Cheshire and Wirral Partnership
NHS Foundation Trust

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Management of Slips, Trips and Falls

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Type of document	Guidance
Target audience	All CWP staff including temporary staff
Document purpose	To outline and provide guidance to effectively manage the risks associated with slips, trips and falls involving service users, staff and others.

Approving meeting	Clinical Practice and Standards Sub-Committee	Date December 2020
Implementation date	1st February 2021	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
GR1	Incident reporting, management and review policy
CP1	Admission and discharge from hospital policy
GR26	Safe manual handling of people and loads policy
GR2	Health and safety arrangements and responsibilities
GR3	Risk management policy
GR46	Camera Surveillance CCTV policy

Document change history	
What is different?	Removal of FRAT as guided by NICE Guidance
Appendices / electronic forms	Inclusion of PAINAD scale and link to Dis DAT tool
What is the impact of change?	

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Matrons, Occuptional Therapists, Physiotherapist, Clinical Education Trainers, Dementia Lead
Corporate services	Via policy discussion forum
External agencies	N/A

Financial resource implications	None

External references
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart 1 – Guideline for falls management

IDENTIFY RISK
All inpatients must have an initial Falls Risk Assessment completed on admission

All individuals referred to community physical health services must have a Falls Risk Assessment completed as part of their initial assessment.

Community Mental Health Teams, Community Learning Disability Teams and Children and Young Peoples (including CAMHS) community services must complete an Initial Falls Risk Assessment if there is any indication that the individual is a risk of falls on their referral into the service.

If staff record a yes in any area of the Initial Falls Risk Assessment then a Multi Factorial Assessment (MFA) must be completed to assist staff to identify why the person may be at risk of falling

MANAGE THE RISK
Devise an individualised care plan based on the risk assessment to reduce, remove or manage risk

Actions may include: medical review, environmental adaptations, review of medicines, toileting plan, support to increase fluids or therapy assessment as identified in the MFA

Involve the MDT including the patient and family if able to. Keep the team updated especially when circumstances change,
Consider the use of written information such as information leaflets

Ensure appropriate action are taken and documented

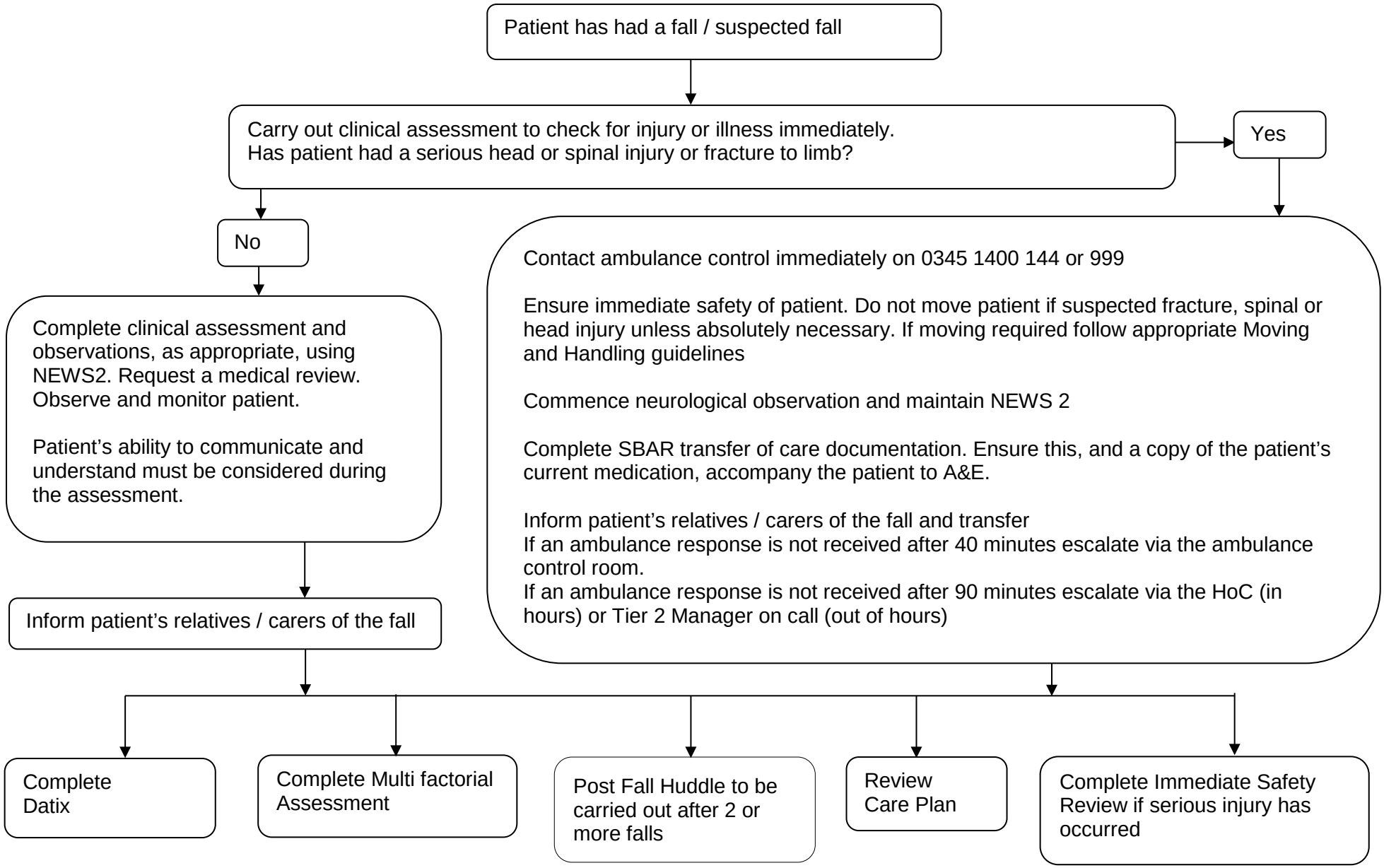
REVIEW
In the event of a fall, review the MFA and update the care plan, including interventions to try to reduce the risk of further falls

