Falls Prevention and Management (Adult Inpatients) Procedure

NHS Lothian

Contents

1.0 Introduction

Hospital falls in Scotland remain a significant patient safety concern, with falls being one of the most common and serious adverse events.

Falls disproportionately affects frail and older patients, where several factors are known to increase the risk of a fall within the inpatient setting.

These factors relate to:

1. Frailty and age-related frailty – People who are frail, score high on the clinical frailty score, people who are aged 65 and over with frailty, reduced mobility, balance issues and chronic conditions all increasing risk.
2. Physical and medical factors – such as medication side effects, dizziness, acute illness, muscle weakness and impaired vison all increasing risk.
3. Inadequate risk assessments – where consistent falls risk assessments are essential. Missed or incomplete assessments heighten the risk to vulnerable patients
4. Environmental hazards – such as cluttered wards and inadequate space leading to increased risk.
5. Poor condition of hospital buildings – which can create unsafe environments if not maintained, increasing the risk
6. Hospital pressures – long waits leading to rushed movement of patients and limited staff supervision can increase risk.

   Updated NICE guidance (NG249, 2025) emphasises early identification, comprehensive assessment and tailored interventions.

1.1. Purpose

This document outlines current NHS Lothian and NICE guidance on procedures for adult inpatients falling in a hospital setting.

1.2. Scope

This document applies to all adult patients in a hospital inpatient setting.

1.3. Definitions

Fall: A fall is defined as an unexpected event which causes a person to rest on the ground, floor, or lower level (NICE, 2025)

High Risk Patient: Those with a history of falls, frailty, cognitive impairment, acute medical issues and/ or sensory deficits who are exposed to an unsafe environment.

Families, Carers or Representatives: All individuals identified by the patient as part of their support network including relatives, partners, close friends, chosen family, carers, legal guardians, advocates or other trusted people who support a person to express their wishes or act on their behalf when needed, including when the person cannot communicate or make decisions independently due to cognitive, communication or capacity-related difficulties and regardless of legal, biological or household status.

2.0 Roles and Responsibilities

Falls prevention involves managing a patient's underlying falls risk factors and optimising the environment.

The challenges of falls prevention require an interdisciplinary approach to a patient's care.

Some aspects of falls prevention are standardised while others must be tailored to the individual patient.

As with all interventions, falls prevention measures need to balance with other considerations relating to the patient's treatment whilst in hospital.

2.1. Advanced Nurse Practitioners (ANPs)

To carry out a comprehensive clinical assessment, identifying underlying causes such as infection, dehydration, cardiac issues, or medication side effects.

Specialist ANP's would undertake frailty assessment and comprehensive geriatric assessment to identify risks, performing medication reviews, optimise treatments, and deliver personalised interventions for conditions that contribute to falls.

2.2. Nursing Staff

To carrying out timely falls risk assessments and identifying risk factors such as mobility issues, medications, sensory deficits, delirium, and environmental hazards.

Develop and implement person-centred care plans to ensure safe environments, assist with mobility, toileting, and positioning, and monitor high risk patients closely.

Provide patient and family education, encourage strength balance activities, support regular vision/hearing checks, and maintaining a safe environment.

Identify early changes in condition and coordinate multidisciplinary interventions to reduce falls risk.

2.3. Medical Staff

To carry out a comprehensive clinical assessment, identifying underlying causes such as infection, dehydration, cardiac issues, or medication side effects.

Review and optimise medications that increase fall risk, including sedatives, antihypertensives, opioids, and drugs affecting cognition or balance.

Diagnose and treat conditions contributing to falls (e.g., delirium, neuropathy, vision/hearing issues) and order appropriate investigations.

Through the MDT collaborate with nursing and therapy teams to develop individualised person-centred care plans, ensure appropriate monitoring, and communicate risks to patients and families.

2.4. Occupational Therapists (OTs)

To assess daily activities, identifying environmental hazards, and recommending adaptations or assistive equipment to improve safety.

Support patients perform tasks safely and reducing early fall risk.

2.5. Physiotherapists (PTs)

To conduct detailed assessments that identify individual factors contributing to falls.

To assess patients' strength, balance, gait, and mobility.

To assess functional mobility, prescribe walking aids, and support rehabilitation after a fall.

2.6. Pharmacists

To conduct medication reviews to identify and reduce Fall Risk Increasing Drugs (FRIDs), such as sedatives, antidepressants, antipsychotics, opioids, and antihypertensives.

To undertake a polypharmacy assessment and anticholinergic burden, optimise prescribing, and recommend safer alternatives.

Collaborate with the wider healthcare team to implement personalised fall prevention plans.

2.7. Dietitians

To support patients and staff by identifying and addressing nutritional and hydration risks that may contribute to frailty, dizziness, weakness and reduced engagement in rehabilitation.

To provide expert assessment and intervention for patients identified through MUST or relevant screening, ensuring that malnutrition, dehydration and other nutritional factors are recognised and incorporated into the person centred-care plan.

To work closely with nursing, medical and allied health professionals' teams to optimise nutritional status, support safe participation in therapy and contribute to the overall multidisciplinary approach to reducing falls risk.

2.8. Estates & Facilities

To maintain a safe physical environment, ensuring good lighting, non-slip flooring, hazard free walkways and prompt repair of faults that contribute to falls.

2.9. Medical Physics

To ensure safe, reliable use of medical devices, including bed alarms, sensor systems, and patient monitoring technologies that alert staff when high risk patients attempt to mobilise

2.10. Domestic Staff

To maintain a clean, clutter free, and safe environment. Keeping floors dry, using clear signage, and ensuring walkways remain unobstructed.

To spot hazards and report concerns promptly to nursing staff.

2.11. Volunteers

To complement the skills, knowledge and experience of staff teams.

To spot hazards and report concerns promptly to nursing staff

3.0 Falls Prevention Procedure

All adult inpatients require a falls risk assessment to be carried out within 24hrs of admission. The risk assessment is located in TRAK as part of the person-centred care plans.

