored into MDT decision making if a person needs a more frequent observation than hourly or general rounding.
- Some risk factors may mean that a person is more likely to come to harm if they fall, and these should be considered when assessing if more frequent observation is required. Risk factors may include, but are not inclusive of, a high Rockwood frailty score, a person being on blood thinners meaning bleeding following a fall could result in a reduced clotting response, osteoporosis which could result in bones breaking easily during a fall, or a known postural hypotension which may increase the likelihood of a fall when standing up to mobilise.

7.4 Responsibilities:

- **Legal Framework to support the use of observations to reduce the risk of harm:** Frequent observations are intrusive and can impact a person's dignity and feeling empowered on our wards. As such where patients are informal (not detained or held under a legal power) consent should always be sought when the person has capacity to make the decision around managing their falls risk. As with all MCA's and best interests' discussions staff should be making all efforts to support the person to make their own decision. Where consent is not given, and the patient appears to lack capacity for this decision then an MCA should be undertaken to determine if the person does have capacity to make this decision. If the patient does not have capacity, then a Best Interests meeting should be held

to ensure that care is provided in line with the persons best interests. Staff should involve an IMCA if there are no family members to support in this process.

- **Legal status of patients**

Due to the restrictive nature of such close engagement and observation, it is expected that any patients who require to be observed within eyesight or within arm's length will usually be either detained under the 1983 Mental Health Act, or subject to a Deprivation of Liberty Safeguard. If this is not the case the patient's Responsible Clinician needs to review the patient's legal status at the earliest opportunity. However, there may be patients who do not meet the criteria for detention under the Mental Health Act, which may be the case if the primary risk identified is potential falls. If this is the case when deciding to implement or continue with the close engagement and observations the level of risk posed needs to be balanced against the patient's human rights. In addition, the patient and family where possible are to be involved in the decision to implement this intervention and consent to the restriction should be obtained.

- **Allocation**

In line with practice around therapeutic observation, more frequent observation levels will be allocated to a staff member to undertake for a maximum of 2 hours at a time.

There should be an observation care plan created which details the individual risk factors requiring a more frequent level of observation, the rationale for the observation and periods of increased risk and risk management plan.

This care plan should be written using the CPFT Enhanced observation Recording form. To avoid misinterpretation that more frequent observations will reduce the risk of someone falling we are not encouraging the use of arm's length observations, as this may instil a belief and expectation that staff would be actively doing something manual to stop a person falling.

We would encourage the use of level 2 intermittent observations, (and unlike Therapeutic observations these could be every 15 minutes as there is no increased risk to a pattern of checking when the risk is one of falling) or level 3 (within eyesight) to allow prompt engagement and intervention should we observe someone starting to fall. Prompt intervention may simply entail the post falls check list being undertaken without delay and escalating for further support from the MDT.

There is no expectation that levels of observation will manually prevent someone from falling.

7.5 Actions to take in the event of a fall

- **Inpatients**

The staff member who has identified that a fall has occurred must immediately alert the nurse in charge/ raise the alarm. The below flow chart details the action to take after a patient has fallen.

Staff should then ensure the patient is kept comfortable, check for injuries and complete basic observations using National Early Warning Score (NEWS2).

If the initial assessment indicates that there is no obvious injury, the registered nurse will complete a risk assessment to ascertain whether the patient can be moved safely following the moving and handling policy.

A physical health check, body map and observations using the NEWS2 will be repeated after 30 minutes. If injury is observed after reassessment, the registered nurse will call the doctor on duty or relevant emergency services.