Review MFA following a change in circumstance i.e. ward move or a change in health status

Ensure appropriate actions are taken and documented

SPECIAL NOTE
Ensure any person who has fallen is managed in accordance with the care plan.
Ensure all falls are recorded on Datix.
As part of discharge planning, identify which risks still remain and what follow-up is required to continue to address this risk.
A Falls Huddle must be carried out for inpatients after 2 or more falls.

Quick reference flowchart 2 – Falls management process for Inpatients



1. Introduction

Over 200,000 people every year are admitted to hospital for treatment after a fall and up to 14,000 people a year die in the UK as a result of an osteoporotic hip fracture. Each year approximately 200,000 falls are reported in acute hospitals in England and Wales, with more than 36,000 reported in Mental Health Units and 38,000 reported in community hospitals.

Falls by inpatients are associated with increased duration of stay in hospital and a greater chance of unplanned re-admission or of discharge to residential or nursing home care.

It may not be possible to completely stop people falling but we can mitigate the risks if we are able to assess them correctly and introduce interventions specific to that person, which are documented and shared. Falls are among the most common and serious problems facing the older population.

The incidence of falls and the severity of fall related complications rise steadily after the age of 60 and the impact of a fall (or series of falls) often goes beyond physical pain and can lead to long term disability, anxiety, depression, social isolation and a loss of confidence.

Falls have been reported to the National Reporting and Learning System, which is overseen by NHS England from all types of locations where healthcare is provided to patients. This data shows incident rates of falls in hospitals and nursing homes are almost three times the rates for community dwelling persons over the age of 65 years and that falls comprise a quarter of all types of patient safety incidents reported from Mental Health Units.
The process for managing assessing and monitoring the risks associated with slips, trips and falls involving patients, staff and others form part of the criteria of the NHS Resolutions (NHSR) Risk Management Standards for Trusts.

2. Purpose

The purpose of this guidance is therefore to ensure that an integrated multi-professional approach is adopted for the management of all patients who are at risk of falling or who have already fallen. This will ensure that each individual patient has an adequate falls assessment undertaken and an appropriate management plan initiated and implemented.

The NICE Guideline CG161 provides recommendations for the assessment and prevention of falls in older people and includes assessing and preventing falls in older people during a hospital stay (inpatients). People 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 included in the NICE Guideline recommendations for assessing and preventing falls in older people during a hospital stay.

