Integrated Policy for the Prevention & Management of Patient Falls v3.0

Key Points

To assume all patients aged 65 years and over have a risk of falls
Removal of numerical risk score

Key Changes

- *A*n amalgamated policy for primary and secondary care
- Change in method or risk identification
- Falls Care Bundles
- Actions following an inpatient fall
- RCA Process (injurious falls)
- The direct link to Deprivation of Liberty for patients who are risk of falls but lack capacity.
- Scoping exercise to be completed for all patients who have more than one fall during a single admission

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Meta Data

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Relevant External Standards/ Legislation	NHSLA 4.4 Slips, Trips & Falls (Patients) Falls – The Assessment & Prevention of falls in Older People – clinical guideline 21 (2004) – National Institute Of Clinical Excellence The National Framework for Older People(NSF) (2001) – Department of Health NPSA/RRR001 – Essential Care after an inpatient fall (2011) NICE – Falls: assessment and prevention of falls in Older people (June 2013)
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Revision History

Version	Status	Date	Consultee	Comments	Action from Comment
0.1	Draft	2007	Falls Prevention & Management Steering group		Approved
0.2	Draft	05/08	Nursing & Midwifery Strategy Group	Re-format appendix 2 Short synopsis of policy as appendix Appendix	
1.0	Final	06/08	Safety Committee For Ratification		
2.0	Final	06/11	Nursing and Midwifery Board For ratification		Approved and Ratified

2.1	Draft	Oct 2013	Maged Sonkor; Consultant for Elderly Care Sam Foster Chief Nurse; Sue Hyland Deputy Chief Nurse; Head Nurses; Rachael; Blackburn Clinical Governance Barbara; Jukes Falls Coordinator Community Clinical Directors; Corporate Nursing	Comments on formatting use of key principles and awaiting insert from community team	Insert received from Community Team
2.2	Draft	Jan 2014	Barbara; Jukes Falls Coordinator Community Bridget Leach Falls Coordinator Sue Hyland Deputy Chief Nurse	Policy includes community content	
2.3	Draft	Feb 2014	Sam Foster Chief Nurse Barbara; Jukes Falls Coordinator Community Bridget Leach Falls Coordinator Sue Hyland Deputy Chief Nurse, Site Head Nurses and Associate Head Nurses	To add a hyperlink for both the inpatient and community RCA for injurious falls. Clarify position on exclusion of paediatrics Reword high visibility and specialing to increase nurse to patient ratio	Comments incorporated..
2.4	Draft	April 2014	Bridget Leach Falls Coordinator	Amended attachments falls bundle level 2 fall with head injury and when a patient falls.	
2.5	Draft	May 2014	Falls Steering Group Members	Amended falls bundle following feedback from pilots To provide clear definition on the use of crash mats in the clinical are	Changes made.

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1. Circulation

This policy applies to all staff that have direct patient contact as part of their role working within Heart of England Foundation Trust (HEFT) whether employed on a permanent, temporary or honorary contract.

2. Scope

Includes:

- All adult inpatients 65 years and over, including those in A & E and emergency assessment areas
- All patients who have a history of falls or who fall during their hospital stay
- All patients who have a clinical condition that will pre-dispose them to falls
- All adult patients who access community services.

Excludes:

- Staff and visitor falls are not included in this policy – this is included in Management and Prevention of Slips, Trips & Falls policy http://sharepoint/policies/Office%20Documents/Forms/DispForm.aspx?ID=1426
- Paediatrics and neonates can be excluded from this policy; there is no national requirement to have a policy for paediatrics in relation to falls.

3. Definitions

- A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO 2012)
- A fall from height could be a fall from any place, including a place at or below ground level from where a person could fall and sustain an injury

- Older Adult, for the purpose of this policy, the chronological age of 65 years and over is accepted as the definition of an older adult.
- Injurious fall, for the purpose of this policy an injurious fall is defined as a fall that results in a significant head injury or a fracture (excludes digits)
- Osteoporosis – A disease characterised by low bone mass and micro-architectural deterioration of bone tissue, leading to enhanced bone fragility and a consequent increase in fracture risk". (WHO 2003)
- Fragility Fracture: fractures that occur because of mechanical forces that would not usually cause a fracture e.g. from a fall from a standing position.
- FALLS acronym to support Harm Free Care at HEFT (see attachment 1)
    - Footwear
    - Assessment
    - Level of observation
    - Leave it low
    - Safe Environment

4. Reason for Development

The Trust has a statutory obligation to their patients and the public to ensure it has robust systems in place to mitigate the risks associated with patients falling whilst under our care.

5. Aims and Objectives

To identify any patients at high risk of falling and minimise the risk of injury associated with a fall.

- To acknowledge the risk of falls on all inpatients aged 65 years and over. (NICE 2013)
- To identify the risk of fall on patients supported at home or in community care settings aged 65 years and over
- To demonstrate appropriate interventions are in place to protect patients recognised as high risk of falls.
- To ensure any patient that has had a fall a robust review of care is undertaken and any additional interventions are actioned to minimise the risk of further falls.

6. Key Principles for Inpatients at HEFT.

- The Trust will apply the **FALLS** acronym to all patients to support Harm Free Care at HEFT.
- All patients aged 65 years and over are considered to have an increased risk of falling whilst an inpatient at HEFT.
- All in-patients aged 65 years and over will receive, as a minimum, the Falls Care Bundle Level One within 2 hours of admission (attachment 1)
- All falls care bundles must be reviewed as a minimum weekly or sooner if change in condition or **IMMEDIATELY** after the patient has fallen.
- Patients with any co-existing medical conditions who are 65 years and over will require either level one or level two falls care bundle **(see attachment 1)**
- Any patient under 65 years with a pre-disposing medical condition that increases their risk of falling or who have a history of falls will require a falls care bundle.
- Patients under the age of 65 years and have a condition that may pre-dispose them to falls must have an appropriate falls care bundle completed on admission and reviewed as minimum weekly.
- Any patient that falls whilst an inpatient must have a clinical review and have a full set of observations recorded including a MEWS score calculated. Patients previously not considered at risk but subsequently fall will require a falls care bundle.
- Any patient that falls must have appropriate first aid administered.
- Patients who have sustained a head injury (or suspected injury) as a result of a fall must have a medical review and be commenced on ½hourly neurological observations **(see attachment 2 for management of head injury)**
- Any fall, which leads to the patient complaining of pain, a noticeable limb deformity or has hit their head during the event must have a medical review within one hour.
- Where no injury is suspected, patients must have a clinical review within four hours. **(attachment 3)**
- All patients that have suffered a fall **must have analgesic offered post fall**. For all injurious falls, analgesic must be reviewed alongside the clinical review of the patient. Administration of pain relief must be recorded within the datix incident. f the patient declines pain relief this must also be recorded within the datix incident as well as the medical notes.
- Falls that occur at night are reported via i-bleep system, any head injuries on obvious limb deformity to be recorded as red category all other falls classified as amber.
- As a minimum standard, all patients at risk of falls that do not have appropriate well fitting footwear must be offered a pair of anti-slip socks to wear.
- All patients should have their beds left at the lowest level post any interventions from staff.