A multifactorial, multidisciplinary approach must be applied for all patients identified as more vulnerable or at high risk of falls. This approach ensures that multiple contributing factors are assessed and managed together.

3.1. On Admission

On admission the following general safety checks should be implemented.

- Assess and document mobility immediately.
- Provide a walking aid if required and ensure its within reach.
- Ensure call bell is present and within reach.
- Check that the patient is wearing appropriate footwear.
- Confirm use and availability of glasses and hearing aids if needed.

This should be followed by the following 5 key screening questions ('5Qs')

If the patient answers **Yes** to any, they are classed as 'more vulnerable' to falls:

1. Fallen in the past 6 months (including current admission)?
2. 4AT > 0 or acute confusion (delirium)?
3. Attempts to walk alone despite being unsteady/unsafe?
4. Patient or relative expresses fear or anxiety about falling?
5. Does clinical judgment suggest high falls risk?

If the answer to any of the above questions is **yes**, a full falls risk assessment should be carried out and documented in the person-centred care plans on TRAK. This must be:

- Started ASAP for all adults on admission
- Completed within 24 hours
- Complete a multifactorial falls assessment
- Reviewed after any fall, deterioration, or transfer

3.2. Risk and Review

All patients identified as a falls risk must be discussed with the MDT and any assessments made documented for example: Cognitive assessment & delirium screening, Bladder/bowel assessment, Postural hypotension & arrhythmia assessment, Medication review focusing on drugs increasing falls risk.

3.2.1. Review Frequency

High risk: review daily

- Low risk: review every 3 days

For more vulnerable patients a Safety Bundle must be applied, including:

- Communicating mobility status in safety briefs
- Adjusting bed/chair height for safe transfers
- Close observation for cognitively impaired patients
- Documenting observation level (e.g., cohorting, bed placement)
- Bedrail assessment using the rationale for use of bedrails assessment on TRAK
- Increased care rounding

3.2.2. Patients with Dementia or Delirium

Patients with dementia or delirium are automatically considered high risk and require:

- 4AT delirium screening
- TIME Bundle (Triggers, Investigate, Manage, Engage) tool to for early recognition and management of delirium in patients
- A multifactorial falls assessment

3.2.3. What is a Multifactorial Falls Assessment?

This involves a multidisciplinary assessment of all factors which could contribute to a patient's risk of falls and the documentation of an intervention bundle which must be documented in a patient's person-centred care plans (Falls Risk Assessment section), MDT notes and any other relevant person-centred care plans (e.g. medication, continence, delirium)

The following MDT participation is recommended where appropriate:

- Nursing
- Medicine
- Physiotherapy
- Occupational therapy
- Pharmacy

The assessment should include the following:

A. Cognitive Assessment & Delirium Screening

- Conduct a cognitive assessment and a delirium screen (e.g., 4AT)

B. Bladder and Bowel Function Assessment

- Screen for continence issues
- Diagnose any dysfunction and document a treatment/management plan

Continence issues significantly increase falls risk, especially in confused or frail patients.

C. Cardiovascular/Orthostatic Assessment

- Assess for postural hypotension
- Assess for arrhythmias

These assessments address physiological contributors to falls (e.g., dizziness, collapse).

D. Medication Review

- Undertake a comprehensive medication review
- Identify drugs that heighten falls risk (sedatives, antihypertensives, anticholinergics, psychotropics)

E. Mobility & Functional Assessment

- Immediate mobility assessment at admission
- Safe walking aid provision

F. Environmental & Equipment Safety

- Ensure correct bed/chair height
- Ensure visual/hearing aids are present
- Confirm safe footwear and call bell access

G. Observation and Supervision Level

Identify patients needing increased supervision due to:

- cognitive impairment
- unsafe mobility
- Clearly document the required intensity of observation (e.g. continuous or increased intervention, cohorting)

3.2.4. Daily Falls Risk Review for High-Risk Patients

Patients identified as high risk on the Falls Risk Assessment must have their falls risk reviewed daily.

Daily review ensures risk factors are reassessed and interventions remain appropriate.

The daily review should include the following components:

1. Cognitive status

- Review for new delirium, changes in alertness or orientation
- Reassess sensory aids (glasses/hearing aids must be in use.

2. Mobility & transfers

- Check whether mobility status has changed
- Ensure walking aids remain appropriate and within reach

3. **Continence**
    - Review continence needs (bladder/bowel dysfunction may evolve)
4. **Cardiovascular status**
    - Check for symptoms of postural hypotension or arrhythmias
5. **Medication review**
    - Consider new meds or dose changes that impact fall risk
6. **Environmental safety check**
    - Call bell in reach
    - Bed/chair height appropriate
    - Clutter removed
    - Safe footwear in use
7. **Observation level**
    - Confirm if supervision level remains appropriate
    - Update documentation if risk-taking behaviour or confusion increases

These daily checks ensure the person-centred care plans remains dynamic and patient centred.

3.2.5. Person-centred care plans Update Requirements

Person-centred care plans updates must be documented in the TRAK Person Centred Person-centred care plans (Falls section).

Updates should include:

A. New risks identified: (e.g. new delirium, increased toileting frequency)

B. Changes to mobility or supervision level: (e.g. now requiring intermittent or continuous intervention)

C. Updated interventions: (e.g. hydration plan, medication change, physiotherapy referral)

D. Reassessment after falls or acute deterioration (e.g. sepsis, delirium, fracture, etc): Every fall triggers a full reassessment and person-centred care plans update.

Where required, daily review should involve relevant MDT members, including:

- Nursing
- Medical team

- Physiotherapy
- Occupational therapy
- Pharmacy.

3.3. Tailored Interventions for Falls Prevention

Interventions must be individualised based on the patient's specific risk factors identified during the multifactorial assessment.

Examples of specific risk factors assessments and interventions can be viewed in the appendices section.