3. Definitions

A **slip** is to slide accidentally, causing the person to lose their balance; this is either corrected or causes a person to fall.
A **trip** is to stumble accidentally, often over an obstacle causing the person to lose their balance; this is either corrected or causes a person to fall.
A **fall** is **defined** as an event which causes a person to, unintentionally, rest on the ground or other lower level.
An **incident** is defined as being found on floor, whereby a slip, trip or fall has not been witnessed but the outcome may be the same.
A **near miss** is defined as a prevented fall where the interaction of another prevents the fall from happening.

4. Scope

This guidance applies to all permanent, locum, agency and bank staff who are involved in the care of patients with Cheshire and Wirral Partnership NHS Foundation Trust (CWP).

5. Health Care Professional Responsibilities

Whether on admission to an inpatient ward or unit, at the point of initial assessment in the community or following transfer between services; it is the responsibility of the assessing clinician to obtain the patient's history of falls and to complete the Initial Falls Assessment Tool (Appendix 1). If risks are identified, a qualified clinician must complete the Multi-Factorial Assessment Tool (MFA) (Community MFA Appendix 2 and Inpatient MFA Appendix 3) which will direct the interventions and care required.

The clinician must ensure that all documentation is completed including the Initial Falls Assessment. Patients who have a 'YES' to any one of the five screening questions on this assessment must also have a Multifactorial Risk Assessment (MFA) completed. A care plan based on the risks identified from the MFA must be included in the patient's care records.

It must also be noted in the patient's careplan how carers and relatives wish to be contacted, day or night, should a fall occur.

Inpatient services to record this information in the contingency section of the careplan; Community staff to record in written Consultation Document

6. The Falls Group

CWP has a Falls Group that meets bi-monthly in line with NICE guidelines. The aim of the group is to:

- Monitor best practice and review falls incidents, themes and trends;
- Ensure learning from falls related incidents are shared widely across CWP and actions are able to be implemented and monitored;
- Review and maintain the Slips, Trips and Falls Policy.

The Falls Group includes, in its membership, specialists who can advise other teams or individuals on any operational issues relating to falls reduction and management.

7. Risk Factors for slips, trips and falls

Reducing the risks of falls depends on identifying those most at risk of falling and co-ordinating appropriate interventions. Interventions which target both multiple risk factors for individuals (intrinsic risk factors) and environmental hazards (extrinsic risk factors) are the most successful. (For Assessment and Intervention Advice, and Guidance for Staff see Appendix 4 and Appendix 5)

Research consistently indicates the following as being the key risk factors for falling:

- Age; falls are more common from the age of 75 years;
- Falls history, including causes and consequences such as injury and fear of falling;
- Balance, gait, transfer or mobility problems;
- Degenerative joint disease, motor disorders including stroke, Parkinson's disease and neurological degeneration including dementia;
- Frailty;
- Postural hypotension / dizziness;

- Polypharmacy and side effects of medication, in particular, centrally sedating drugs, e.g. benzodiazepines, phenothiazine, anti-depressants and blood pressure lowering medications;
- Lack of spatial awareness;
- Seizures;
- Changes in prescribed medication;
- Visual and hearing impairments;
- Acquired Brain Injury;
- Learning Disability;
- Physical inactivity leading to muscle weakness;
- Cognitive impairment / Dementia;
- Confusion;
- Delirium;
- Continence problems;
- Alcohol intake;
- Inappropriate footwear / poor foot health;
- Syncope syndrome - a temporary loss of consciousness usually related to insufficient blood flow to the brain;
- Environmental factors including - poor lighting, steep steps, loose carpets or rugs, slippery floors, clutter;
- Lack of safety equipment such as grab rails;
- Unfamiliar environment / disorientation.

8. Falls in dementia

The annual incidence of falls in people with dementia is 40-60%. Serious injury is more common and one quarter of patients with dementia who fall sustain a fracture: three times the age adjusted figure for expected fracture incidence. In addition, patients with dementia who fall have a poorer prognosis than cognitively normal older fallers. They are less likely to make a satisfactory recovery from injury, five times more likely to be institutionalised and after a fractured neck of femur have a 6 month mortality of 72% which is more than three times that of cognitively intact patients.