- The use of specialist hi-low beds should be considered for patients with a history of falls or those judged to be at high risk
- Ward/clinical environment should be clutter free and cleaning/maintenance work should not create any additional risks to patients.
- Patients aged 65 years and over are to be offered a falls prevention information leaflet **(attachment 4).** If the patient is unable to receive the leaflet, this can be given to the patient's relatives or carers.
- A patient notification leaflet will be given to all patients/relatives/carers who have sustained a fall whilst an in-patient at HEFT. **(attachment 5)**
- All falls must be reported via the Trust Datix reporting system within 2 hours of the incident occurring
- Any falls where the level of harm has been upgraded to injurious/severe or catastrophic must have the datix incident upgraded to reflect the severity of the injury. These falls require a Root Cause Analysis (RCA) to be completed. http://sharepointap/governance/Shared%20Documents/RCA%20-%20Injurious%20Fall%20in%20Hospital.docx
- Any patient that has suffered two or more falls during a single admission will require a scoping event to be completed to establish if the appropriate interventions are in place.

6.1 Key Principles for Community Services in Solihull.

- All patients aged 65 years who are receiving care from Solihull Community Services will be considered at risk of falls.
- **Part 1 Community Falls assessment** and if indicated **Part II Falls Assessment and Care Plan** should be completed at time of initial assessment or visit for:
  - All community patients aged 65years and over;
  - Any patients under 65 years with a pre-disposing medical condition that increases their risk of falling or who have a history of falls.

  If Part II must be reviewed, as a minimum weekly, or sooner if change in condition. When:
  - A patient has a new fall
  - Has increased anxiety about falling
  - Reduction in mobility
  - Changes in medication that may affect falls risks
  - Changes in Health or Social Care need
  - Family concerns
  - Changes in care plan
  - Or **immediately** after a fall.
- Any patient that falls must have appropriate first aid administered.
- Patients who sustain a head injury (or suspected) as a result of a fall must have a medical review either by GP or by attendance at an Emergency Department (E.D)
- In Intermediate Care, setting ½ hourly neurological observations should be undertaken**. (see Community Attachment 5 - Post Fall Guidelines)**
- Any fall that results in the patient complaining of pain, a noticeable limb deformity or has signs of serious head injury must be referred to an E.D setting for appropriate review and treatment.
- Where no injury is evident, patients are to be reviewed within 24 hours.
- All falls whether observed or unobserved, require an incident report (via DATIX) to be completed
- Home hazards need to be minimised and clutter free environment created for patients and staff safety. If the environment is deemed unsafe this must be reported to the Line Manager and a risk assessment completed **(See Community Attachment 1 -Home hazard assessment)**
- All equipment is to be assessed to determine suitability for the patient's current needs. This should include the correct use of walking frames and sticks
- Chair and beds need to be at the appropriate height for the clinical activity being undertaken. If the bed has been elevated this must be returned to the lowest level before leaving the patient.

- All patients at risk of falls are to be advised on the importance of wearing well fitting footwear at all times.
- Patients aged 65 years and over are to be offered a Falls Prevention Information Booklet if the patient is unable to receive the leaflet this can be given to the patient's relatives or carers.
- Any falls where the level of harm has been upgraded to injurious/ severe or catastrophic must have the datix incident upgraded to reflect the severity of the injury. These falls require a Root Cause Analysis (RCA) to be completed. http://sharepointap/governance/Shared%20Documents/RCA%20-%20Patient%20Falls%20in%20the%20Community.docx

6.2 Additional Risk Factors that can contribute to patients falling

- Some patients can be more susceptible to falls due to their presenting condition or pre–existing medical conditions these include delirium or dementia, cardiac, neurological or muscular skeletal conditions, side effects from medication, problems relating to balance and mobility.
- The risk of falls is increased when patients are in unfamiliar environments; clinical staff should attempt to orientate patients to their surroundings, this includes showing patients where to find the toilet and bathroom and how to use the nurse call bell.
- Patients should have suitable well fitting footwear to walk around in slippers without backs are not ideal and can contribute to the patient falling. All inpatients without appropriate footwear are to be offered anti-slip socks, if the patient refuses to wear the socks this must documented within the patient's medical records.
- Patients at high risk of falling require a medication review to ascertain if any of the patients medication could be considered a contributing factor and whether a medication change maybe an option.
- Patients that take any medication that has a sedative effect or can cause a drop in blood pressure can have an increased risk of falling. Information on medication can be found on http://www.rcplondon.ac.uk/sites/default/files/documents/medicines-and-falls2.pdf
- Any walking aids used by the patient are to be left within easy reach. Aids and equipment require a review by the Physiotherapy team. to ensure they are suitable for use and not likely to contribute to the patient falling
- Other contributing risk factors include
    - Patients aged 80 years of age or over.
    - Patients that have been admitted to hospital or referred to community services as a result of a fall
    - Patients who have had a fall in the past 6 months
    - Patients who are unable to mobilise without assistance
    - Patients who are restless or agitated due to alcohol/drug withdrawal
    - Patients with Parkinson's disease
    - Patients with a visual impairment not corrected by glasses
    - Patients that have been admitted following a stroke
    - Patients who suffer from urinary frequency /urgency

6.3 Falls Risks in the Emergency Department

- All patients aged 65 years and over whom present in the Emergency Departments will be asked if they have a history of falls. If they have a history of falls and do not require admission to hospital, the GP will be asked to consider referral to falls services in the community
- All patients who have attended the Emergency Departments (E.D) as a result of a fall are considered to be at risk of further falls and the falls risk reduction bundle is to be instigated **(attachment 6)**
- G.P's are to be notified of the need to follow up any patients aged 65years and over who are being discharged from E.D following treatment for a fall.