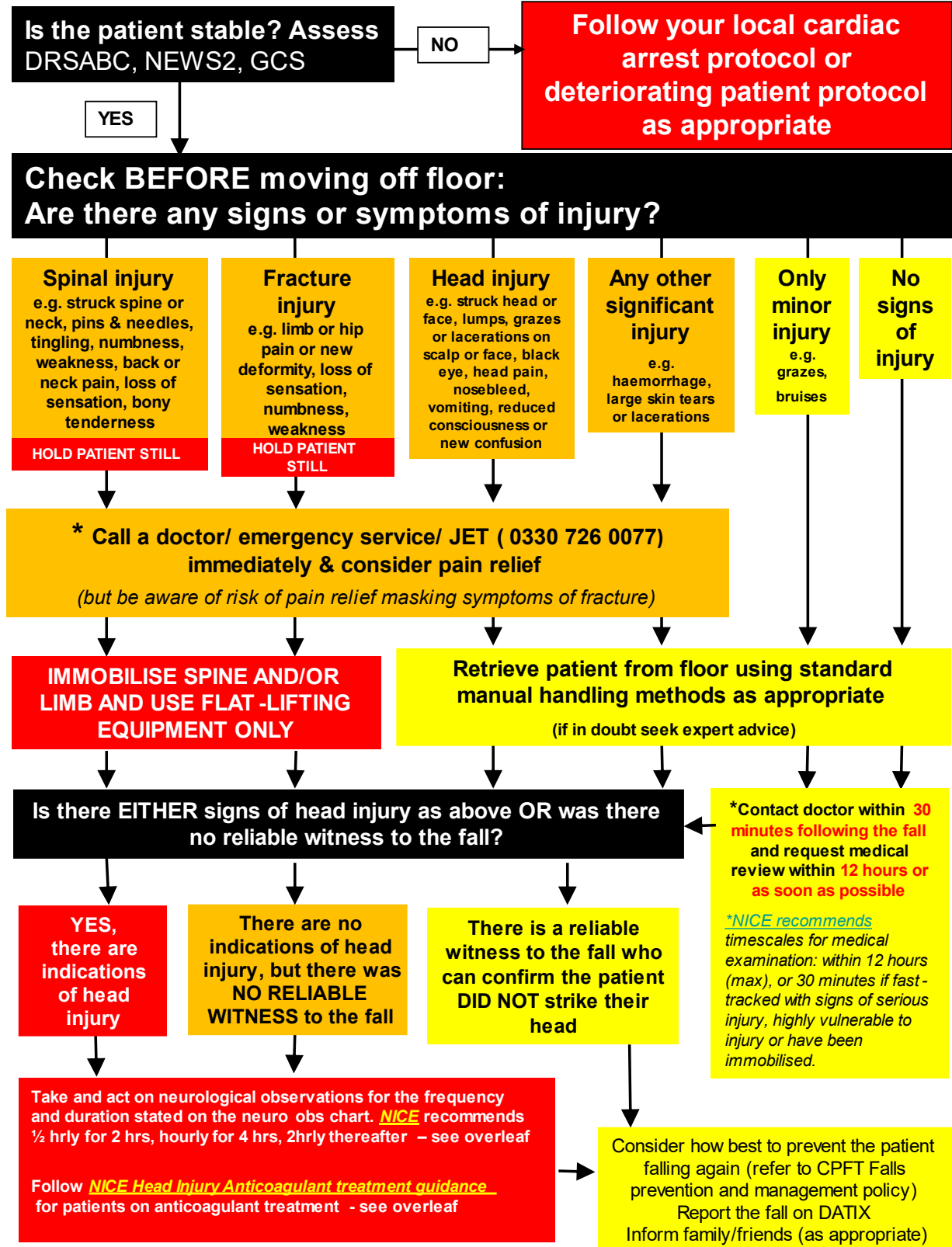
Where a patient has sustained an injury, a risk assessment should be completed and correct moving and handling techniques and equipment should be used to move the patient, without causing further injury. The nurse will call the doctor on duty or relevant emergency services as required.

Immediately after the event the nurse in charge should:

- complete a DATIX incident report – including RIDDOR if indicated.
- record the event in the patient electronic record, complete the Post Falls Checklist, and review the Falls Risk Assessment.
- Continue to check with the individual who has fallen for 24-hours after their fall, to identify if any new signs of injury have emerged. The checks must include any changes to pain levels, posture and weight bearing ability/mobility, neurological status if head injury sustained and NEWS2.
- Inform the doctor on-call.

POST-FALL FLOW CHART FOR NURSE ACTIONS

This is a brief memory aid - if in doubt refer to your local post-fall protocol and/or seek senior advice.



- Community

If a patient falls when a clinician is present or is found on the floor, the clinician should refer to the Community Falls Guidance flow charts in Appendix 5 & 6. If an individual is obviously injured, the individual should be kept comfortable and should not be moved whilst an ambulance is called.

If the initial assessment indicates that there is no obvious injury, the clinician will complete a risk assessment to ascertain whether the patient can be moved safely, considering their physical abilities and cognition, while following the moving and handling policy and request appropriate assistance as required.

The staff member should:

- Review the cause of the fall and any actions that could be taken to maintain the patient's safety following the fall.
- Inform GP.
- Complete a DATIX incident report and update the patient electronic record with the event details.
- Review the falls risk assessment if this is in place. If a falls risk assessment is not in place, discuss falls prevention strategies, including a falls risk assessment, with the patient.
- Provide the patient/ service user and/or relative should be advised to contact GP if any new signs of injury have emerged e.g., changes to pain levels, posture and weight bearing ability/mobility.

7.6 Fractures and Serious Incidents

Slips, trips, and falls that result in a fracture requiring surgical intervention are usually considered to be a severe harm incident and, in accordance with National guidance (NHS England, Level of Harm) and Trust Policy, will require reporting, discussed at an appropriate level (Directorate review and Trust Incident Safety Panel) and determine a proportionate response for learning to be undertaken in line with the Trust's Incident Management Policy and Patient Safety Incident Response Framework (PSIRF) Policy and Plan. There are various learning response tools, and this may include completing a Patient Safety Incident Investigation (PSII). Please refer to the incident management policy or PSIRF policy/plan for learning response tools as well as for degree of harm grading in line with Learn from Patient Safety Event (LFPSE). Consideration must be given of this incident may be reported as a RIDDOR incident after consulting with the Health and Safety Manager.

Slips, trips, or falls that result in a fracture (or other significant injury including psychological harm) that do not require surgical intervention, require reporting as above may be discussed at Incident Safety Panel and a proportionate response undertaken.

7.7 Reporting Falls Incidents on Incident Reporting System Datix

Within the community, if a fall occurs within the patient's own home, a DATIX incident report is required only for falls that occur while a clinician is present (for both witnessed and unwitnessed falls). However, if the clinician arrives shortly after a fall or is involved in managing the post-fall incident, and the patient has sustained harm/ long lie, they should complete a DATIX. If a fall is reported by a patient that occurred at any other time, a DATIX report is not required. The staff member should ensure that a Falls Risk Assessment is completed/ reviewed.