9. Assessments

The Trust's falls assessment tools, in conjunction with multi-disciplinary interventions, aim to reduce the risk of patient falls. The tools will identify patient's level of need to minimise the risk of falling and, by implementing appropriate interventions, reduce the number of falls incidents.

9.1 Initial Falls Assessment Tool

An assessment of falls risk must be carried out on all patients using the Initial Falls Assessment Tool at the following stages:

- On admission to hospital;
- On first referral to community physical health services;
- On transfer to other wards/areas;
- When risk factors change;
- Community Mental Health Teams, Community Learning Disability Teams and Children and Young People including CAMHS must complete an Initial Falls Risk Assessment if there is a risk of falls indicated for any individual referred into these services.

Patients who have a 'YES' to any one of the five screening questions on the Initial Falls Risk Assessment should have a multifactorial risk assessment (MFA) and care plan completed.

A Patients Falls Prevention Leaflet can be provided by staff and the risk factors and management plan explained to them and their families, as appropriate.

If a person falls the mechanism of the fall must be discussed and documented and a MFA assessment completed. If deemed appropriate a referral should be made to the appropriate service.

9.2 Non-communicative patients

If a patient is non-communicative staff could consider completing either the Disability Distress Awareness Tool or the PAINAD Tool (Appendix 6) to assist them in caring for a patient and understand changes in presentation.

9.3 Multifactorial Falls Assessment Tool (MFA)

As important as identifying risk factors is, it is necessary to understand and appreciate the interaction and probable synergism between multiple risk factors. Several studies have shown that the risk of falling increases dramatically as the number of risk factors increases.

As with all clinical guidance the assessment tool does not preclude clinical judgement. This tool includes a clinician's assessment based on their clinical judgement.

A multifactorial falls risk assessment may include the following:

- Identification of falls history;
- Assessment of gait, strength, balance and mobility;
- Assessment of fracture risk;
- Assessment of perceived functional ability and fear relating to falling;
- Assessment of visual impairment;
- Assessment of cognitive impairment and neurological examination;
- Assessment of urinary incontinence;
- Assessment of environmental hazards;
- Cardiovascular examination and medication review. (This should include a lying and standing blood pressure, performed as soon as practicable, and that appropriate actions are taken when orthostatic/ Postural Hypotension is identified).

9.4 Post Falls Huddle

A Post Fall Huddle to be carried out after 2 or more falls in inpatients. The huddle should be multi-professional and held as soon as possible after the patient fall occurred. It is advisable to keep the huddle brief, involve the patient (and family) if possible and update the care plan (Appendix 7).

10. Fractures

Fractures can be characterised as: displaced or non-displaced.

A displaced fracture occurs when the bone breaks into two or more parts.

However, not all fractures are obvious to the naked eye and do not result in deformity, these are known as non-displaced fractures. A non-displaced fracture occurs when the bone cracks, but maintains its proper position and alignment and staff must be aware that only a small movement in a certain direction can cause displacement.

Other signs of a fracture are pain, tenderness on palpation and reluctance to weight-bear on the affected limb. If staff are at all concerned that a patient may have sustained a non-displaced fracture they must ask for medical assistance.

11. Actions to take following an inpatient fall (see Quick Reference Flowchart 2)

If a patient experiences a fall in any in patient setting then the following interventions must be followed.

- Carry out immediate clinical assessment to check for injury and illness immediately
  - Refer to medical practitioner immediately if serious injury suspected. Clinical staff to assess if patient has a serious injury requiring immediate attention such as a serious head, fracture of major limb or spinal injury. Clinical staff to contact ambulance service immediately if required. Ensure immediate safety of patient; do not move the patient unless absolutely necessary, so as not to further exacerbate the injury;
- Information for ambulance control
  - Nursing staff must inform ambulance control that the patient has a suspected fracture or other serious but non-life threatening injury, and must also ensure that all appropriate clinical information is handed over as part of the call, indicating that we as a healthcare provider cannot safely treat the patient;
- Undertake clinical observations
  - In in-patient areas this must include blood pressure, pulse, temperature, respiratory rate and oxygen saturations recorded on NEWS 2. Commence neurological observations when a head injury is known or suspected. Patient's ability to understand and communicate must be considered during the assessment;
- Complete SBAR for transfer
  - Clinical staff to complete SBAR and ensure document and copy of the patient's current prescription accompanies the patient/patient escort to Accident and Emergency Department;
- Communication with next of Kin
  - Contact next of kin and inform of current situation as agreed at the point of admission;
- Complete Datix;
- Reassess the patient
  - Reassess patient using the falls assessment tool. Commence or reassess falls care plan in nursing/clinical records;
- Documentation
  - Clinical staff to document in clinical records the chronology of events, the factors observed and the response to care. Detail circumstances surrounding the fall, e.g. where and when did the fall occur, what the patient was doing will be documented;
- Complete Immediate Safety Review
  - This should be undertaken by ward manager following a serious incident. The findings of which should be shared through CWP's Falls Group;
- Falls Safety Huddle
  - If patient has had two or more falls, a falls safety huddle should occur.