6.4 Observation and Visibility

- All patients are to be provided with care that meets their clinical needs and maintains their safety.
- Some patients may require a higher level of observation due to their risk of falls or inability to call for help should they require assistance, these patients should have increased nursing observation
- To ensure appropriate and adequate observation of patients at risk of falls, wards and clinical areas need to implement processes for managing high-risk patients. The use of a tag system, which requires a member of staff to be present in the bay, can work in preventing patients falling. Other alternative options include cohorting same sexed patients at risk of falls into one bay were clinical conditions allows.
- For some patients the safest option is to increase the nurse patient ratio in the ward area. If this cannot be achieved with the current staffing levels this should be escalated through the site operational team
- If the patient is identified as lacking capacity, requiring continuous supervision and is not free to leave this is a Deprivation of Liberty (DOL's) .A DOL's application is required. Flowchart for decision making on Deprivation of Liberty http://sharepoint/safeguardingadults/Lists/Announcements/DispForm.aspx?ID=32 Documentation to apply for DOLS http://sharepoint/safeguardingadults/Lists/Announcements/DispForm.aspx?ID=29

6.5 Communication

- All patients who are identified, as being at risk of falls should be discussed with the wider multi-disciplinary team (MDT) The clinical area must have a local process in place for sharing and dissemination of information on patients who are at risk of falling.
- It is the responsibility of the transferring nurse whether it is from E.D to a base ward or base-to-base ward to inform the receiving ward if the patient is at high risk of falling or has fallen during the admission.
- The receiving ward must make appropriate provision to care for the patient in a safe environment. E.G. source appropriate equipment (Hi-Low bed)
- When it is necessary to move patients who are at high risk of falls or who have fallen during the admission the 'on site' POD leads/first on Sisters/Night Practitioners and duty Matrons must be made aware of any patients that have been identified as being at risk of falls before the move takes place.
- Where possible, patients with a history of dementia or delirium and high risk of falls are only to be transferred when there is a defined clinical need and not to add flow or capacity. The receiving area must ensure an appropriate level of observation can be achieved.
- All patients who are at risk of falling are to be offered a copy of The Falls & Fractures in Hospital Patient Information leaflet. If the patient is unable to read or comprehend the information provided the leaflet can be given to the patient's relatives/carers.
- Any patient that has fallen during their hospital admission, or are identified as being at high risk of falling, the information will be shared upon discharge with the patients G.P and any additional care agencies involved with patient care.

6.6 Equipment

- Any equipment that is used must be risk assessed prior to use to ensure it is appropriate for the individual needs, when not in use e.g. crash mats these must be stored securely to prevent casing a hazard to both patients and staff.
- **Bed rails** Can be in place for patients who are at risk of rolling out of bed. Any patients where the use of bedrails are deemed appropriate for use a bedrails risk assessment must be completed as per the Use of Bed rails Policy.

http://sharepoint/policies/Office%20Documents/Bed%20Rails%20Policy%20and%20Procedure%20-%20v4.0.pdf

- **Hi-Low beds** Allow the bed to be lowered to almost ground level therefore reducing the risk associated with patients falling out of bed.
- **Movement alarm devices** – these detect patient movement and alert staff with an audible buzzer or bleep, with the assumption that staff can then intervene to prevent the patient from falling.
- **Crash mats** are to be used at the bedside to reduce injury associated with falling/rolling out of bed.
- **Specialised equipment** such as 'hemi-tables' are only to be used if prescribed by a therapist and their use should be reviewed by the therapist during treatment sessions
- **Additional Equipment** the use of anti-slips socks are available for use on all patients and can be ordered from iproc using the code is **CVW032**
- **If movement sensors are required for patients at home referral to Safe and Sound Service (community Housing) is required**

6.7 Discharge Planning

- All patients who present to the emergency department following a fall will have their G.P. notified and recommended for follow up by the community falls service.
- G.P's will be notified upon discharge of any patient that has fallen whilst an in-patient at HEFT.
- Follow up referrals for falls can be either via community falls services or by Consultant led falls clinic. within HEFT arranged via the patients G.P or via
- The patient's risk of falls is to be communicated to any care agencies involved in the patient's care and is to be included in their discharge documentation this must also include the dates of any falls that occurred in hospital and detail any injuries sustained because of a falls.

7. Responsibilities

7.1 Individual Responsibilities

7.2 Chief Executive

- The Chief Executive retains overall responsibility for polices within the Trust. Operational responsibility for this policy is designated to the Chief Nurse.

7.3 Chief Nurse

- The Chief Nurse will take the executive lead for the Falls Policy and will be responsible for the development, approval and review of the policy. They will oversee the implementation of this policy and supporting procedure and provide reports, as required, to the Trust Board in this regard.

7.4 Site Head Nurses

- The Head Nurses will oversee the implementation of this Policy and supporting Procedure across their respective sites.

7.5 Matrons / Community Matrons

- Matrons are responsible for overseeing the implementation of the policy within their own areas of responsibility
- Ensure that falls management maintains a high profile within their area.
- Ensure appropriate equipment and resources are available to support the management of patients assessed as being at risk of falls.
- Ensure falls incidents are investigated appropriately.

- Ensure action plans from Root Cause Analysis for injurious falls are progressed.

7.6 Senior Sisters / Charge Nurses / Community Service Lead

- Are responsible for local dissemination and implementation of policies within their wards and departments.
- Address local issues related to patient falls.
- Ensure that any falls incidents are reported in accordance with Incident reporting policy.
- Be aware of the rate of falls in their areas.
- All falls incidents are investigated appropriately including Root Cause Analysis are completed for injurious falls.
- That the clinical staff have received falls awareness training

7.7 Clinical Site Leads, Duty Matrons, Night Coordinators and Site Practitioners

- To assist A & E, and other assessment areas, in identifying an appropriate placement for patients at risk of falling.
- To ensure that ward moves, and moves within a ward are kept to a minimum.
- To avoid, where possible, moving frail older patients between the hours of 8pm & 8am.