When undertaking a Multidisciplinary review, it is important that the following are discussed and outcomes documented.

- Strength and balance training (physiotherapy)
- Environmental and functional assessments (occupational therapy)
- Medication optimisation (pharmacy)
- Footwear or foot health recommendations (podiatry)
- Osteoporosis assessment and fracture risk optimisation
- Utilising MUST or relevant nutritional screening tool

3.4. Patient, Family, Carer and Representatives Education for Falls Prevention

Where possible and appropriate, patients and their carers, advocates or representatives should be involved in discussions and decisions around falls risks and relevant information shared which combines practical advice, self-management and awareness of falls risk factors.

Online resources, booklets and hospital-based education are available to support these discussions

The key themes that should be discussed with patients and carers are:

A. Understanding Why Falls Happen

- One in three older adults fall each year, but younger adults can also be at risk.
- Many falls are preventable with awareness of personal risk factors.

B. Key ways to reduce Falls Risk

- Staying active and maintaining balance/strength
- Looking after eyesight and hearing
- Keeping hydrated and eating well
- Addressing continence issues
- Reviewing medications
- Creating a safe home environment

C. Common recommendations include:

- Wear safe, supportive footwear
- Ensure good lighting and reduce clutter
- Use walking aids correctly
- Stand up slowly to prevent dizziness
- Report any changes in balance, vision, continence, or medication effects
- Encourage safe mobilisation and appropriate use of walking aids
- Support routines (hydration, toileting schedules, safe footwear)
- Help keep the environment tidy and free from obstacles
- Know how to respond if a fall occurs
- Be aware of delirium risk and notice sudden changes in cognition

For inpatients it is expected that the following points are discussed with both the patients and carer (where necessary).

- Why the patient has been identified as ‘more vulnerable’
- How to use the call bell and why it must always be within reach
- Encouraging patients to ask for assistance before mobilising
- Importance of wearing appropriate footwear and using sensory aids

- How staff will support them (supervision, mobility plans)
- Reporting concerns about mobility, confusion, or fear of falling
- Bring appropriate footwear, glasses, hearing aids from home

3.4.1. Available Patient and Carer Education Materials

- Up and About – Taking positive steps to avoid falls (Public Health Scotland)
- Age Scotland guides:
  - Worried about slips, trips and stumbles
  - Keeping active in later life
  - Keeping your feet in later life
- Age UK – Staying Steady booklet (vision, feet, home safety, balance advice)
- Falls risk signs and patient information posters

4.0 Procedure when a Fall Occurs

4.1. Immediate Safety Check at the Scene

A. Make the area safe

- Ensure no immediate dangers (wet floors, obstacles, equipment hazards)

B. Do NOT move the patient immediately

- Only move them if they are in imminent danger.

C. Provide reassurance

- Stay with the patient until help arrives.

D. Commence rapid clinical assessment (ABCDE) including a full injury check (also knowns as a top to toe).

4.2. Rapid Clinical Assessment (ABCDE)

NHS Lothian uses an ABDCE Assessment for Deteriorating Patients. Assess for:

- Airway obstruction
- Breathing difficulty
- Circulation issues (bleeding, pulse, BP)
- Disability (GCS, new confusion, head injury signs)
- Exposure (injuries, bleeding, deformities)

If serious injury is suspected, escalate immediately to medical team/emergency response. (Examples: head injury, suspected fracture, reduced GCS, arrhythmia related collapse)

4.3. Full Injury Check

Evaluate for:

- Head trauma
- Lacerations
- Bruising
- Limb deformity (possible fracture)
- Pain on movement
- Reduced mobility compared to baseline

Any injury must be promptly identified and treated.

4.4. Vital Signs & Observation Monitoring

Record:

- BP (lying/standing if safe)
- HR
- Respiratory rate
- Oxygen saturation
- Temperature

NEWS2 should be calculated. If abnormal, escalate to medical review.

4.5. Document the Fall

Full documentation in the patient record must be made as soon as possible following medical review (within 6 hrs), and must include:

- Time and location of fall
- Circumstances leading to fall
- Witness accounts
- Injury assessment
- Interventions performed

Furthermore:

- Record in TRAK (Person-centred Person-centred care plans)
- Complete top to toe assessment on TRAK.
- The Falls Risk Assessment must be re-completed after a fall.
- Complete Adverse Event reporting.
- DATIX to be completed in line with current guidelines and SAE reporting.

4.6. Medical Review

A medical assessment must occur if:

- The fall was unwitnessed
- Head injury occurred
- Neurological changes observed
- Serious injury suspected
- The patient is on anticoagulants

4.7. Post Fall Observations

Based on injury and clinical status:

- Increased frequency of neurological observations if head injury suspected
- Repeat vital signs monitoring
- Monitor pain, cognition, mobility

Observation pathways are included in the policy appendices.

Neurological observations should be carried out as per appendix 7 - Assessment and Management of Adult Inpatients (following a fall) with Actual or Suspected Head Injury.

4.8. Reassess Falls Risk & Update Person-centred care plans

Implement tailored interventions such as:

- Adjusting walking aids
- Reviewing medications
- Treating underlying infection/dehydration
- Correcting delirium
- Improving environment safety
- MDT referrals

4.9. Notify family/Next of kin.

- Inform family of fall and circumstances leading to the fall.
- Invite family to discuss interventions to reduce risk of further falls

5.0 Discharge Planning for Patients at Risk of Falls

5.1. Reassess Falls Risk Prior to Discharge

Before discharge, staff must ensure the patient has:

- A current Falls Risk Assessment

- Updated multifactorial assessments (cognition, mobility, continence, cardiovascular, medication review)
- Revised interventions based on any changes during admission

This ensures discharge decisions are based on the patient's true, current level of risk.

5.2. Ensure All Injuries and Post Fall Care Have Been Addressed

If the patient has fallen during admission:

- All injuries must have been properly assessed and treated
- Post fall review processes completed

Patients must not be discharged until medically stable following any inpatient fall.

5.3. Provide Patient & Carer Education Before Discharge

Education must include:

- Why the patient is at risk of falls
- How to prevent falls at home
- How to get help if a fall occurs

Carers should be educated on:

- Safe mobility and supervision
- Recognising deterioration (delirium, unsteadiness)
- When to seek help

Document within the patient notes on TRAK that the patient and carer have been provided with education (the care plan has a drop-down menu option communication).

5.4. Ensure Equipment and aids are in place before leaving hospital

The patient must be discharged with:

- Correct walking aids (provided if required)
- Advice about safe footwear
- Glasses/hearing aids in use
- Any assistive devices arranged through OT/Physio if needed

5.5. Referral to Community Falls Services if needed

If ongoing support is required, staff may refer to Local Partnership Services who provide:

- Medication review
- Walking aids
- Personal care alarms

- OT and PT services
- Hearing and vision checks

This referral must be made before the patient leaves hospital, with consent.

5.6. Communication at Point of Discharge

The following must be communicated:

A. Handover to GP and community teams

- Summary of any falls during admission
- Updated medication list
- Outstanding investigations or referrals

(Falls policy requires continuity of care.)

B. Clear discharge plan for managing falls risk

- Supervision requirements
- Mobility status
- Follow up appointments

5.7. Written Information for the Patient

Patients should receive:

- Falls prevention leaflets (e.g., Up and About, Age Scotland/UK guides – resources below)
- Information about local falls services (East, West, Mid, Edinburgh teams).

5.8. Check the home environment is Safe (if applicable)

If the patient has high ongoing risk:

- OT home assessment referral can be made
- Carers informed about hazards (clutter, lighting, loose rugs)
- Community team can follow up if urgent

5.9. Confirm support is in place for Vulnerable Patients

Prior to discharge, verify:

- Care package adjustments (if increased support needed)
- Community alarm activated (if applicable)
- Family/carers aware of supervision needs

6.0 Policy and Governance

6.1. Local Ward Governance

- Local teams to monitor implementation of the Falls Policy and related procedures.
- Regular audits and adverse event reporting via DATIX.

6.2. Education, Training and Workforce Governance

The education, training and workforce function is overseen by the Falls Strategic Programme Board, supported by the Inpatient and Community Falls Groups and relevant subgroups.

There is an education editorial subgroup that maintains the falls education and resources online for staff and the public internet site. Any feedback that comes in is reviewed and added where applicable, building up information on falls and covering information and knowledge gaps.

There is the national module for falls and frailty at informed level. This is not a mandatory module but recommended as a basic module for all levels. This can be accessed on TURAS: Falls, frailty, and bone health: prevention and management | Turas | Learn.

The Lothian falls prevention and management framework (2025-2028) outlines nineteen commitments under five pillars: Prevention; Collaboration: Person centred; Education and knowledge; and Data Informed.

The framework sets out the ambition to reduce the risk of falls and minimise harm from falls whilst supporting people to live longer, healthier lives and is an enabler across a number of ambitions outlined in the LSDF pillars.

6.3. Policy

NHS Lothian maintains several policies under governance oversight, including:

- Falls Prevention and Management (Adult Inpatients) Policy [link provided following approval]
- Includes procedural adherence, Adverse Event reporting, and local monitoring responsibilities.
- Slips, Trips and Falls Health & Safety Policy
- Covers environmental governance and H&S regulatory compliance (RIDDOR, risk assessments).

7.0 Evidence, Links and Appendices

7.1. Evidence Base

Overview | Falls: assessment and prevention in older people and in people 50 and over at higher risk | Guidance | NICE

World guidelines for falls prevention and management for older adults: a global initiative | Age and Ageing | Oxford Academic

7.2. Links

Up and about: Taking positive steps to avoid trips and falls - Publications - Public Health Scotland

Guide to bed rail use and risk assessment v2.1

Lying and standing blood pressure

Worried about trips, slips and stumbles

Keeping Active in Later Life

Keeping your feet in later life

Staying steady downloadable information guide | Age UK

Falls Support and Education – NHS Lothian | Staff

Lothian Falls Prevention and Management Framework – Falls Support and Education

SPSP Acute Adult Programme

Adverse Event Management Policy

Falls, frailty and bone health

Lothian-Strategic-Development-Framework-for-website-08042022.pdf

Appendix 1: Examples of assessment tools and interventions

Risk factors	Assessment tools/ requirement	Interventions
Cognitive Impairment, Delirium, or Dementia	4AT TIME Bundle MoCA	• Enhanced observation if unsafe to mobilise independently • Ensure hearing aids and glasses are present and functioning (reduces disorientation) • Use clear signage and orientation cues • Avoid bed moves unless clinically necessary • Minimise nighttime disturbances • Treat underlying causes of delirium (infection, dehydration, constipation, drugs)
Mobility, Gait, and Balance Problems	Mobility assessment Vestibular assessment Falls assessment	• Physiotherapy review for mobility assessment and strengthening programme (as per MDT involvement guidance) • Ensure correct walking aid is provided and within reach at all times • Encourage safe footwear with grip • Adjust bed and chair height to support safe transfers • Use mobility signage in bedside areas to communicate assistance requirements
Cardiovascular Causes (e.g., postural hypotension, arrhythmias)	Lying and standing Bp Fluid balance 24hr Tape MUST	• Implement slow, staged position changes (supine → sitting → standing) • Hydration optimisation

		• Review antihypertensives contributing to hypotension • Medical assessment for arrhythmias or syncopal symptoms • Compression stockings if indicated • Document and monitor lying/standing BP trends
Medication-Related Risks	Documented medication review for drugs increasing falls risk. Documentation of any adverse reactions Pain assessment	• Review sedatives, hypnotics, antipsychotics, antidepressants, antihypertensives, opioids • Reduce or deprescribe where safe • Adjust dosing times (e.g., sedatives at night only) • Close monitoring following medication changes
Continence Issues (urgency, frequency, incontinence)	Bladder and bowel assessment BASICS Catheter bundles Waterlow	• Prompted toileting or scheduled toileting routines • Ensure safe access to toilet/commode • Provide night-time lighting • Avoid unnecessary catheterisation • Treat infection, constipation, or other reversible causes • Keep continence pads appropriately fitted and changed
Vision or Hearing Impairment		• Ensure glasses and hearing aids are in use and functioning (an

		NHS Lothian admission requirement) • Clean lenses regularly • Ensure adequate lighting and minimise glare • Refer to optometry/audiology as needed (NHS Lothian lists these as useful MDT services)
Environmental & Equipment-Related Risks	Bedrail assessment	• Ensure call bell is always within reach (mandatory admission check) • Declutter the area around bed/chair • Ensure footwear is safe, well fitting, and non slip • Maintain bed/chair at the safest height • Use bedrail decision tools — apply only if indicated (as per Safety Bundle) • Ensure walking aids are accessible and not out of reach
Behavioural or High Risk Mobility	Patient engagement assessment Behaviour charts Overnight charts Getting to know me Traffic light person-centred care plans Unmet needs assessment	• Enhanced supervision (observation levels must be clearly documented) • Bed placement near staff base if appropriate • Cohorting where safe • Encourage regular meaningful activity and mobilisation • Use of sensor alarms only where part of an agreed protocol (optional and context dependent)

Appendix 2: MDT Discharge Planning Checklist for Patients at Risk of Falls

1. Final Falls Risk Review (Before Discharge)

☐ A current Falls Risk Assessment has been completed or updated before discharge.

☐ Any fall that occurred during admission has triggered reassessment.

☐ Multifactorial risk factors re reviewed (cognition, mobility, continence, cardiovascular status, medications).

2. Medical Stability Confirmed

☐ All injuries from any inpatient fall have been assessed and fully managed.

☐ The patient is medically stable with no ongoing acute post fall concerns.

3. Patient & Carer Education Provided

☐ Patient/carer educated on personal falls risk and strategies to prevent falls at home.

☐ Advice provided on what to do if a fall occurs at home (e.g., calling 999/111).

☐ Written materials given (e.g., Up and About, Age Scotland/UK resources).

4. Mobility & Equipment Check

☐ Correct walking aid issued and within patient's capability.

☐ Footwear is safe and appropriate.

☐ Glasses/hearing aids provided and functioning.

☐ OT/Physio assessment completed if mobility has changed.

5. Medication Review Completed

☐ Full medication review conducted with attention to drugs increasing falls risk (sedatives, hypotensives, psychotropics).

☐ Changes communicated clearly to patient/carer and documented for GP.

6. Home Environment & Support Plan

☐ Home safety considerations discussed (lighting, clutter, carpets, access routes).

Supported through Falls Pathway community assessments.

☐ OT home assessment referral made if environment poses risk.

☐ Carers informed of supervision or assistance requirements.

7. Referral Pathways Activated (If Needed)

☐ Referral made to Local Partnership Services for:

- Home safety review

- Medication review
- Walking aids
- Personal care alarms
- OT/PT follow up
- Hearing/vision checks

8. Communication at Discharge

☐ GP notified of:

- Any inpatient falls
- Updated medication list
- Current falls risk level
- Required follow up

☐ Community services notified and handover completed (District Nursing, HSCP services, Falls Team).

☐ Care package updated if increased support is required.

9. Written Discharge Information Given

☐ Falls prevention information leaflet provided.

☐ Local falls service contact details included.

☐ Emergency guidance provided (when to call 999 or 111).

10. Final Safety Check Prior to Leaving

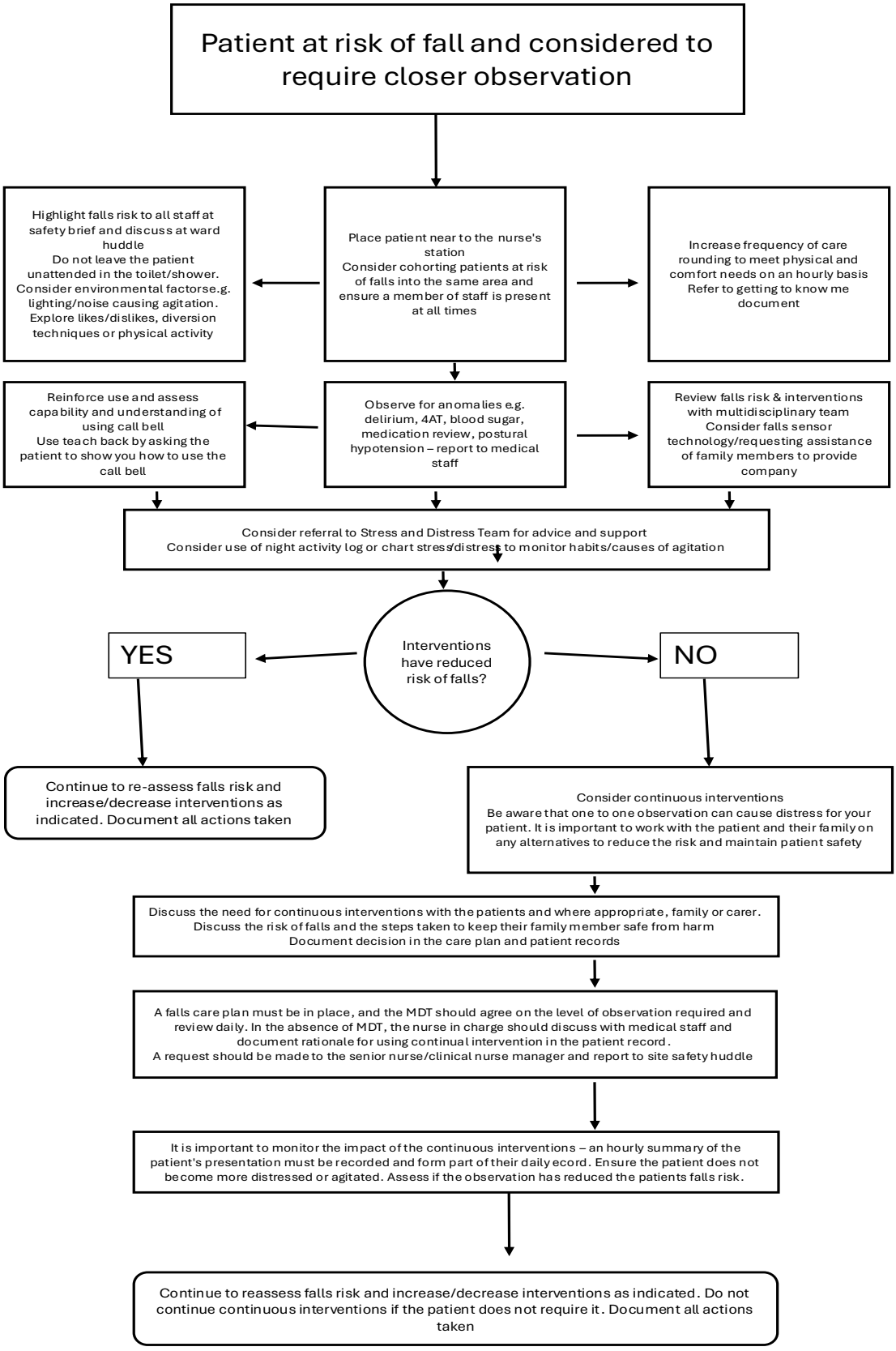
☐ Patient able to transfer safely to transport.

☐ Patient/carers understand mobility plan and risks.

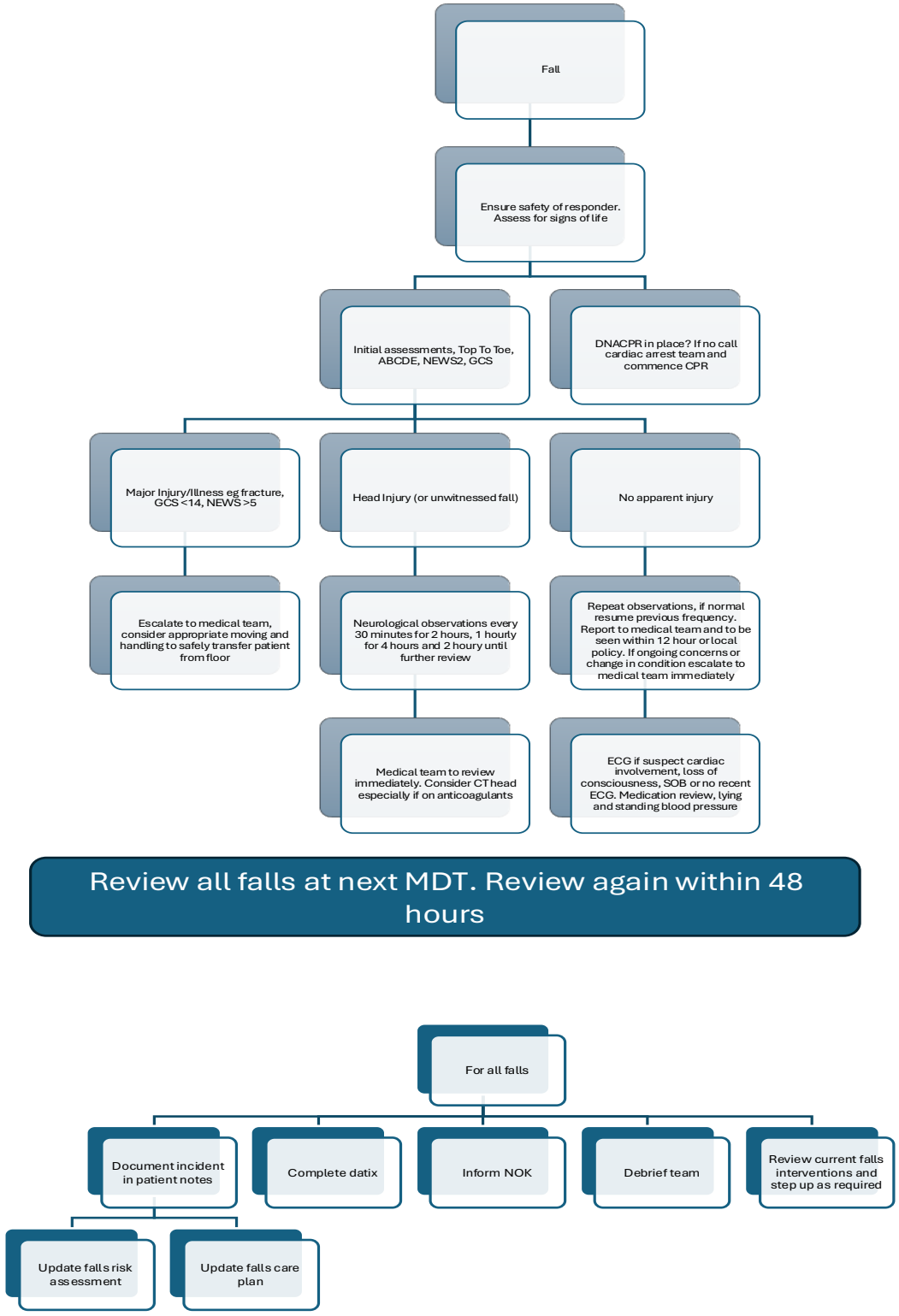
☐ All equipment sent home (walking aid, glasses, hearing aids).

☐ Discharge plan aligns with patient's cognitive status and functional ability.

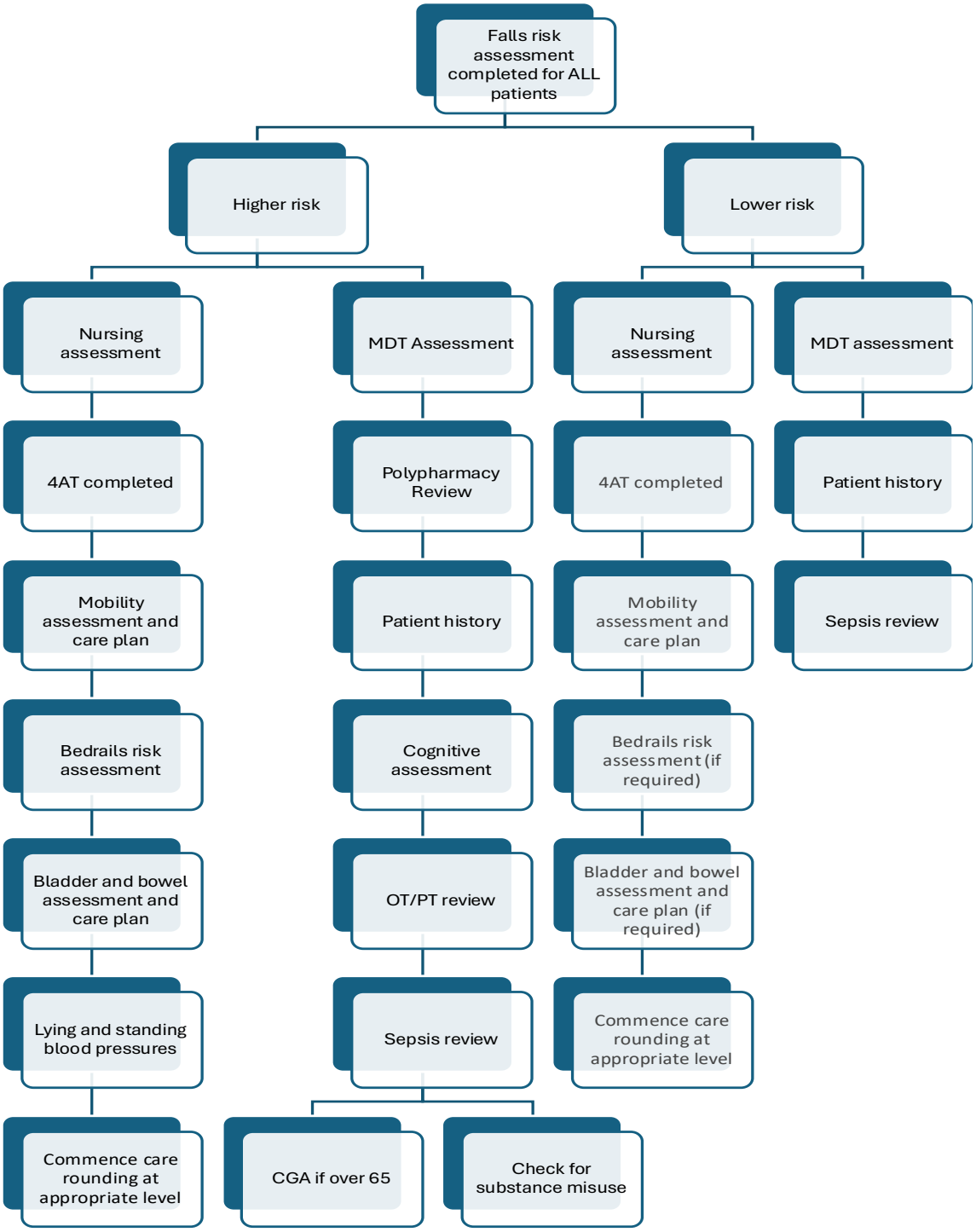
Appendix 3: Observation Pathway for Falls Prevention



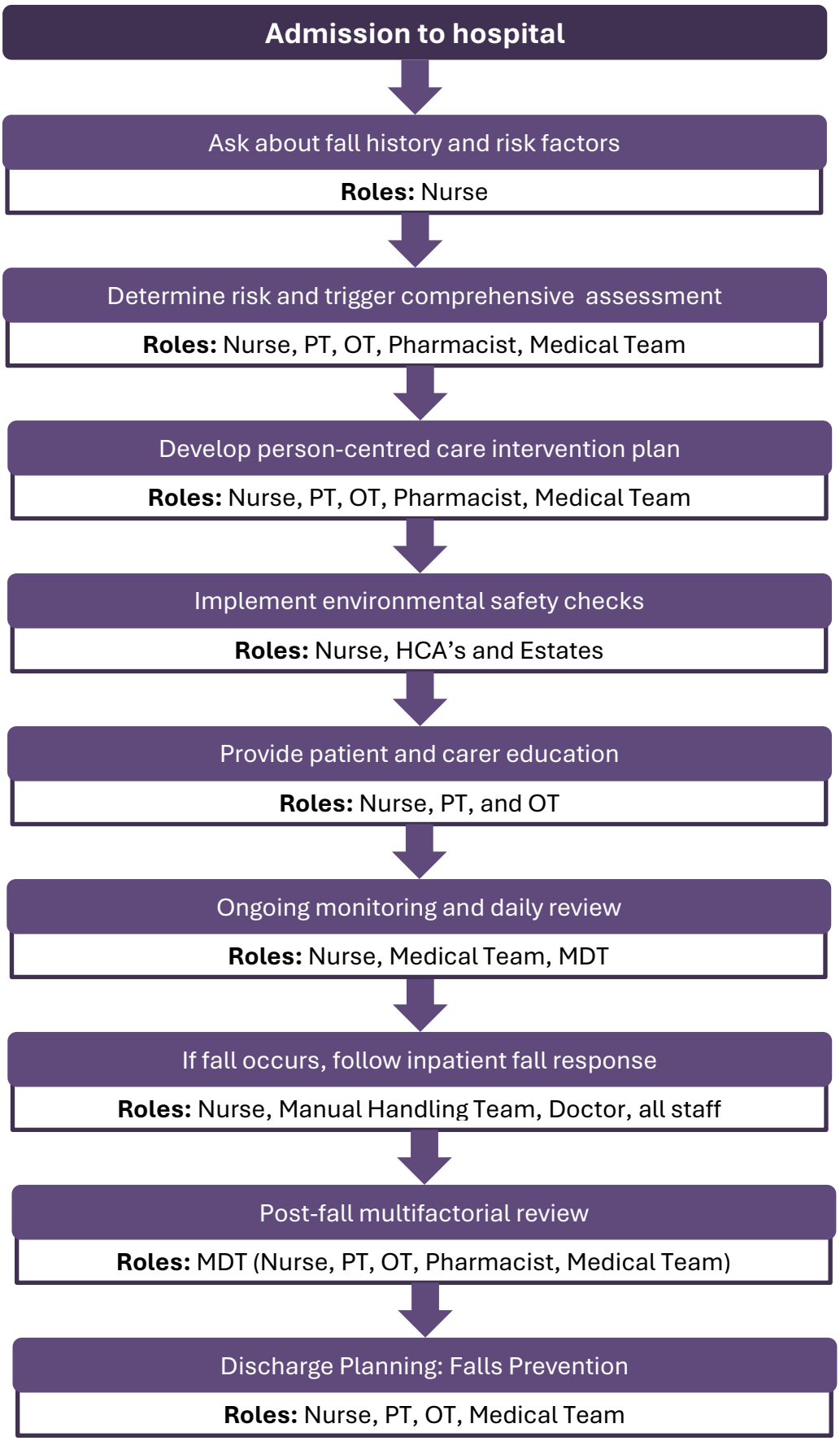
Appendix 4: Immediate Actions Following a Fall Flowchart



Appendix 5: Falls Risk Assessment Intervention Flow Chart



Appendix 6: Falls Prevention Flowchart with Roles and Responsibilities



Appendix 7: Protocol: Assessment and Management of Adult Inpatients (following a fall) with Actual or Suspected Head Injury (v1.0)

1.0 Purpose

This document supports a standardised approach for assessing patients post-fall with a potential head injury in acute service.

This is providing a protocol on the frequency of observations and an escalation plan for all the clinical team to review and consider as part of the post-fall review.

2.0 Aim

The aim of this protocol is to provide a standardised approach for the safe assessment and management of inpatients (following a fall) with actual or suspected head injury.

This protocol provides guidance for nursing and medical staff on appropriate neurological observations, and the urgency of medical review and Computerised Tomography (CT) brain scan, following an adult inpatient fall, in line with current National Patient Safety Agency (NPSA) and National Institute for Health Care and Excellence (NICE) recommendations[1,2]

3.0 Rationale

This protocol was initially produced and piloted in Cardiothoracic Respiratory (CTR) as part of a local initiative to improve post-fall care. In 2011, the (National Patient Safety Agency (NPSA) highlighted the importance of identifying injury following inpatient falls to reduce harm[1]. The NPSA recommended that all hospitals have a post-fall protocol/guideline to include the frequency and duration of neurological observations and advice on the urgency of medical review and imaging, in line with National Institute for Health Care Excellence (NICE) guidance[2].

4.0 Standard protocol

Complete Glasgow coma score observations on eNEWS if the patient presents with:

- a witnessed fall with head injury or if a patient had an unwitnessed fall with head injury
- External bruising, swelling or laceration to head
- Symptoms suggesting brain injury (vomiting, headache, dizziness, altered consciousness or behaviour)
- On *therapeutic* anti-coagulation* (not thromboprophylaxis)
- Pain or tenderness of head

Glasgow Coma Scale (GCS) 15 when found
½ hourly neurological observations for 2 hours **1 hourly neurological observation for 4 hours** **2 hourly neurological observations to continue for 24 hours or until reviewed by clinician** **If GCS drops at any time, change observations to ½ hourly and escalate** **Request URGENT medical review in the event of:** • **Agitation/change in behaviour** • **GCS falls by 3 points (eyes/verbal) or 2 points (motor)** • **Any other fall in GCS if sustained for 30 minutes or more** • **Persistent vomiting or severe headache**
GCS 14 or less when found
Urgent medical review (<15 minutes) **½ hourly neurological observations to continue until Computerised Tomography (CT) scan** **or** **GCS reaches 15: then follow protocol above** For patients who are normally confused with no change in usual behaviour & have GCS 14 (E4 V4 M6) post fall, follow the GCS 15 protocol above

Carry out CT Head (within 1 hour) if any of the following are present:

- GCS ≤12 initially or GCS < 15 persisting at least 2 hours post injury,
  unless GCS 14 (E4 V4 M6) in a patient who is normally confused and shows no change in normal behaviour 2 hours post injury
- Suspected skull fracture (including basal skull e.g. hemotympanum, CSF leakage from ear/nose, Battles sign)
- Post-traumatic seizure
- Focal neurological deficit
- >1 episode of vomiting within four-hour period

Carry out CT Head (within 8 hours) if any of the following are present:

Loss Of Consciousness (LOC) or amnesia since injury ***plus*** any of:

- Age ≥65 years ***or***
- History of bleeding disorder ***or***
- Dangerous mechanism of injury (fall from height ≥1m or 5 stairs) ***or***
- >30 minutes of amnesia for events before injury.

continued on next page

Consider CT Head if on *therapeutic* anticoagulation* with if no other indication for scan.

*Unfractionated heparin, treatment dose Low Molecular Weight Heparin (LMWH), warfarin and Direct Oral Anticoagulants (DOAC) (rivaroxaban, dabigatran, apixaban, edoxaban).

5.0 References

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