12. Actions to take following a fall in any community setting

- If a patient experiences a witnessed fall in any community setting, the clinician must undertake a clinical assessment;

- This may include blood pressure, pulse, temperature, respiratory rate and Oxygen saturation;
- Check for injury and illness immediately and consider appropriate medical intervention such as GP/or emergency services;
- If the fall is witnessed or the patient is found on the floor then a Datix must be completed. All information must be recorded on EMIS or Clinical Record System. NOK must be informed with the patients consent.

Appendix 1 - Initial Falls Assessment Tool for all services

Complete on initial assessment, admission, transfer or if condition changes*.	Yes	No
Is there a history of one or more falls in the last year?		
Do they appear unsteady when mobilising?		
Is the patient anxious about falls?		
Does the person show signs of being confused or disorientated?		
Are they on 4 or more medications or on a medication that increases falls risk?		

*Patients MUST be reviewed if their condition changes

Appendix 2 – Community Multifactorial Falls Assessment

History of present condition	
How many falls in the past 12 months?	
Is there a pattern to the falls?	Yes No
Is there a diagnosis of osteoporosis?	
Is the patient taking medication for osteoporosis?	
History of taking long term steroids?	
Any previous fractures?	
Is there a diagnosis of rheumatoid arthritis?	
Smoking status (current smoker, non-smoker)	
Alcohol status (Alcohol use / Current non-drinker / Daily drinker)	
Does patient have any underlying physical health conditions? (see Section 7 of the Management of Slips, trips and Falls Guidance)	
Is the patient on 4 or more medications?	
Is the patient on blood pressure medication?	
Clinical recordings	
Weight	
Height	
BMI	
Lying Blood Pressure	
Standing Blood Pressure	

Outcome measures				
Timed up and go	Unable	0-14 seconds	15 -29 seconds	30+ seconds
Chair sit to stand test	Unable	0-14 seconds	15 -29 seconds	30+ seconds
Four point balance test	Feet together	Semi-tandem	Tandem	Single leg stand

Outcome				
Is Patient at risk of falls?	Yes		No	
Falls risk identified?	If yes what is the risk?			
Medical condition	Osteoporosis	Dizziness	Medication	Other
Decreased balance	Mobility / transfers	Gait abnormality	Impaired Vision	

Other	Hearing impairment	Poor foot health	Alcohol misuse
	Continence	Cognitive decline	Smoker
	Nutrition	Coping Skills	Environment

Action Plan		
Falls risk identified	**Action / Intervention required**	**Review Date**