7.8 Registered Nurses

- Implement falls risk reduction bundle, either level one or two, dependant on clinical history and condition for all patients age 65 and over.
- Complete a bedrails risk assessment for all patients assessed as being at risk of falling.
- Follow the 'Action to take when a patient falls in hospital' (**attachment 3**)
- Report all inpatient falls using DATIX incident reporting system.
  Ensure the multi-disciplinary team is aware of patients who are at risk of falls or who have fallen as an inpatient.
- **Community nurses** are required to undertake falls risk assessment part one and two (if applicable) on all patients aged 65 years and over.

7.9 Medical Staff

- Document previous falls history in the clerking documentation.
- Ensure a documented medication review has taken place.
- Review patients after a fall in accordance with 'Action to take when a patient falls in hospital.
- Ensure on discharge that those patients at risk of recurrent falls are referred for appropriate follow up in the community or ambulatory care service within Trust -

7.10 Physiotherapists

- Carrying out an assessment of gait and balance on all patients admitted to hospital with a fall or following a fall as an inpatient.
- Provide advice to other members of the MDT on the best methods of patient movement and mobility.

7.11 Occupational Therapists

- Carrying out an assessment to identify any discharge requirements on all patients referred to the service with a fall or following a fall as an inpatient.

7.12 Pharmacists

- Pharmacists will be required to undertake medication reviews for all patients identified at high risk of falls and on a level two falls bundle.

7.13 Portering and Phlebotomy Staff

- Portering staff are responsible when returning patients to the clinical area to leave the patient with their bed at the lowest level. Porters must clarify with a member of the nursing team if the bed rails are to be in place.

- If porters are returning patients to sit in a chair they should ensure that a member of the nursing team is informed and the patient is left safe before they leave.
- Phlebotomy staff will ensure they leave the bed at the lowest level and check with the nurse in charge if bedrails are in use.

7.14 All staff groups

- All staff must ensure that the work environment is safe and hazard free in order to minimise the risk of a patient falling.

7.2 Board and Committee Responsibilities

The Trust Board has overall responsibility for ensuring there are safe systems of practice in place to enable the effective delivery of patient care

7.21 Nursing & Midwifery Board

The Nursing & Midwifery Board will be responsible for the approval of the policy and any changes to the policy following periodic review when appropriate in the light of new evidence or national guidelines.

7.22 Falls Steering Group

The Falls steering group will meet monthly and will receive site reports on the progress and compliance with the policy and escalate any concerns identified.

7.23 Nursing & Midwifery Performance Committee -

Will receive and endorse reports from site quality & safety groups regarding compliance with the policy, this will be measured via the Nursing Metrics.
Breaches of the policy will be escalated to the site's Quality & Safety meetings and any action plans are to be discussed to the Nursing & Midwifery Performance Group.

8. Training Requirements

- The Trust is aware that the successful implementation of this policy is reliant on adequate and effective training and awareness raising for all clinical staff
- Falls Awareness Training is included in the Trust Mandatory Training list
- All clinical staff commencing employment with the Trust will receive falls awareness training as part of the Corporate Induction programme
- Further training opportunities are available in the form of the VITAL programme for Nurses, Healthcare Assistants and junior doctors
- Bespoke training can be provided in response to an identified speciality need or request

Community Teams

- All community clinical teams are required to attend Community Falls Awareness training on appointment and update training session every 3 years
- Training sessions will include Falls Awareness, Risk Assessment , Prevention and management of falls and the use of risk tools and referral pathway

9. Monitoring and Compliance

Criteria	Mechanism	Frequency	Responsible	Monitoring Committee
Duties	Nursing Metrics Incident Reporting Governance Information Report	Monthly Six monthly Quarterly	Corporate Nursing Falls co-ordinator Governance information manager	Nursing and Midwifery Board
Requirements to undertake appropriate risk assessments	Nursing Metrics Safety Thermometers	Monthly monthly	Corporate Nursing	Nursing and Midwifery Board
Organisations expectations in relation to staff training	Attendance at Mandatory Training and Induction recorded on OLM	Monthly	Learner Registry	Mandatory Training Committee
Process for raising awareness	Daily Harm Alert for Injurious Falls	Daily	Corporate Nursing	Nursing and Midwifery Performance Committee

10. References

1 Essential care after an inpatient fall

Reference number

1295

Central Alert System (CAS) reference

NPSA/2011/RRR001
Issue date13 January 2011
Action date (if applicable) (date field) 14 July 2011

DH Gateway reference

15328
http://www.rcplondon.ac.uk/sites/default/files/documents/medicines-and-falls2.pdf
Prevention and management of osteoporosis: report of a WHO scientific group WHO Scientific Group on the Prevention and Management of Osteoporosis (2000: Geneva, Switzerland)
Putting Safety First Ways to Prevent Falls Patient Information Booklet produced in associated with Solihull Local Council

11. Attachments

Attachment 1	Falls Screening Bundle
Attachment 2	Fall with Head Injury
Attachment 3	Actions to take post fall
Attachment 4	Falls and Fracture Patient Information Leaflet
Attachment 5	Falls Notification Leaflet
Attachment 6	Falls Prevention A/E

Community Falls Attachments

Attachment 1	Falls Home Safety Checklist
Attachment 2	Community Falls Screening Tool (Part 1)
Attachment 3	Community Falls Assessment and Care Plan (Part 2)
Attachment 4	Post Falls Assessment Guidelines (WMAS I Stumble)

Falls Screening Bundle For All patients aged 65 years and over and any patients considered to be at risk of falls.