Some falls incidents may be behavioural in nature, and it may be perceived by the clinician that the patient has intentionally put themselves on the floor. For falls which appear behavioural a falls DATIX still needs to be completed, unless the patient states prior to, or following the fall, that they had a clear intention to place themselves on a lower level.

For guidance on completing Falls incidents on DATIX, see appendix 8.

7.8 Falls and Safeguarding

When a fall occurs, there may be circumstances where a safeguarding referral is also required. The table in Appendix 3 should be used as a guide when considering if a fall requires a Safeguarding Adults referral, and is to be used in conjunction with CPFT / Cambridgeshire County Council / Peterborough City Council's Safeguarding Adults policies and procedures.

In accordance with the Safeguarding Policy and Section 42 of the Care Act 2014, there needs to be evidence or a strong suspicion where the local authority has reasonable cause to suspect that an adult (18 or over) in its area (whether or not ordinarily resident there):

1. has needs for care and support (whether or not the authority is meeting any of those needs),
2. is experiencing, or is at risk of, abuse or neglect, and
3. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this part of the Act or otherwise) and, if so, what and by whom.

Further information regarding safeguarding can be found in the Trust's Safeguarding Adults Policy on the Trust intranet.

7.9 Falls from a Height

The Trust has a duty of care to provide a safe and secure environment that provides protection against falls from heights in CPFT Properties/demised areas. Patients may be confused or may be intent upon self-harm due to the nature of their illness. Similarly, those with learning difficulties may be unaware of imminent danger or lacking in co-ordination. The following information therefore provides guidance on how to prevent any person from accidentally or intentionally falling, or climbing, from a window or structure and sustaining a significant injury because of the lack of, or defect to, a restrictive mechanism, window or physical barrier.

- All windows, irrespective of height from the ground will be restricted to an opening of less than 100mm.
- Departmental Managers are always responsible for ensuring that windows and areas where a fall from height risk exists, are safe, and that restrictors and barriers are in place, or, that any defects are reported immediately (including out of hours) to the Estates Provider and that appropriate interim action by departmental staff is taken.

Other areas posing a risk of falls from heights

Where there is a foreseeable risk that vulnerable individuals have access to an area where they could accidentally or intentionally fall from a height of 2 Metres or above, control measures need to be taken to either restrict unsupervised access or provide sufficient physical barriers to prevent a fall. Examples of risks could include:

- Stairways and walkways.
- Fire ladders and escapes (including external maintenance ladders)
- Verandas, patios, and gardens.

Where such a risk has been identified, a Risk Assessment should be undertaken, with immediate local managerial actions taken to ensure the safety of those who may use the areas.

Departmental Managers responsibilities in relation to falls from height:

1. Ensure regular environmental checks are undertaken including checking of windows and restrictors and reporting immediately any defects or issues identified to the Estates Provider.

2. Ensuring that risk assessments are carried out at a frequency of no less than annually or more frequently, proportionate with the risk of the area, using the Datix Risk Assessment. Together with ensuring that appropriate action is taken in the interim, this could mean locking the window where possible, or the area isolated.
3. Ensuring that defects are reported immediately (including out of hours) and appropriate action taken to protect patients against falls from heights whilst remedial work is in progress; including ensuring damaged windows are locked or sealed, if appropriate to a maximum opening of 100mm, until Estates staff have repaired the defect.
4. Ensuring that appropriate action to prevent falls from heights is taken immediately where a patient appears to be at higher risk.
5. Ensuring that any adverse event of an actual or potential injury relating to fall from heights is reported via the DATIX and that appropriate local action is taken.
6. Senior Locality Managers are responsible for ensuring annual risk assessments are undertaken by departmental managers. See Appendix 8 Windows Risk Assessment Questionnaire for further information.

All Trust Staff

It is the responsibility of every member of staff to help provide a safe environment, ensuring vigilance at all times, and informing the Estates Provider of defects (for example obvious defects - broken glass, or where a window has been tampered with) and where appropriate, reporting any adverse incidents.

Safe Use of Bedrails

Bedrails can be used to help prevent individuals falling out of bed and injuring themselves. They are not designed or intended to limit freedom of individuals, by preventing them from leaving their beds voluntarily; nor are they intended to restrain people whose condition disposes them to erratic or violent movement.

Bedrails are not appropriate for all individuals and their use may be detrimental. As a result, bedrails should be used only after a full, documented Risk Assessment has been carried out. For further information and guidance, refer to the CPFT Bed Rail Policy.

8.0 ASSOCIATED DOCUMENTS

This policy should be read in conjunction with the Trust's policies and guidance listed below:

- Physical Healthcare policy for Mental Health and Learning Disability Services
- Safeguarding Adults Policy
- Moving & Handling policy
- Management of Medical Emergencies Policy
- Resuscitation Policy
- Medicines Policy
- Therapeutic observations and engagement policy
- Bed rails Policy
- Admission transfer and Discharge Policy
- Health & Safety Policy
- Clinical Risk Assessment Policy
- Risk Assessment Policy
- Incident Management Policy including Serious Incidents & Near Misses
- Safe Handling of Heavy Plus Sizes People Protocol

9.0 REFERENCES & ACKNOWLEDGEMENTS

NICE Falls in older people: assessing risk and prevention, Clinical guideline [CG161]

NICE Head injury: assessment and early management, Clinical guideline [CG176]

PHE Falls: Applying all our health

RCP National Audit of In-patient Falls

Department of Health (2007) Essence of Care Benchmarks for the Care Environment.

Department of Health, London. www.dh.gov.uk/publications

DoH Health Building Note 00-10 Part A Flooring https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_A_Final.pdf Health and Safety Executive Slips and trips – general information <http://www.hse.gov.uk/slips/index.htm>

Risk of falling from windows – general information
<https://www.hse.gov.uk/healthservices/falls-windows.htm>

Slips and trips in health and social care – general information
<https://www.hse.gov.uk/healthservices/slips/index.htm>

Work at height – general information
<https://www.hse.gov.uk/work-at-height/index.htm>

Safe use of bed rails – general information
<https://www.hse.gov.uk/healthservices/bed-rails.htm>

Estates and Facilities Alert EFA/2013/002 Window restrictors

Husk J., Potter J., and Lowe D (2006) National Audit of the Organisation of the Services for Falls and Bone Health Royal College of Physicians January 2006

National Patient Safety Agency (2011) Essential care after an inpatient fall. Rapid Response Report. NPSA/2011/RRR001

National Patient Safety Agency (2007) Slips Trips and Falls in Hospital. The Third Report of the Patient Safety Observatory February 2007

10 MONITORING COMPLIANCE

Monitoring Compliance

The trust wide falls steering group will oversee the audit program which will incorporate participation in the National Audit of Inpatient Falls, Royal College of Physicians audit program and the local CPFT Falls Audit program.

The Falls Steering Group will collect and analyse DATIX reports in relation to falls to identify emerging themes and develop action plans, where required.

Clinical and ward managers will ensure critical incidents are analysed, and action plans put in place to reduce risk.

The outcome of the National and local audit program, along with the analysis of Datix incidents will be reported to the Falls Steering Group and presented to the Patient Safety, Risk & Experience Group as appropriate.

Document Section		Control	Check to be carried out	How often will the check be carried out	Responsible for carrying out the check	Results of check reported to	Frequency of reporting
Page	Section	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?

11 APPENDICES

1. Equality & Diversity Impact Assessment
2. Falls Prevention Pathway Dashboard (SystemOne)
3. Safeguarding and Falls
4. Falls Prevention Pathway Community and Primary Care
5. Patient fall during a visit – Post falls guidance for CPFT community staff
6. Patient found on the floor – Post falls guidance for CPFT staff.
7. When a patient is found on the floor – Post falls guidance for community staff 'I STUMBLE'
8. Windows risk assessment questionnaire

APPENDIX 1: EQUALITY AND DIVERSITY IMPACT ASSESSMENT

An Equality and Diversity Impact Assessment has been completed to assess the potential impact this policy might have upon protected groups or how it is likely to influence the Trust's ability to comply with the Public Sector Equality Duty.

The author of this document has considered any potential impacts. There are *no* specific adverse impacts for people with protected characteristics identified.

If you require this policy in a different format (e.g. larger print, Braille, different language or audio) please contact the Corporate Governance Team (corporategovernance@cpft.nhs.uk).

Who will be affected by the content of this document? (e.g. staff, patients, service users etc.)	Staff, patients, carers, family
What are the desired outcomes of this document?	To ensure all patients receive a risk screen/ assessment as identified with preventative measures agreed and those who fall are treated with dignity and respect and all safety precautions taken.
What does this policy, function, process link to in terms of wider business plans and objectives?	Falls prevention

Evidence Considered:

Please see Reference list

When assessing potential impacts of this document on equality groups, the following has been demonstrated, in accordance with General Duty of the Equality Act 2010:
(Please tick the appropriate boxes)

Age <i>Consider age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Armed Forces Community	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment

Disability <i>Consider any attitudinal, physical and social barriers.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Carers <i>Consider part-time working, shift-patterns, general caring responsibilities.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Gender Identify or Reassignment <i>Consider transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Marriage and Civil Partnership	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Pregnancy and Maternity <i>Consider working arrangements, part-time working, infant caring responsibilities.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Race <i>Consider difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Religion or Belief <i>Consider people with different religions, beliefs or no belief</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Sex (Gender) <i>Consider men and women (potential to link to carers below).</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment

Sexual Orientation <i>Consider heterosexual people as well as lesbian, gay and bi-sexual people.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment
Other <i>Consider and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.</i>	<input type="radio"/> Positive	<input type="radio"/> None	<input type="radio"/> Negative	<input type="radio"/> Comment

Engagement and involvement

Have you consulted or engaged stakeholders in testing and/or gathering evidence to support the content of this policy? No
 If so, with whom?
 If not, why not?

Action Planning for Improvement:

	Action/s required to address gap:	Target Date	Executive Lead
Gaps and Challenges	NA		
Monitoring, evaluating & reviewing	Policy will be reviewed every 3 years in line with Trust policy procedures	Feb 2028	Director of Nursing, AHPs & Quality

Agreement by:	Signature:	Date:
Equality, Diversity and Inclusion Lead (if required)	Sue Rampal Equality and Diversity	04/02/2025
Chair of Approving Executive Led Group (Level 2)	Patient Safety Executive Group	January 2025
Document Author	Director of Nursing, AHPs & Quality	January 2025

APPENDIX 2 FALLS PREVENTION PATHWAY DASHBOARD (SYSTEM ONE)

There is a trust wide falls prevention dashboard which houses all relevant templates. This is available on service dashboards and/or the clinical tree.

The screenshot shows a web application window titled "CPFT Falls Prevention Pathway Dashboard". At the top, there is a search bar with "Exact date & time" selected, showing "Tue 02 Jan 2024" and "13:18". A warning message states: "Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button" with a "Hide Warning" link. Below this, there are tabs for "Dashboard", "Community", and "Inpatient". The main content area has a purple header with the title "CPFT Falls Prevention Pathway Dashboard" and the text: "This template is designed to facilitate the recording of Patient falls. Please select below which setting the patient is in. Here you will find all the templates you need for data recording." There are two buttons: "Community" and "Inpatient". Below this, it says "Below you can see history of all falls templates and their recording in the dashboard?". A large empty box is labeled "Open Referrals In". At the bottom right, there are two checkboxes: "Show recordings from other templates" (checked) and "Show empty recordings" (unchecked). A dark blue footer bar contains buttons for "Information", "Print", "Suspend", "Ok", "Cancel", and "Show Incomplete Fields".

APPENDIX 3 SAFEGUARDING & FALLS

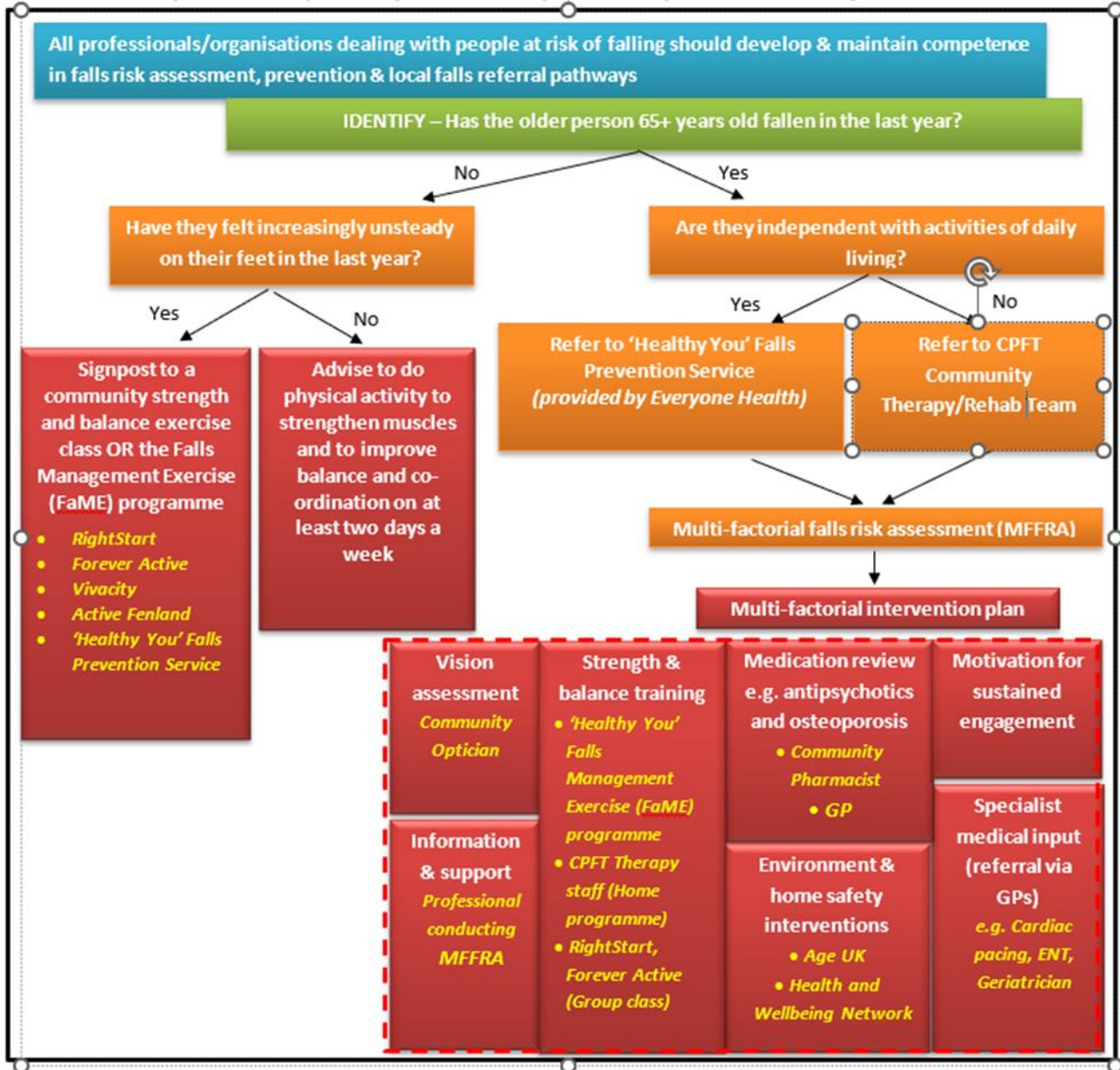
The table below should be used as a guide when considering if a fall requires a safeguarding adults referral, and is to be used in conjunction with CPFT/Cambridgeshire County Council/Peterborough City Council's Safeguarding of Vulnerable Adults policies and procedures.

SAFEGUARDING REFERRAL NOT REQUIRED	SAFEGUARDING REFERRAL REQUIRED	SAFEGUARDING REFERRAL REQUIRED	SAFEGUARDING REFERRAL REQUIRED
<p>- Choose 'no' to possible safeguarding on DATIX.</p>	<p>-Choose 'yes' to possible safeguarding on DATIX.</p>	<p>-Choose 'yes' to possible Safeguarding on DATIX. -Discuss potential MASH referral with ThinkFamily practitioner.</p>	<p>-Choose 'yes' to possible Safeguarding on DATIX. -MASH referral. -Discuss with ThinkFamily Practitioner for further advice.</p>
<p>A single fall resulting in no harm when the cause is related to the service user's mental health, gait or spatial/perceptual deficits (cause originating from the service users mental/physical presentation). No evidence of abuse.</p>	<p>Recurring falls in relation to one or more adult service users in which the cause of the fall(s) originate with the service user(s) mental/physical presentation. The fall(s) result in no harm but there is potential for harm given consideration for the potential of neglect. For example: a lack of 'Falls' care planning or a lack of staff adherence to the falls care plan.</p> <p>A single fall in a care setting when the cause of the fall is the result of an environmental problem/medication/potential staff neglect issues. Examples include:</p>	<p>Recurrent falls that affect two or more adults that result in harm.</p> <p>A fall on a wet floor in a care setting. Investigation into a fall on a wet floor in a care setting should consider:</p> <ul style="list-style-type: none"> • Was the floor cleaned properly? • Was the floor cleaned up after a spill within an appropriate timeframe? • Was a wet floor sign put out while the floor was drying? • Did the service user have capacity to understand any signage displayed? • Did staff encourage service users away from the wet floor? 	<p>A pattern of recurring falls resulting from the same or related environmental problem/medication/potential staff neglect issues in a care setting.</p> <p>A single fall in a care setting that results in serious harm, ill-health or death.</p>

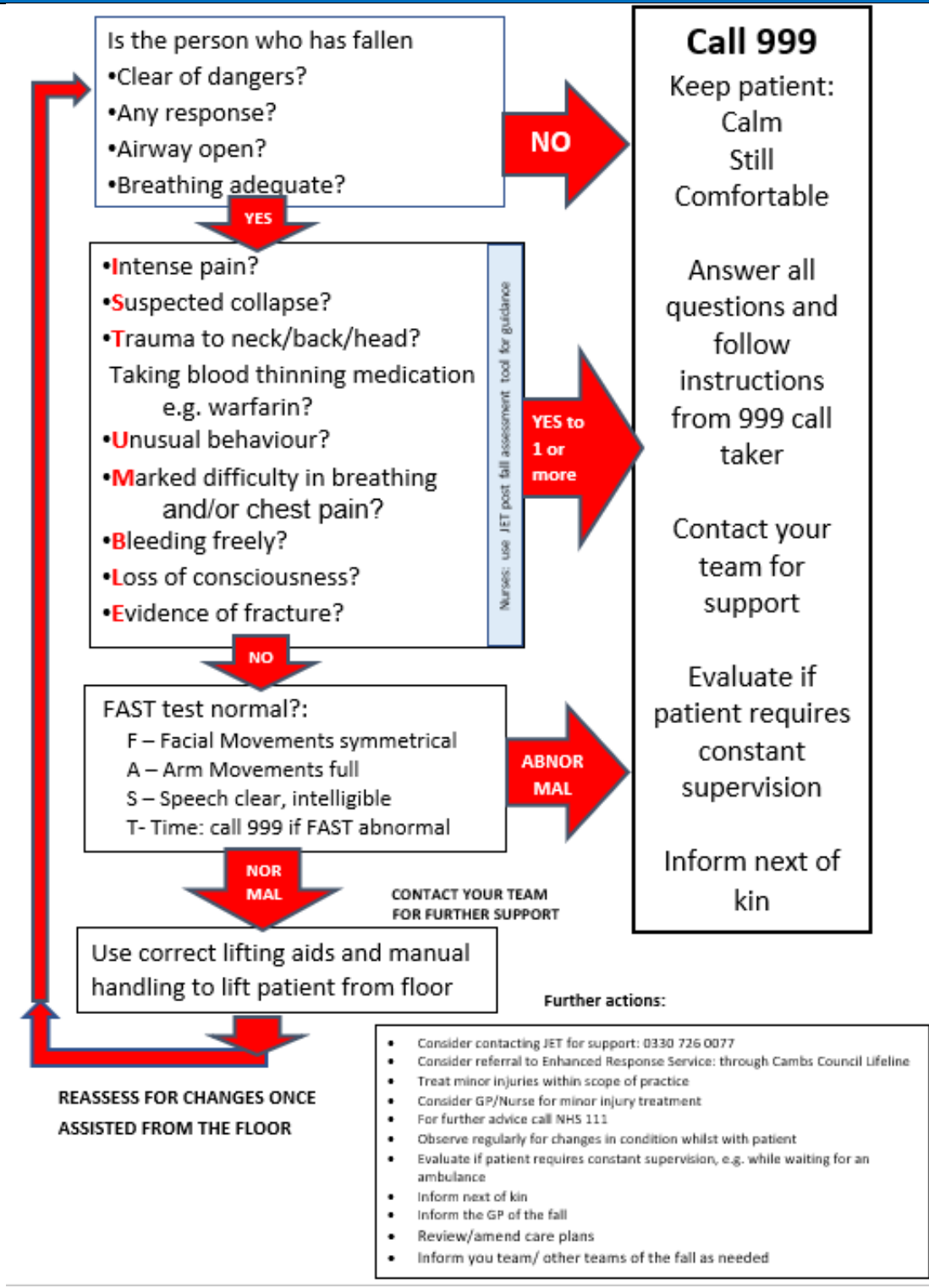
	<ul style="list-style-type: none"> • Medication, e.g. over-sedation, side effects such as dizziness. • A trip hazard, e.g. wet floors, ill-fitting carpets, clutter, furniture/ equipment in pathways. • Poor lightning. • Inappropriate height of furniture like chairs and sofas. • Lack of walking aids/support provided when need is identified. <p>A single fall where the falls was predictable, but no preventative measures in place.</p>	<ul style="list-style-type: none"> • Are care plans re; 'falls' appropriate? <p>If the above preventative measures were present, a fall on a wet floor may still be considered an accident. A single fall where the risk had been identified but no protective measures put in place or protective measures planned but not implemented.</p>	
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APPENDIX 4 FALLS PREVENTION PATHWAY COMMUNITY & PRIMARY CARE

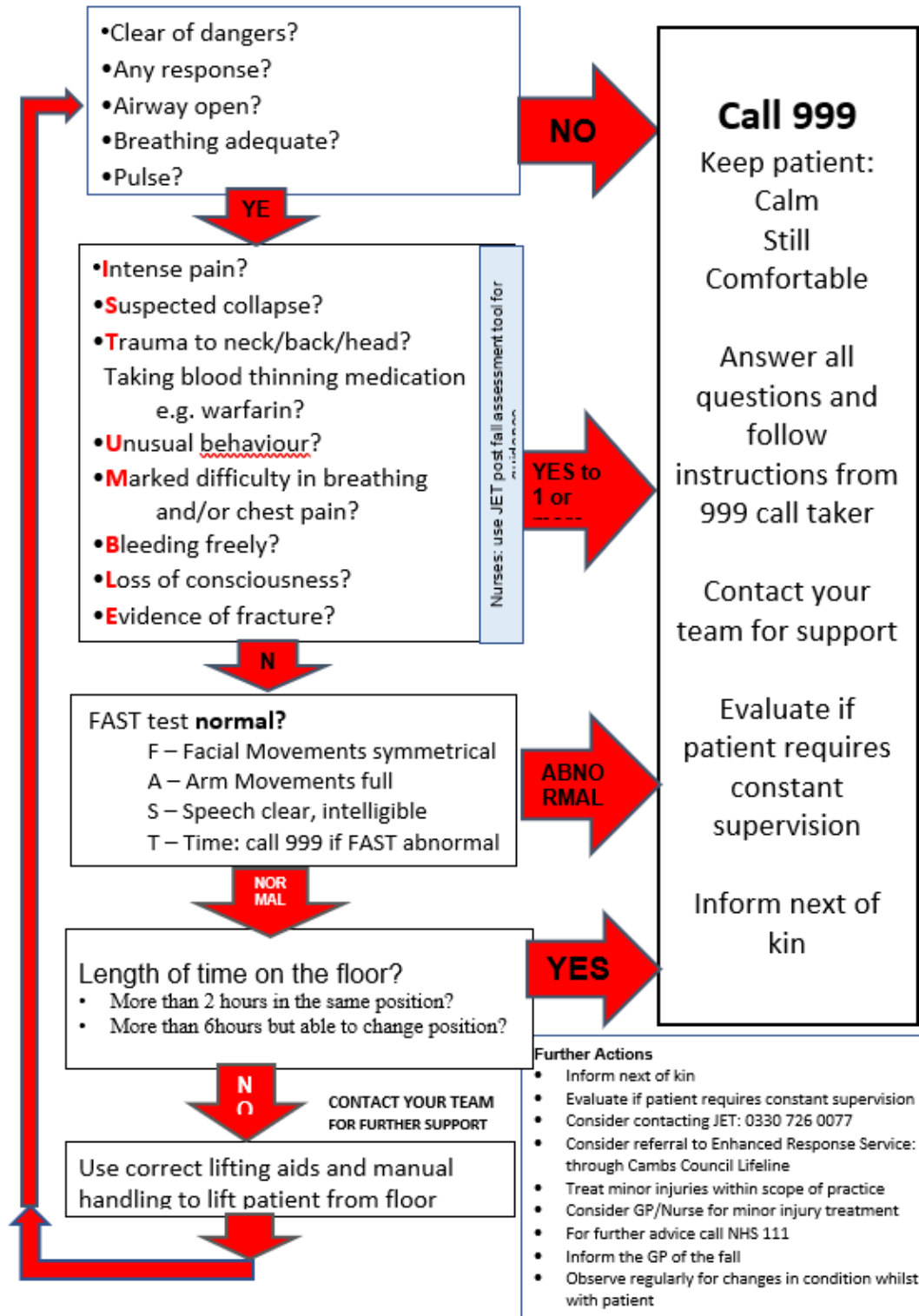
Falls prevention pathway: Community & Primary Care Level – v2j



APPENDIX 5 PATIENT FALL DURING A VISIT - Post falls guidance for CPFT community staff



APPENDIX 6 PATIENT FOUND ON THE FLOOR - Post falls guidance for community staff



APPENDIX 7 'I STUMBLE' - GUIDANCE

Intense Pain

- New pain since fall, including:
 - Head or back pain
 - Headache, chest pain and abdominal pain
 - Consider both pain from injury caused by fall or medical causes

Suspected Collapse

- Ask resident if, before their fall, they:
 - Tripped - Collapsed
 - Felt Dizzy - Felt Nauseous

Trauma to Neck/Back/Head

- New pain in neck/back/head following fall
- New lump or dent in head with/without bleeding
- Any new numbness/paralysis in any limbs

Unusual Behaviour

- New confusion
- Acting differently to normal self e.g. agitated, drowsy, quiet
- Difficulty speaking e.g. slurred speech, words mixed up, marked stuttering

Marked Difficulty in Breathing/Chest Pain

- Severe shortness of breath, not improved when anxiety is reduced
- Unable to complete sentences
- Blue/pale lips, blue fingertips, becoming lethargic or confused

Bleeding Freely

- Free flowing, pumping or squirting blood from wound
- Apply constant direct pressure to injury with clean dressing (elevate if possible)
- Try to estimate blood loss (per mugful)

Loss of Consciousness

- Knocked out
- Drifting in and out of consciousness
- Limited memory of events before, during or after fall
- Unable to retain or recall information/repeating themselves

Evidence of Fracture

- Obvious deformity e.g. shortened/rotated, bone visible, severe swelling
- Reduced range of movement in affected area
- Unusual movement around affected area

In all **999** cases remember to keep resident: CALM, STILL & COMFORTABLE
If any bleeding is present, apply constant direct pressure with a clean dressing

Post-fall flow chart adapted from ISTUMBLE for CPFT use with agreement November 2022

APPENDIX 8 WINDOW RISK ASSESSMENT QUESTIONNAIRE

To be carried out by Departmental Heads Annually or more frequently, proportionate with the risk, until full window restriction is implemented.

Unit	Department	Manager	Signature	Date
Question	Yes/No	Action required	By Whom	Target Date
<p>Are all opening windows (each pane), which open at a level above 2 metres from the external ground floor level (even if this opens to a roof top or ledge) permanently restricted to an opening of no more than 100mm?</p> <p>If you are awaiting fitting or restrictors have you taken appropriate action to prevent falls from heights?</p>				
<p>Where any window that opens below 2 metres from the external ground floor level have a significant risk of injury following a fall from the window due to the nature of the material onto which a person will fall (e.g. glass, spikes, barbed wire, water, chemicals etc) are the windows permanently restricted to an opening of no more than 100 mm?</p> <p>Where there any windows below 2 metres where there is a foreseeable risk of accidental or intentional harm to self or others through the absconding of an inpatient, are the windows permanently restricted to an opening of no more than 100mm?</p> <p>If No, to the above have you sought approval from your Senior Manager and instructed Estates Department to fit restrictors?</p>				
Unit	Department	Manager	Signature	Date
Question	Yes/No	Action required	By Whom	Target Date
<p>If you are awaiting fitting of restrictors, have you taken appropriate action to prevent falls from heights?</p>				
<p>Where any window restrictors are fitted, can they be manually disengaged?</p> <p>If Yes, to the above, has this been reported to Estates?</p> <p>Do you consider all fitted restrictors able to resist accidental or forcible destruction using exceptional physical force?</p> <p>If No to the above, has this been reported to Estates?</p> <p>If you are awaiting remedial work on restrictors have you taken appropriate action to prevent falls from heights?</p> <p>Are all specialist tools to open restrictors held only by Estates staff?</p> <p>If No to the above, are you taking action to ensure departmental staff and patients will not have access to tools capable of disengaging restrictors?</p>				

Unit	Department	Manager	Signature	Date
Question	Yes/No	Action required	By Whom	Target Date
<p>Do any window restrictors fitted or windows appear defective?</p> <p>If Yes, to the above has this been reported to Estates Department and have these windows been locked or sealed, if appropriate to a maximum opening of 100mm, until Estates staff have repaired the defect, and have staff ensured that they take appropriate action whilst awaiting Estates staff to take remedial action, this could mean locking the window, where possible, or restrictions to the vicinity?</p>				
<p>Do you consider your department needs a higher specification of window or window restrictor due to a higher risk of harm to self and others?</p> <p>If you answered yes to the above, have you sought approval from your Senior Managers and Estates informed of the additional specification required.</p>				
<p>If your area subject to environmental controls with regards to removing ligature points?</p> <p>If Yes, to the above, do your windows comply with environmental controls in relation to ligature points?</p> <p>If No, to the above have you informed the Estates Department or sought Line Management approval for remedial work to be undertaken?</p>				
Unit	Department	Manager	Signature	Date
Question	Yes/No	Action required	By Whom	Target Date
<p>Are there any other areas, such as balconies, fire ladders and escapes, stairways and walkways, that vulnerable service users, public or staff could access where physical barriers are insufficient to prevent an accidental or intentional (vulnerable service users) fall from a height?</p> <p>If you answered yes, to the above have you considered appropriate arrangements to prevent such a risk?</p>				
<p>Where additional physical barriers are considered, have you sought approval from your Senior Managers and Estates informed of the additional specification required?</p>				
<p>Where work by staff is carried out at height*, are there sufficient arrangements in place to prevent any person falling a distance liable to cause personal injury?</p>				