Appendix 3 – Inpatient Multifactorial Falls Assessment and Intervention Guidance

All Interventions must be made in collaboration with the patient where possible. **Staff maintain responsibility to maintain interventions to reduce the risk of falling for patients with cognitive impairment.**	**Yes**	**No**
Does patient have any underlying physical health conditions? (see Section 7 of the Management of Slips, Trips and Falls Guidance)		
Medication that may suppress central nervous system Use of 1 or more for more than two weeks?		
Poly pharmacy Is the person on 4 or more medications? Is patient requiring analgesia? Has patient had a medication review?		
Alcohol intake Does patient consume more than 1 unit per day?		
Postural Hypotension Record BP after 5 mins rest in supine position, record again after 1 min standing up. A drop in systolic BP > 20 and /or drop in diastolic >10 suggests postural hypertension **or** if patient is symptomatic i.e. dizzy on standing/sitting up?		
Vision Does patient have difficulty reading newspaper or book, cannot recognise an object across the room or has recently started wearing bifocals? Are glasses close to hand and clean so patient can see through them?		
Hearing Patient has difficulty hearing conversational speech? Does patient wear a hearing aid and is it switched on?		
Gait Patient is unsteady on feet, shuffles or takes uneven steps or is housebound		
Transfers Patient lacks control or is unsteady when moving between surfaces		
Balance Patient needs to hold onto furniture and requires stick or walking frame?		
Environment Are there any slip / trip hazards such as clutter or poor lighting? Is call bell at hand and can patient use it? Is patient using the correct equipment to minimise falls risk including for example; slip mats for chairs, walking frames and safety straps for wheelchairs		
Footwear Is patient's footwear supportive and well-fitting with non-slip soles?		
Confusion Does the patient show any signs of confusion, dementia, delirium or disorientation?		
Osteoporosis risk factors: Is the patient on medication for Osteoporosis? Any previous history of fractures? Early menopause or early hysterectomy < 45 years		
Steroids Has patient been taking steroids for 3 months or more?		
History of fractures		
Reduced mobility Has patient had any long-term immobility?		
Smoking Does patient smoke or have they a history of smoking?		
Weight Low BMI or high BMI?		

Has nutrition and hydration assessment been undertaken?		
Continence Is the patient incontinent of urine? Do you need commode or urinals? Are they accessible and within reach?		
Patient Involvement Has patient and /or their family or carers been involved in the falls assessment and has falls leaflet been provided?		

Action Plan		
Falls risk identified	**Action / Intervention required**	**Review Date**

Appendix 4 - Assessment and Intervention Guidance

Problem	Intervention	Referral
History of Falling	Review incidents – action plan to prevent future falls. Discuss fear of falling and realistic preventative measures. Does patient know how to get up after a fall?	OT Physiotherapist GP
Number of Medications	Ask if any symptoms of dizziness. Review medication being prescribed and if appropriate contact Doctor/ Pharmacist for review.	Doctor Pharmacist
Central Nervous System Suppressants	Identify type of medication being prescribed, i.e. hypnotics, anti-depressants, sleeping pills, anti-psychotics. Discuss any changes in sleep pattern and discuss sleep promoting behaviours.	Doctor Pharmacist
Alcohol Intake	Discuss immediate and long-term fall risk. Longer alcohol clearance times in old age and potential interaction with medication. More than one small glass of wine/ small sherry/ small measure spirits/ ½ pint lager or beer per day can increase falls risk. Too much alcohol is toxic to bone tissue.	Relevant local healthcare professionals
Postural Hypotension	Raise awareness of stabilising after changing position and before walking. Extra pillows to raise head or consider raising bed if severe. Avoid dehydration. Refer to doctor for medication review if appropriate as PH can be a medication side-effect. Arrhythmias can cause falls.	Doctor Pharmacist
Vision	Raise awareness of risks of falls due to blurring and difficulty in judging distance. Consider review of use of bifocals / varifocals as research shows that they can cause falls. Separate glasses for distance and reading may be better. Advise to concentrate on walking and be deliberate/ cautious, especially in new situations and on uneven surfaces. Advise on use of contrasting colours to show risk areas e.g. top of stairs. Vision tested and corrected in past year? People ≥ 65 are entitled to annual free eye test. Spectacles clean? Check Diabetes and Glaucoma are monitored regularly. Cataracts? Ensure good lighting and remove clutter.	Optician Doctor (for referral to eye clinic) OT
Hearing	Has hearing been tested and corrected as much as possible? Lower voice and speak into best ear to maximise hearing. Consider hearing aid? Is hearing aid in working order? Does patient have wax in their ear?	Audiology Doctor Nurse
Walking/Gait	Consider simple test such as Timed Up & Go. Evaluate of range of movement and gait, balance and consider strength exercises. Is footwear safe? Does patient have problems with their feet? Appropriate selection and use of walking equipment?	Physiotherapist OT Falls Clinic Podiatry
Transfers	Raise awareness of risks when transferring. Refer for more detailed assessment on transfers and gait, balance and strength exercises. Are any environmental modifications necessary to increase safety? Moving & handling assessment?	Physiotherapist OT
Balance	Raise awareness of risks and how to move safely. Consider modifications to avoid stooping/ stretching overhead. Refer for assessment for gait, balance and strength exercises and/or walking equipment. Older people with gait instability and lower limb weakness are at an increased risk of falling.	Physiotherapist OT
Environmental Hazards	Raise awareness of risks of hazards i.e. irregular floor height. Correct if possible. Remove or secure rugs (double sided Velcro, adhesive or non-slip mat underneath). Explain characteristics of	OT Community Equipment