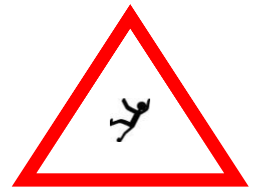
Screening questions:	Is the patient age 65 or over? YES / NO Is the patient considered to be at risk of falls? YES / NO		*Sign and date*		If NO to both questions no further action required
CONSIDER	**ACTIONS – if required**	**Date of Initial Review + RGN Sign**	**1st Review Date/Initials**	**2nd Review Date/Initials**	**3rd Review Date/Initials**
F	**Footwear** to be well fitting if not, offer anti-slip socks *socks supplied* **YES / NO**				
A	**Assessment** All patients over 65 years will be considered to be at risk of falls whilst an inpatient at HEFT.				
L	**Level of observation** Observation needs to be appropriate to risk and clinical need				
L	**Leave it low before you go** All beds should be left at the lowest level following any intervention				
S	**Safe Environment** • Clutter free environment • All patients to have access to call bell • Lighting in the bay/ward must be suitable to promote safety • Orientate patients into their environment				

✓ Tick those that apply	If any High Risk ✓ Criteria complete Level 1 & Level 2 Bundle (1-15)	Signature & Date
	All patients admitted with a fall *(date fall occurred if known)*___/____/___	
	Fallen in the last 3 months	
	Fallen whilst in hospital *(date fall occurred)*_____/_____/_____	
	Admitted with an acute stroke	
	Known dementia or a delirium	
	Parkinson's Disease	
	Confused and restless	
	Visual impairment/blind	
	Alcohol or drug dependant	
	Incontinence	

If no High Risk criteria identified above complete Level 1 Bundle (1 to 7)

		Date of Initial Review + RGN Sign	**1st Review Date/Initials**	**2nd Review Date/Initials**	**3rd Review Date/Initials**
1 Medication	Avoid the use of sedative medications. If the patient is prescribed sedation, request a medication review.				
2 Communication	Clear communication of mobility status shared via verbal handover, electronic handover, Jonah Board, MDT meetings				
3 Information	Patient/ Family provided with copy of Falls & Fracture in Hospital leaflet		Date leaflet provided: ___/___/___		

<table>
<tr><td>4
Urinalysis</td><td>Undertake urinalysis to consider for signs of infection, which could increase risk of falls</td><td></td><td colspan="2">Date completed: ___/___/___
Results in notes: YES NO</td></tr>
<tr><td>5
Visual Impairment</td><td>Is the patients eye sight corrected by spectacles?
N.B. Patients with visual impairment or who are registered blind to be placed on Level 2 falls bundle</td><td></td><td colspan="2">Glasses with patient: YES NO
Comment:</td></tr>
<tr><td>6
Therapy Intervention</td><td>Uses mobility aids?
Requires mobility assessment and/or new walking aid YES / NO</td><td></td><td colspan="2">State aids required;
Consider Eat Drink and Move Care Bundle</td></tr>
<tr><td>7
Discharge Planning</td><td>Consider whether a referral required to community falls service</td><td></td><td colspan="2">Referral made:</td></tr>
<tr><td colspan="5">Falls Bundle Level 2 for High Risk (1-15)</td></tr>
<tr><td colspan="3">Complete in conjunction with level one when patient is identified at High Risk</td><td>Registered Practitioner Sign & Date</td><td>Actions</td></tr>
<tr><td colspan="3">8 Medication
Medication review required?
Dr /Pharmacist………………….
Date requested____/_____/____</td><td></td><td>Changes to medication made are to be recorded on the e-TTO</td></tr>
<tr><td colspan="3">9 Nursing Assessment
Record lying and standing BP
Record radial pulse manually for 1 minute to for check for arrhythmias
Date completed____/_____/_</td><td></td><td>Deficit noted YES / NO
Doctor informed: YES / NO / N/A
Additional Comments:</td></tr>
<tr><td colspan="3">10 Visibility & Specialist Equipment
Consider placement on ward due to risk and clinical need and
Consider additional equipment/ resources to be used</td><td></td><td>(✓ all that apply) Increase nurse patient ratio
Hi/Low bed in use
Crash mats in use
Bedrails assessment completed and required
Bed alarms in place</td></tr>
<tr><td rowspan="3">11 Physiotherapy Assessment</td><td colspan="2">Balance and gait assessment required</td><td></td><td>Date completed
____/____/____sign________</td></tr>
<tr><td colspan="2">Mobility planned discussed at MDT recorded in patients medical record</td><td></td><td>Date completed
____/____/____sign________</td></tr>
<tr><td colspan="2">Appropriate chair available at bedside</td><td></td><td>Date completed
____/____/____sign_____</td></tr>
<tr><td colspan="3">12 Falls Coordinator
Referral made to falls coordinator Date requested____/_____/____</td><td></td><td>Seen by Falls Coordinator</td></tr>
<tr><td colspan="3">13 OT Assessment
Site/ Home visit planned Date for visit____/_____/____</td><td></td><td>Comments post visit</td></tr>
<tr><td rowspan="2">14.Discharge Planning</td><td colspan="2">Follow up in falls clinic</td><td></td><td></td></tr>
<tr><td colspan="2">Follow up via Community falls Service</td><td></td><td></td></tr>
<tr><td colspan="3">15 Additional Assessment
Referral for FRAX Assessment required FRAX assessment: Tool for the assessment of bone density and fracture risk)</td><td></td><td>Arranged by:</td></tr>
</table>

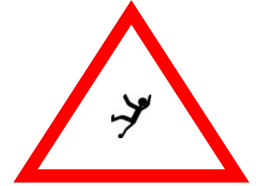


Name PID

Fall with Head Injury or Suspected Head Injury

Process	Interventions	Tick all that apply	Sign and Date
Immediate action to be taken	Administer immediate first aid as necessary Specify actions taken...		
	Registered Nurse to complete full set of neurological observations Time completed... GCS........./15		
	Patient to receive a medical review within one hour Time of reporting............. If initial GCS is below 15 review within 30minutes		
	Out of hours i-bleep to be recorded as red catergory Time of reporting.............		
	Review Falls Bundle Update to Level 2 (if not previously on level 2)		
	Instigate additional safety measures (specify)...............		
	Enter incident on to Trust Datix reporting system Datix number..................		
	Inform next of kin or appropriate contact of incident Time notified..............		
Monitoring Neurological Observations	Neurological observations to be recorded **as stated ,if at night the patient must be woken up** • ½hrly for first 2 hours • If GCS remains at 15 then hrly for 4 hours • 2hrly for 6 hours		
	If GCS below 15 continue with ½hrly neurological observations		
Escalation To medical team or Critical Care Outreach Team	If GCS drops by 2 points or new onset of symptoms e.g. • Vomiting • Headaches • Dizziness • Pain or tenderness • Altered conscious level		
	Patient requires urgent review within 30minutes from either Medical team or Critical Care Outreach. Time of escalation...........		
Additional Factors for Consideration.	Patient with cognitive impairment or dementia consider other factors such as • Change in behavior • Increased levels of agitation, restlessness or listlessness • Patients require 30-minute review time of request...		