	furniture that cause risks and suggest low cost alternatives. Remove obstacles and clutter where possible. Suggest pendant alarm. Pull cords within reach from floor. Ensure good lighting. Consider Telecare equipment.	Services
Confusion	If chronic problem consider memory aids, orientation aids. Do MMSE. If acute, is there underlying medical reason such as *e.g.* UTI or chest infection?	Doctor Nurse OT
Osteoporosis Risk	If established osteoporosis or high risk factors present, are they having bone strengthening medication to treat/ prevent osteoporosis (*e.g.* Bisphosphonates, Calcium and Vitamin D)? Did patient receive information *i.e.* leaflet on 'Healthy Bones"?	Doctor Nurse

Appendix 5 - Guidance for staff outlining likely causes of slips, trips and falls and suggested actions

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) recognises its responsibilities under Health and Safety legislation and the importance of providing a working environment that is safe and healthy for all employees, contractors, voluntary workers, visitors and members of the public.

CWP will endeavour to protect staff and other persons, to whom it has third party liability at law, from the effects of slips, trips and fall hazards, by good management and risk assessment.

Employee's responsibilities:

- Identify the hazards
    - Look around the ward/workplace (including outdoor area) for anything that may be a slip or trip hazard, such as poor floor surfaces, etc;
- Decide who might be harmed and how
    - Consider who will come into the ward/workplace and whether they are at risk;
- Evaluate the risk
    - Consider the precautions already taken and assess whether they adequately deal with the risks;
- Record your findings;
- Review assessment from time to time
    - If there is any significant change, you should review the risk assessment to make sure that precautions are still adequate;
- Slips and trips - likely causes
    - Slip and trip accidents may have different causes, but often have the same result. By looking at the contributing factors separately, it is possible to work out more accurately the cause of the slip or trip accident.

A. Slip hazards
    - Spills and splashes of liquids and solids;
    - Wet floors (following cleaning);
    - Unsuitable footwear;
    - Rain, sleet and snow, ice;
    - Change from a wet to dry surface (footwear still wet);
    - Unsuitable floor surface / covering;
    - Dusty floors;
    - Sloping surfaces.

B. Trip hazards
   - Loose floorboards / tiles;
   - Uneven outdoor surfaces;
   - Holes/cracks;
   - Changes in surface level - ramps, steps and stairs;
   - Cable across walking areas;
   - Obstructions;
   - Bumps, ridges and protruding nails etc;
   - Low wall and floor fixtures - door catches, door steps;
   - Electrical and telephone socket outlets.

C. Fall hazards
   - Staff not trained in moving and handling service users;
   - Over reaching;
   - Climbing on furniture;
   - Rushing down steps / stairs, ladders and faulty equipment.

D. Factors which increase risk
   - Risk assessments not carried out regularly;
   - Poor or unsuitable lighting;
   - Wrong cleaning regime / materials;
   - Moving goods / carrying / pushing or pulling a load;
   - Rushing around;
   - Distractions / fatigue;
   - Drugs and Medications.

Managing risk

There are many simple measures that can be taken to reduce or eliminate risks. The following table gives some suggestions.

Hazard	Suggested action
Spillage of wet and dry substances including bodily fluids	Clean up spills immediately. If a liquid is greasy, ensure a suitable cleaning agent is used. After cleaning, the floor may be wet for some time. Place an appropriate sign to tell people the floor is still wet and arrange alternative bypass routes.
Untrained staff or lack of continuous training of staff	Trained staff must be used to carry out the required duty, i.e. moving and handling of service users.
No risk assessments	Risk assessments should be done at regular intervals, also incidents must be reported and control measures put in place.
Miscellaneous rubbish, for example plastic bags	Keep area clear, remove rubbish and do not allow to build up.
Slippery surfaces	Access the cause and treat accordingly, with appropriate cleaning method, regime/material.
Poor lighting	Improve lighting levels and placement of light fittings to ensure more even lighting of all floor areas
Changes of level	Improve lighting, add apparent tread nosing.