When a Patient Falls in Hospital



Call for Assistance

Immediate	Registered Practitioner to attend to patient to assess level of injury
Complete assessment	Airway Breathing Circulation Pain Limb movement/ deformity
On return to bed	Complete full examination to establish any injuries Confirm if patient has any pain Complete full set of MEWS Observations If a head injury is suspected commence ½ hrly neurological observations
Review	Inform medical team or hospital at night team via i-bleep.

Timescale for Review

One-Hour Review	For any patients with A head Injury Pain Obvious limb deformity
Four-hour Review	For all other patients to be reviewed within four hours
Escalation of review	**Patients for urgent review** Change in patient's condition Escalation of MEWS Change in behaviour or altered conscious level

Falls at Night

I-bleep system to be used	Red catergory for head injury, pain or obvious limb deformity Amber catergory all other falls.

Produced in accordance with NPSA Rapid Response Alert NPSA/2011/RRR001 BL 2013

Patient Information Leaflet

Falls & fracture

prevention in hospital

Information for patients, relatives & carers

Bridget Leach, Falls Co-ordinator, August 2013

review date Aug 2014

Advice for patients, relatives and carers on reducing falls in hospital

Heart of England NHS Foundation Trust is committed to minimising the risk of inpatient falls and subsequent injuries that can occur in hospital.
Unfortunately patients in hospital (and residential/nursing homes) are statistically more likely to fall than in their own home. This may be due to their illness and frailty along with being in a strange and unfamiliar environment. This is a particular risk for patients who are confused and agitated or for those with a dementia.
This leaflet has been developed to inform you of the steps we are taking to reduce falls in hospital.

What measures are in place?

- Highlighting those patients who are at risk of falling
- Guidelines for staff to follow if a patient is identified as being at risk of falls or has fallen whilst in hospital
- Staff training programmes
- A Falls Co-ordinator who is able to offer advice on falls prevention
- Availability of specialist Falls Services to investigate the reason for a person falling
- The ‘Call don’t fall’ card to remind patients to call for assistance if they want to mobilise but are unsteady.
- Non slip socks to reduce risk of patients slipping

How can you help?

As a patient

- Let us know if you have fallen before or feel unsteady on your feet
- Let us know if you have ever broken a bone
- Tell a member of staff if you feel anxious about moving around
- Use the nurse call bell to ask for assistance to move about the ward
- Always take care when standing or getting up from your bed/chair
- Use your walking aid when moving around
- Wear well fitting footwear
- Listen to the advice given you by the therapy team or nurses
- Ensure you wear your glasses or hearing aid if you have them
- If you have many different tablets to take at home ask someone to bring them in, it may be useful for the doctor or pharmacist to see them

As a relative or carer

- Share any information you have on previous falls or broken bones
- Avoid moving furniture when you visit and put your chairs away when you leave.
- Avoid leaving any bags etc at the side of the bed.
- Ensure the patient realises you are leaving
- Inform the nursing staff as you are leaving
- Place the nurse call bell by the patient as you leave
- Ensure they have appropriate, well fitting slippers/shoes, and have their glasses/hearing aid.

If there is a risk of falling we may do one or more of the following

- Move the patient to an area of the ward where close observation is easier-particularly if the patient is confused and unable to use the call system or follow instructions.
- Review and sometimes alter their current medications.
- Consider the safe use of bed rails using policy and guidelines.
- Consider using an alert system that alarms when a patient, who is unable to call for assistance attempts to mobilise without assistance.
- Use a specialist bed that goes lower than a normal hospital bed.
- Consider referral for specialist Falls Assessment.

- Those at risk of falling are at risk of breaking a bone, this is a particular risk for patients with osteoporosis (a common condition where the bones become more fragile) We can assess a patients likelihood of having the condition and consider treatment to maintain bone health and reduce fracture risk.

Use of bed rails

- Bedrails are a useful piece of equipment used to minimise the risk of a patient falling, rolling or sliding from bed.

However;

- Inappropriate use of bed rails has resulted in injury and, though extremely rare in hospital settings, even death caused by entrapment.
- **For example; if a patient is restless and confused they may attempt to climb over, through or round the rail and become trapped or fall OVER the rail (thus increasing the height from which they fall) which can cause injury or entrapment.**
- If a patient is considered to be at risk of falling whilst in hospital an assessment will be made by nursing staff to decide if the use of bed rails is advisable or not whilst the patient is in hospital.

If a fall occurs..

- All inpatients that fall will be reviewed by a doctor to ascertain if there has been any injury
- A falls incident will be completed and the patients next of kin will be informed (with the patients permission)
- A note of the fall will be made in the patient’s medical record.

Additional sources of information

You may wish to visit the **Health Information Centre** located within the hospitals or alternatively you can contact us:
Telephone 0121 424 2280
Email: healthinfo.centre@heartofengland.nhs.uk

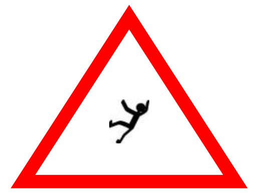
You Plus- Healthy living advice
Freephone: 0800 015 3265
1 Cappice Way, Chelmsley Wood Shopping Centre
Birmingham, B37 ST5

For Further Information about Falls and Falls Prevention:

Age UK
Telephone: 0800 169 6565
www.ageuk.org.uk

National Institute of Clinical Excellence (NICE)
www.nice.org.uk/guidance/CG21/publicinfo/pdf/English

NHS Choices
www.nhs.uk/conditions/falls/pages/what-to-do



Attachment 5

Relative/Carer notification of patient fall

Patient name: ____

Date of incident: ____

Time of incident: ____

Location (ward location and exact location): __________________________

____

Brief description of what occurred: ________________________________

____

____

Immediate action taken: (including time of medical review and any investigations ordered)

____

____

____

____

Action taken to prevent recurrence ________________________________

____

____

Given copy of Falls & Fracture Prevention in hospital leaflet? **Yes** ☐ **No** ☐

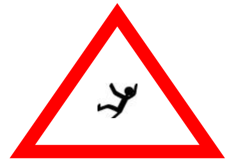
Signature: __________________________ **Profession:** __________________

Being Open
Saying sorry when things go wrong

If you require any further information please speak to the nurse in charge

0164_Falls notification_SM_11_05_11

Name
PID



Adult Falls Prevention within the Emergency Department

To be implemented for all patients aged 65 years and over or are attending following a fall.

CONSIDER	Implemented	✓All that apply
Assessment	All patients aged 65 years and over have an increased risk of falls in hospital	
Footwear Should be well fitting if not, offer anti-slip socks Is the patient likely to wander without supervision	Patient has suitable well fitting footwear	
	Anti-slip socks provided	
	Patient refused to wear anti-slip socks (Document any discussion re reason why)	
Level of observation Observation needs to be appropriate to risk and clinical need Is the patient confused & agitated	Does the patient need to be nursed on a high low bed due to their high risk of falls	
	Can the patient be prioritised to be moved to an approriate ward area	
	Does the patient need to be nurses in a “high traffic area” to ensure the supervision is adequate to their needs	
	Has the patient been given the nurse call bell and explained how to use it	
	Is the patient able to use call bell	
	Consider increasing the patient –nurse ratio to manage the patient safely	
Safe Environment Clutter free environment	Ensure all equipment and patients belongings do not cause hazzards to the patient	
	Patients who can mobilise to the toilet are shown where the toilet facilities are	
Medication Is the patient taking any medication that can increase their risk of falls.	Sedatives	
	Opiates/ codeine cased analgesics	
	Anti-hypertensives	
Discharge Planning from E.D Consider whether a referral required to community falls service	Referred to Community Falls service	

Completed by Insert Name

______________________________________**Signature**__________________________

Date ------/-------/----- **Time**__________**hrs**

Additional Comments

Falls Home Safety Checklist

	Yes	No	Actioned
Are walkways free from cracks, holes, leaves and debris?			
Are stairways (indoor and outdoor) clearly marked and in good repair?			
Can the depth of each step be clearly seen?			
Is there a light switch at the top and bottom of the stairs?			
Are there solid handrails or bannister on both sides of the staircases (Including outside steps)?			
Are the stairs free of clutter?			
Are light switches and plugs easy to reach?			
Is there enough light to illuminate rooms and passage ways? Are lights glare-free?			
Are there nightlights in the bedroom, bathroom and hallways?			
Is there non- slip backing on bath mats?			
Are there slip-proof strips or mats in the bath or shower?			
Are bathroom grab bars securely fastened to the walls?			
Do floor coverings lie flat and stay put?			
Are all floorings non-slip?			
Are walking areas free of electrical cords and clutter?			
Is telephone easy to reach from each room in the home?			
Are emergency phone numbers listed by each phone?			
Are regularly used items at arm's reach?			
Are there animals present that pose any hazards?			
Can access be gained in an emergency (e.g. key safe present)?			
Does bed linen pose any trip hazard?			
Do walking frames fit through doorways (without releasing safety catches)			

Name of Patient: ____________________

Date of Birth: ____________________

NHS number: ____________________

Community Attachment 2

Community Falls Risk Screening (part 1)

- **SCREEN ALL PATIENTS AGED 65 OR OLDER**
- **USE CLINICAL REASONING TO SCREEN PATIENTS UNDER THE AGE OF 65**

Definition of a fall: 'an unexpected event in which the participant comes to rest on the ground, floor or lower level'

Falls Risk Screening	
Has the patient fallen in the last 12 months?	YES / NO
Does the patient or relatives report anxiety or fear about risk of falling?	YES / NO
Does the patient report any balance or mobility problems?	YES / NO
Is the patient on 4 or more prescribed medications per day?	YES / NO
Can the patient get up out of the chair without using arms?	YES / NO
If all NO→no further action. If YES to any 3 or more→complete Falls Assessment and Care Plan document (part 2)	

Comment Box

Assessor Name: Signature:

Date: Time:

NB Triggers for review would be

- New falls
- Increased anxiety about risk of falling
- Reduction in mobility
- Changes in medication
- Changes in health or social care needs
- Family concerns
- Changes in Care Plans

Name of Patient:
Date of Birth:
NHS number:

Community Falls and Assessment Care Plan Part 2

Assess for presence of risk factors in the first column. Undertake suitable interventions and make referrals as appropriate

Risk factors	Interventions Tick box of relevant completed actions	Comments
History of falls / Fear of falling	□ Discuss recent / previous falls. Identify causes □ Consider GP referral for reported 'blackout' or unexplained fall' □ Consider presence of infections e.g. urinary tract infection □ Provide 'Top Tips to Prevent Falls' leaflet □ Provide other relevant falls leaflet available on falls intranet page □ Discuss use of a pendant alarm □ Consider a height of furniture/bedrail assessment/chair sensors/cushioned floor mats □ Discuss fear of falling and realistic prevention measures □ **Referral options: GP / IMC / MSK / CES / OT**	
Mobility problems	□ Check for recent deterioration in mobility – can they get out of the chair without using their arms? □ Consider referral for assessment of gait, balance and strength exercise and/or walking aids □ Discuss the importance of keeping mobile and active □ Consider walking aids and equipment □ **Referral options: GP / PT / IMC / MSK / CES /OT/MHCT**	
Environ-mental hazards	□ Advise on reducing potential home hazards e.g. leaving lights on in dark areas, keeping floor clear of trailing wires, removing rugs / mats, using non-slip mats in bath / shower □ Consider referral to 'Safe and Sound' Service □ Advise about local suppliers of disability equipment or following assessment request equipment from joint stores □ Ensure patient is able to manage access and use of the toilet. Refer to OT if not □ **Referral options: OT / IMC / CES / Safe and Sound/Social Services**	
Medication problems	□ Check for possible side effects of the prescribed medication (Check medication list on page 2 or seek advice from Pharmacist or GP) □ Advise the patient on increased falls risk by known side effects □ Consider need for medication review □ Check if there are any difficulties with administration and/or collection of medication □ Advise the patient to drink plenty of fluids when taking oral prescribed medication (unless fluid restricted) □ **Referral options: GP / PH/VW**	
Feet / footwear problems	Advise to wear good supportive non slip footwear both in- and outdoors □ Consider a referral to podiatrist if balance/gait problems are related to foot deformities or disease (ensure patient meets referral criteria) □ Referral options: POD	

Vision problems	□ Advise annual eye test over 75yrs, bi-annual for over 65years □ Advise caution in use of bifocals / vari-focals □ Check if Diabetes and Glaucoma are monitored regularly □ Refer to GP for eye assessment if vision has altered as a result of a resent illness □ **Referral options: GP / OPT**	
Bone Health problems/ Osteo-porosis	□ Check Risk Factors for Osteoporosis (see page 3) □ Discuss the importance of calcium and vitamin D □ Advise importance of exercise, nutrition and □ Advise that exposure to sunlight every day between May and September will increase vitamin D and help to keep bones healthy □ Advise the patient to raise any concerns about bone health, previous fracture(s) and/or administration of osteoporosis medication at the next GP visit □ Advise about local exercise groups □ Referral options: GP / PH / DT/FT	
Postural Hypotension Dizziness problems	□ Inform regarding the need to stabilise oneself before walking after standing up from bed or chair □ Measurement of lying/standing blood pressure (using best practice guidelines) □ Check hydration and medication for side effects □ Referral options: GP / PN / DN / PT	
Cognitive impairment	□ Advise client/family member regarding availability of assistive technology □ Consider referral to GP for further investigations or avoidance of crises situation □ Referral options: GP / OT / CES	

Onward Referral key		
GP – General Practitioner	MSK – Musculoskeletal	OPT – Optician / Optometrist
PN – Practice Nurse	DN – District Nurse	PH – Pharmacist
PT – Physiotherapist	OT – Occupational Therapist	DT – Dietician
IMC – Intermediate Care	AC – Age Concern / AgeUK	POD – Podiatrist
FALLS – Falls Team	CES –Community Equipment Service	VW – Virtual wards
MHCT -		
Name: Signature: Date: Time:		

West Midlands Ambulance Service NHS

NHS Foundation Trust

- Clear of Dangers
- Any Response
- Airway open
- Breathing adequate
- Pulse

No → **Call 999**

Yes ↓

Intense pain
Suspected collapse
Trauma to neck/back/head
Unusual behaviour
Marked difficulty in breathing/chest pain
Bleeding freely
Loss of consciousness
Evidence of fracture

Yes to 1 or more → **Call 999**

No ↓

FAST Test Normal

No → **Call 999**

Yes ↓

Use correct lifting aids and manual handling to lift resident from the floor.

↓

Treat minor injuries within scope of practice
Consider GP/Practice Nurse for minor injury treatment
Observe regularly for changes in condition
Seek further advice if necessary

Reassess

↓

Documentation & pilot log book
Commence falls investigation
Complete a falls referral.

Call 999

Keep patient Calm Still Comfortable

Answer all questions and follow instructions from 999 call taker

Wait with the patient until ambulance arrives

Inform next of kin

West Midlands Ambulance Service NHS
NHS Foundation Trust

Intense Pain

- New pain since fall
- Includes headaches, chest pain and abdominal pain
- Consider both pain from injury caused by fall or medical causes

Suspected Collapse

- Ask the patient if they tripped or collapsed
- Any dizziness or nausea before fall
- Includes near fainiting episode

Trauma to Neck/ Back/ Head

- New pain in neck/back/head following fall
- New lump or dent in head 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 (in mugfuls)

Loss of Consciousness

- Knocked out
- Drifting in and out of conscioueness
- 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 movements in affected area
- Unusual movement around affected area.

In all 999 cases remember to keep the patient **Calm, Still & Comfortable** If any bleeding is present, apply constant direct pressure with a clean dressing.

WMAS/MPERRY

Appendix 1: Equality and Diversity - Policy Screening Checklist

Policy/Service Title: Policy for the Prevention & Mangement of Patient Falls	**Directorate: Corporate Nursing**
Name of person/s auditing/developing/authoring a policy/service: Bridget Leach	
Aims/Objectives of policy/service:	

Policy Content:

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

1. Check for DIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
1.1	Age?	x			x		x
1.2	Gender re-assignment?		x				
1.3	Disability?		x				
1.4	Race or Ethnicity?		x				
1.5	Religion or belief (including lack of belief)?		x				
1.6	Sex?		x				
1.7	Sexual Orientation?		x				
1.8	Marriage & Civil partnership?		x				
1.9	Pregnancy & Maternity?		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

2. Check for INDIRECT discrimination against any group of SERVICE USERS:

Question: Does your policy/service contain any statements/functions which may exclude people from using the services under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
2.1	Age?	x			x		x
2.2	Gender re-assignment?		x				
2.3	Disability?		x				
2.4	Race or Ethnicity?		x				
2.5	Religion or belief (including lack of belief)?		x				
2.6	Sex?		x				
2.7	Sexual Orientation?		x				
2.8	Marriage & Civil partnership?		x				
2.9	Pregnancy & Maternity?		x				

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION = 2
Policy excludes paediatric and neonates

3. Check for DIRECT discrimination against any group relating to EMPLOYEES:

Question: Does your policy/service contain any statements which may exclude employees from implementing the service/policy under the grounds of:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
3.1	Age?		x				
3.2	Gender re-assignment?		x				
3.3	Disability?		x				
3.4	Race or Ethnicity?		x				
3.5	Religion or belief (including lack of belief)?		x				
3.6	Sex?		x				
3.7	Sexual Orientation?		x				
3.8	Marriage & Civil partnership?		x				
3.9	Pregnancy & Maternity?		x				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:							
Question: Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to:		**Response**		**Action required**		**Resource implication**	
		Yes	**No**	**Yes**	**No**	**Yes**	**No**
4.1	Age?		x				
4.2	Gender re-assignment?		x				
4.3	Disability?		x				
4.4	Race or Ethnicity?		x				
4.5	Religion or belief (including lack of belief)?		x				
4.6	Sex?		x				
4.7	Sexual Orientation?		x				
4.8	Marriage & Civil partnership?		x				
4.9	Pregnancy & Maternity?		x				
If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.							
TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION = 0							

Signatures of authors / auditors:
Completed by Maria Mackenzie Corporate Nursing
Date of signing: 08/01/2014