Slopes	Improve visibility, provide handrails, and use floor markings
Unsuitable footwear	Ensure service users and workers choose suitable footwear, particularly with the correct type of sole.

Appendix 6 – Pain Assessment in Advanced Dementia (PAINAD) Scale

Pain Assessment in Advanced Dementia (PAINAD) Scale				
Name:		DoB:		NHS No:
Assessment Date:				
Instructions: Observe the patient for five minutes before scoring his or her behaviours. Score the behaviours according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).				
Behaviour	**0**	**1**	**2**	**score**
Breathing independent of vocalisation	Normal	Occasional laboured breathing Short period of hyperventilation	Noisy laboured breathing Long period of hyperventilation Cheyne-Stokes respirations	
Negative vocalisation	None	Occasional moan or Groan Low-level speech with negative or disapproving quality	Repeated troubled calling out Loud moaning or groaning Crying	
Facial expression	Smiling or inexpressive	Sad Frightened Frown	Facial grimacing	
Body language	Relaxed	Tense Distressed pacing Fidgeting	Rigid Fists clenched Knees pulled up Pulling or pushing away Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract, or reassure	
TOTAL SCORE				

PAINAID Scoring Tool

PAINAID Scoring
The total score ranges from 0-10 points. 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.
PAINAD Definitions
Breathing 1. Normal breathing is characterised by effortless, quiet, rhythmic (smooth) respirations. 2. Occasional laboured breathing is characterised by episodic bursts of harsh, difficult, or wearing respirations. 3. Short period of hyperventilation is characterised by intervals of rapid, deep breaths lasting a short period of time. 4. Noisy laboured breathing is characterised by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing. 5. Long period of hyperventilation is characterised by an excessive rate and depth of respirations lasting a considerable time. 6. Cheyne-Stokes respirations are characterised by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnoea (cessation of breathing).
Negative Vocalisation 1. None is characterised by speech or vocalisation that has a neutral or pleasant quality. 2. Occasional moan or groan is characterised by mournful or murmuring sounds, wails, or laments. Groaning is characterised by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending. 3. Low level speech with a negative or disapproving quality is characterised by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone. 4. Repeated troubled calling out is characterised by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress. 5. Loud moaning or groaning is characterised by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterised by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending. 6. Crying is characterised by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.
Facial Expression 1. Smiling or inexpressive. Smiling is characterised by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look. 2. Sad is characterised by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes. 3. Frightened is characterised by a look of fear, alarm, or heightened anxiety. Eyes appear wide open. 4. Frown is characterised by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear. 5. Facial grimacing is characterised by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.
Body Language 1. Relaxed is characterised by a calm, restful, mellow appearance. The person seems to be taking it easy. 2. Tense is characterised by a strained, apprehensive, or worried appearance. The jaw may be clenched.

(Exclude any contractures).
3. Distressed pacing is characterised by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterised by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. Rigid is characterised by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures).
6. Fists clenched is characterised by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterised by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures).
8. Pulling or pushing away is characterised by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. Striking out is characterised by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterised by a sense of well-being. The person appears content.
2. Distracted or reassured by voice or touch is characterised by a disruption in the behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction, with no indication that the person is at all distressed.
3. Unable to console, distract, or reassure is characterised by the inability to soothe the person or stop the behaviour with words or actions. No amount of comforting (verbal or physical) will alleviate the behaviour.

Appendix 7 – Post fall huddle/ post fall action review for inpatients

Nurse Reviewer: Date:
Patient Name/ID: NHS No:

Instructions:

1. Hold Review as soon as possible after the patient fall occurred.
2. Keep the review meetings brief.
3. Involve the patient (and family) if possible.

Questions	Response	Areas identified for improvement	Agreed actions
Why did this patient fall? (Ask 3 times)			
Was patient at correct fall/injury risk level? Were the appropriate interventions in place?			
What accounted for the difference?			
How could the same outcome be avoided the next time?			
What is the follow up plan?			
Patient's account (if able to share)			
Agreement with the patient for safety (Promise to use call bell; return demo how to use call bell)			

Type of fall: