Birmingham and Solihull Mental Health NHS Foundation Trust

Falls Prevention and Falls Management Policy

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Policy lead	**Trust Clinical Lead – Moving & Patient-Handling and Falls prevention & management SME**	
Policy author *(if different from above)*		
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

This policy is to safeguard service users and staff by reducing the incidence of falls and ensuring safe, timely assistance when a fall has occurred.

This will be achieved by:

1. Preventing falls within our service-user population.
2. Providing safe, careful assistance after a fall to minimise harm and maintain safety for all.

Policy requirement (see Section 2)

This policy sets out the required processes for preventing falls and for safe handling to prevent or reduce harm if a fall occurs.
It specifies:

- Admission Falls Risk Screening to be completed within six hours, with risk-proportionate care planning and safeguards.
- Immediate Post-Fall Response: scene safety, clinical triage, time-critical actions, escalation, and documentation.
- Falls Retrieval (Recovery) options to support safe repositioning or uplift and to facilitate a service user's recovery after the fall.
- Post-Fall Clinical Examination, physiological observations, monitoring, reporting, and learning recommendations.
- Advanced Skills and competencies needed for equipment-assisted retrieval, including the safe selection and use of specialist devices.

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
01/12/2025	5	Dr Louis Watson, Trust Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert	NICE guidance updated. Minor post-ratification amendment. Added section 4.0 Reporting and governance (ECLIPSE notification and surveillance) to formalise incident notification or digest routing to the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert for timely PSIRF learning and risk mitigation. No change to clinical standards, clinical pathways, or scope.	TCGC

Contents Page:

1: Introduction: 3
2 Requirements Falls prevention 5
3.0 Policy Procedure 6
4.0 Reporting and governance 8
5.0 The procedure of Preventing and managing Falls 11
6.0 Medicines optimisation to reduce the risk of falls 11
7.0 Management of Falls 11
8.0 Transfers & Discharges 12
9.0 Escalation (non-punitive): 12
10.0 Training and competence 12
11.0 Falls prevention in community settings. 13
12.0 Responsibilities 14
13.0 Development and Consultation process: 21
14.0 Reference documents 21
15.0 Glossary: 22
16.0 Audit and assurance: 23
17.0 Appendices 24
APPENDIX 1 - EQUALITY ANALYSIS SCREENING FORM 25
APPENDIX 2 - FALLS PREVENTION PROCESS FLOWCHART 30
APPENDIX 3 - IMMEDIATE POST-FALL CARE FLOWCHART 31
APPENDIX 4 – MULTIDISCIPLINARY TEAM (MDT) FALLS HUDDLE GUIDELINE 35
APPENDIX 5 – FALLS RISK INCREASING DRUGS (FRIDS) 37
APPENDIX 6 - SCREEN SHOT OF 'FALL PREVENTION RISK ASSESSMENT' FORM (RIO) 41
APPENDIX 7 - FALLS INCIDENT ECLIPSE REPORTING TEMPLATE (WITH RATIONALE) 43
APPENDIX 8: PREVENTING DETERIORATING HEALTH (PDH) 8 DAILY SIGNS 46

1: Introduction:

1.1 Rationale (why):

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) are committed to providing a safe environment for patients, staff, and visitors. This policy offers practical guidance for managers and staff caring for individuals who may be at risk of falling, with the aim of minimising harm and maintaining safety. It focuses on the prevention of falls and falls management for service users identified by NICE as being at heightened risk of falls.

The Trust seeks to reduce avoidable harm from falls through evidence-based practice and a just, non-punitive safety culture. Staff are supported to pause when unsure, escalate concerns early, and select conservative options where safety or competence may be uncertain.

1.2 Scope

This policy applies, in line with the updated NICE guidance (**NG249**, 2025) and as a Trust extension beyond NG249, to inpatients and, where applicable, to service users in prison and community settings:

a) People aged 65 years and over in hospital.
b) People aged 50–64 years with health conditions that increase falls risk.
c) People under 50 years if a clinician identifies a significant risk of falling.

To support best practice and evidence-based practice, staff must assess both the environment and the individual's circumstances whenever a falls risk is suspected. Where a risk is identified, proportional risk-reduction actions must be implemented. A falls risk assessment must be completed as soon as practicable and always within six hours of admission or from the point the risk is identified (see Appendix 2).

While the primary focus is on inpatient services, this policy also applies to Trust teams supporting service users in community or residential care settings, where relevant and aligned to NICE NG249 (2025).

Note: routine remote monitoring/telecare is not discussed for falls prevention within this policy.

1.3 Falls CG18 Policy Core Definition

For the purposes of this policy, the Trust adopts the NICE definition of a fall as the core reporting definition and uses the Office for Health Improvement and Disparities formulation to clarify exclusion criteria. NICE defines a fall as an "unexpected event" which causes a person to rest on the ground, floor, or lower level. NICE inpatient reporting guidance also defines a fall as an "unplanned or unintentional descent to the floor", with or without injury, whether assisted or unassisted. OHID describes a fall as unintentional and not the result of a "major intrinsic event" or an "overwhelming hazard"

1.3.1 Definition of a fall

A fall is any unexpected, unplanned, or unintentional descent by a service user to the ground, floor, or another lower level, with or without injury, and whether assisted or unassisted. This includes falls from a bed, chair, commode, toilet, or other furniture or equipment to the floor or another lower level

1.3.2 Falls that remain within scope of this policy

The following are within scope and must be managed as falls:

a) Witnessed falls;
b) Unwitnessed falls;
c) Service users found on the floor or another lower level, unless confirmed as Intentional self-placement;
d) falls reported by the service user;
e) Assisted falls (defined as service user using environment to lower themselves to the fall not intentionally); and
f) Falls from a bed, chair, commode, toilet, or other surface to the floor or lower level.

1.3.3 Exclusion criteria

The following are not falls for the purposes of this policy unless later review confirms that a fall occurred:

a) Intentional self-placement onto the floor without loss of balance, slip, trip, collapse, or other unplanned descent;
b) Planned, controlled lowering to the floor as part of care or treatment where there was no loss of balance or stability; and
c) Events wholly attributable to a major intrinsic event, such as stroke, or to an overwhelming hazard, where the Trust records the primary incident under another clinical or safety pathway

1.3.4 Classification where facts are unclear

Where it is unclear whether an event was an intentional act, a collapse, or a fall, staff must document the factual circumstances, escalate for senior clinical review, and classify conservatively in the interests of patient safety until the classification is clarified. In particular, a service user found on the floor must be treated as having fallen unless intentional self placement is confirmed.

1.4 Principles (beliefs):

- Falls and fall-related injuries are common and serious for service users. Risk increases with age: around 30% of people aged 65+ and 50% of those aged 80+ fall at least once a year.
- The human impact includes distress, pain, injury, loss of confidence, reduced independence, and death. Families and carers are also affected. Falls significantly reduce quality of life and place a substantial burden on health services, with costs to the NHS estimated at more than £2.3 billion annually; the average cost of an inpatient fall is around £2,600.
- BSMHFT actively supports people with learning disabilities and those requiring reasonable adjustments, to access the full range of falls prevention and post-fall management within BSMHFT. Staff will work collaboratively with learning-disability teams, reasonable adjustments champions and partner organisations to ensure positive, equitable care experiences for service users and carers, sharing information appropriately to support safe, coordinated care.

2 Requirements Falls prevention

2.1 Admission screening and daily review Standard: every service user and all in-scope inpatients identified as at risk of falls has a completed multifactorial Falls Prevention Risk Assessment (FPRA) within six hours of admission, or within six hours of first identifying a significant falls risk. FPRA findings must result in targeted interventions and a documented falls care plan. Falls mitigations must be reviewed alongside wider care planning and in response to any deterioration indicators, including the trust Preventing Deteriorating Health (PDH) 8 daily signs (see **appendix 8**), so falls controls do not operate in isolation.

2.2 Policy standards (what must be achieved)

2.2.1 Complete the FPRA in Rio within six hours of admission, or within six hours of first identifying a significant falls risk (**Appendix 6**).

2.2.2 Do not use single-score tools or simple categories such as low, medium, or high, and do not convert the FPRA into a rating. Use multifactorial findings to determine specific actions, safeguards, and referrals.

2.2.3 As a minimum, within the first six hours, assess and document:

a. Strength and balance, including sit-to-stand.
b. Falls history and consequences, including injury and fear of falling.
c. Vision.
d. Footwear.
e. Postural hypotension, where clinically appropriate (lying, sitting, and standing blood pressure).
f. Medicines, including identification of falls risk increasing drugs (FRIDs) (Appendix 5).
g. Environment and behaviour factors, including clutter, lighting, furniture, and risk-related behaviour.
h. Access to the call bell and toilet, including a clear route.
i. Continence and nocturia, with an initial toileting plan including night-time arrangements.

2.2.4 Create a personalised falls care plan in Rio that links each identified risk factor to a specific intervention and review frequency.

2.2.5 Discuss what matters to the service user and agree practical goals and preferences (DIALOG+ where used), then document agreed actions.

2.2.6 Review the FPRA findings and falls care plan daily, and after any clinical change, transfer, medication change, or incident, and update actions accordingly.

2.2.7 Triggered review: if any PDH 8 daily sign indicates deterioration or change from baseline, complete a same-shift review of falls mitigations (including mobility support, environment, toileting plan, medication-related risks, and observation and engagement arrangements where applicable), and escalate via the trust deterioration pathway when indicated.

3.0 Policy Procedure

3.1 Immediate Post-Fall Response

3.1.1 **Standard**: all post-fall responses prioritise life- and limb-threats, avoid unsafe manual lifting, and ensure timely clinical assessment and documentation.

3.1.2 **Do not use mechanical devices such as hoists**, HoverJack or Raizer chairs without appropriate advanced training and have been signed off by L&D and the clinical patient handling team.

3.1.3 **Actions**:

- Pause and utilise dynamic Task, Individual, Load, Environment and Other (TILEO) risk assessment for time-critical risks:
  - Suspected head injury,
  - Suspected fracture, or
  - Suspected spinal injury.
- Do not drag or lift by hand.
- If hip or spinal injury is suspected: do not move the person; request urgent clinical assessment; call a doctor or 999 if clinically indicated.
- Use flat lifting only when clinically indicated and safe to do so.
- Do not hoist a service user off the floor unless instructed to by a qualified staff member.
- The qualified staff member who instructs the use of hoist must document in Rio their rationale and submit a manual handling Eclipse within 6 hours.

3.2 After the immediate assessment

3.2.1 **Suspected or confirmed head injury** (including unwitnessed fall, anticoagulation, GCS change, repeated vomiting or severe headache):

- Automatically uplift to at least level 3 continuous observation,
- Couple this with neuro-observation schedule as per **NG232**,
- Maintain until a medically defined cut-off (for example, 12–24 hours of stable observations or as specified by the doctor), then review.

3.2.2 No serious injury suspected and the person can safely remain on the ward:

- Step up to at least level 2 observations for a defined period, typically 24 hours, focusing on:
  - Pain and analgesia,
  - Mobility on first mobilisation post-fall,
  - Orthostatic hypotension checks, and
  - Early signs of delirium or deterioration.
- Any change in level should be entered on the Enhanced Care prescription with the primary indication “post-fall surveillance” and explicit step-down criteria.

3.3 Falls Management Retrieval/Recovery Options

3.3.1 **Standard**: Support the service user to recover or be repositioned using the least-risk method. Pause and escalate early if it is unsafe to proceed, outside your competence, or you are not authorised.

3.4 Sequence

3.4.1 **First-line**: Backward chaining, coaching the service user to self-recover slowly where safe and appropriate.

3.4.2 **If not safe or unsuccessful**: Contact the senior nurse or clinician for direction and oversight. Stabilise, observe, and seek additional support. Call an ambulance where delay may increase harm. Staff are expected and supported to pause and seek help whenever uncertain.

3.5 Equipment-assisted floor retrieval.

3.5.1 Equipment-assisted floor retrieval is not endorsed unless the staff involved have current mandatory Moving and Handling Level 2 practical training and Falls Advanced Practical Retrieval training and are authorised through specialist sign-off by the Trust Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.

3.5.2 Where no suitably trained and authorised staff are available, do not attempt equipment-assisted retrieval. Escalate to the senior clinician, seek additional support and/or call an ambulance if delay risks harm, and refer to this policy.

3.5.3 Where practice gaps are identified, the response is supportive retraining and temporary removal from the authorised list until re-signed off by the Trust Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert. Areas without specialist skills must contact the Trust Moving and Patient Handling Risk Mitigation Lead for advice, support, and training.

3.6 Manager responsibilities for equipment-assisted floor retrieval.

3.6.1 Maintain an up-to-date local register of staff trained, competent, and authorised, including refresher cycles.

3.6.2 Verify authorisation before any equipment-assisted retrieval: current Moving and Handling Level 2 practical training, Falls Advanced Practical Retrieval training, and Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert sign-off.

3.6.3 Assure that transfers and discharges handovers are completed and that onward referrals are actioned and tracked.

3.6.4 Embed falls prevention and patient handling competence in local induction, supervision, and appraisal, and provide quarterly assurance to the Falls Steering Group.

3.6.5 Collaborate with the Trust Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert and the Steering Group.

3.7 Post-Fall Clinical Examination, Observations, And Referrals

Standard: a proportionate clinical assessment is completed within required timeframes, with observation, escalation, and learning.

Requirements:

- Immediate examination if serious injury is suspected; otherwise within six hours.
- Record physiological observations; complete neurological observations when head injury is suspected; escalate promptly if thresholds are breached.

- Update the care plan and implement targeted interventions; make referrals as indicated (patient handling team, physiotherapy, occupational therapy, pharmacy, tissue viability, medical review).

3.8 Post Falls Enhanced Care and Therapeutic Engagement (Therapeutic Observations)

No serious injury suspected and the person can safely remain on the ward; Step up to at least level 2 intermittent observations for a defined period, reassess at 24 hours, for providing closer supervision and post-fall monitoring recommended for inpatients at increased risk of falls in NICE guidance (NG249) and for possible head injury in NG232.

3.8.1 **During this time**, intermittent observation must be delivered as brief, purposeful therapeutic contacts rather than sighting only, in line with the Enhanced Care and Therapeutic Engagement Policy (C05).

3.8.2 **During this post-fall observation period, observations must focus on:**

- Pain assessment and adequacy of analgesia
- Mobility and safety on the first and subsequent mobilisations after the fall
- Orthostatic blood pressure and symptoms of hypotension or syncope
- Early signs of delirium, cognitive change, or other clinical deterioration.

3.8.3 **Any change in observation level** must be prescribed on the Enhanced Care prescription in Rio, with the primary indication recorded as “post-fall surveillance”, clear clinical goals, and explicit step-down criteria (for example, stable physiological and neurological observations, safe mobilisation plan in place, no new delirium).

4.0 Reporting and governance

Standard: Every fall must be recorded on Eclipse, reported to senior staff, reviewed, and learned from in line with PSIRF. This includes witnessed and unwitnessed falls, falls reported by the service user or others, near falls (stumbles/trips), and unplanned lowering to the floor following loss of balance or stability.

4.1 Service users intentionally placing themselves on the floor

Service users intentionally placing themselves on the floor, without evidence of loss of balance, slip, trip, collapse, or other unintentional descent, must not be recorded or reported as a fall on Eclipse. These incidents must be recorded under the most appropriate non-falls Eclipse category, including behavioural incident reporting where relevant, with a clear factual description of what occurred. Where there is uncertainty as to whether the event was intentional or whether loss of balance or stability contributed, staff must describe the circumstances clearly, escalate to the nurse in charge or other senior clinician, and seek confirmation of classification. If subsequent review identifies that the event was an actual fall, the incident must be reclassified and managed as a fall.

4.2 One service user reporting that another service user has fallen

Where one service user reports that another service user has fallen, but staff did not witness the event and the event cannot be confirmed at the time of review, the incident must not be recorded initially as a fall on Eclipse.

In these circumstances, the incident must be recorded under the Eclipse category Deteriorating Health as a possible deterioration or possible unobserved fall concern, with a clear narrative including:

a) The name of the reporting service user;
b) The name of the reported service user;
c) The date, time, and location of the concern;
d) Exactly what was reported;
e) Whether the reported service user was found on the floor or elsewhere;
f) Whether the reported service user confirmed, denied, or could not clarify that a fall occurred; and
g) The immediate assessment and actions taken.

The reported service user must receive a prompt welfare check and clinical review. Preventing Deteriorating Health (PDH) Daily 8 must then be followed for 72 hours from the time of the report.

A daily summary must be entered in RiO for each of the following 3 days, confirming:

a) Whether any PDH signals were identified (**Appendix 8**);
b) Whether the patient remained at no PDH trigger, Tier 1, or Tier 2;
c) Any changes in mobility, assistance level, behaviour, observations, or physical health concerns; and
d) Any actions taken.

If one or more Tier 1 PDH signals are identified during the 72-hour period, staff must escalate to senior staff and hold a falls huddle in the same shift, in line with Appendix 8.

If a Tier 2 trigger is identified during the 72-hour period, staff must escalate immediately to the MDT in line with Appendix 8 and local physical health escalation procedures.

If subsequent assessment, disclosure, CCTV, witness confirmation, injury findings, or other evidence confirms that a fall did occur, the incident must be reclassified on Eclipse as a fall, cross-referenced to the original Deteriorating Health incident, and managed thereafter in accordance with this policy.

4.3 Falls occurring in connection with restrictive practices

4.4 These falls must be reported as restrictive practice incidents (as the primary incident category). The narrative must clearly state that a fall occurred and describe the circumstances. The incident must also be coded, flagged, and/or cross-referenced so it is captured within falls governance reporting and routed in accordance with section 4.3. AVERTS will share the incident with the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert.

4.5 Falls related to patient handling must be reported as falls, with a clear, thorough description of what happened. This must include the TILEO dynamic risk assessment (as per RS21 Manual Handling Policy), the task being undertaken, the plan in place, equipment used (and ID where available), staff involved, immediate actions, and any contributing factors.

4.6 Incidents must be reported as soon as practicable and by the end of the shift as a minimum. Any actual or suspected injury, head impact, or clinical deterioration must be escalated immediately in line with local procedures and section 3.0 of this policy.

4.7 Prohibited and deprecated practices

- No single-score falls risk tools (including RAG/low–medium–high).
- No manual dragging or lifting by hand.
- No equipment to be used without recorded training competence, authorisation, and pre-use checks.

4.8 ECLIPSE notification and surveillance (falls and falls-related deterioration)

Definition: For the purposes of this policy, the Trust Falls Lead is the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert.

Standard: To enable timely review, learning, and targeted risk mitigation, the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert must receive ECLIPSE notifications (or an equivalent automated daily digest where system rules do not permit direct alerting) for all falls incidents and falls-related deterioration incidents defined in section 4.3.4.

Implementation responsibility: The Patient Safety Team (ECLIPSE/LFPSE administrators) will maintain the relevant ECLIPSE distribution list(s) and notification rules to ensure the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert receives the notifications defined in section

Where automated routing is not technically feasible, the Patient Safety Team will provide a daily extract or digest covering the same incident set.

4.9 Falls-related incident set requiring notification to the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert.
Notifications must include incidents recorded in ECLIPSE that meet any of the following criteria:

Falls and near falls. Witnessed or unwitnessed falls, found on floor, near falls (stumbles or trips), and unplanned lowering to the floor following loss of balance or stability.

Post-fall injury and post-fall deterioration. Any fall (or found on floor) where there is actual or suspected injury, head impact or head injury concern, suspected fracture, suspected spinal injury, or clinical deterioration requiring enhanced observation, urgent medical review, transfer to emergency care, or 999 activation.

Deteriorating health events with a clear falls interface. Collapse, syncope or faint, seizure with a fall or found on floor, sudden mobility decline, hypotensive episode with loss of balance, medication or sedation-related reduced consciousness associated with a fall or near fall, or any incident recorded as physical health deterioration where the narrative indicates a fall, near fall, or being found on the floor.

Moving and handling interface and retrieval activity. Any incident involving patient handling at the time of a fall (transfer, ambulation, assisted mobilisation), any equipment-assisted floor retrieval attempt, equipment malfunction, or any incident raising PUWER, LOLER, or MHOR competence or equipment assurance concerns.

Restrictive practice where a fall occurred. Any restrictive practice incident where a fall occurred. The incident narrative must clearly state that a fall occurred and the incident must be routed in accordance with section 4.3.

Harm threshold. Any incident graded moderate harm or above where a fall, suspected fall, found on floor, or falls-related deterioration is part of the event narrative governance**:**

- Notifications are received for patient safety review and improvement purposes.
- Access and onward sharing must be proportionate, role-based, and in line with Trust information governance requirements.
- Patient-identifiable information must not be forwarded beyond those who require it for immediate risk mitigation, investigation, learning response, or governance reporting.

5.0 The procedure of Preventing and managing Falls

5.1 Prevention of Avoidable Falls Governance, compliance, and collaboration

5.1.1 All staff must comply with this policy and work collaboratively with the Patient Handling Trust Lead and the Falls Steering Group on falls-prevention quality improvements and ECLIPSE incident investigations.

5.1.2 All in-scope inpatients must have a Falls Prevention Risk Assessment (FPRA) completed in Rio as soon as practicable and no later than six hours after admission.

5.1.3 Team communication and routine practice process includes, discuss FPRA findings and agreed actions at the next fall's huddle, ward handover, and/or MDT meeting.

5.1.4 Falls prevention must be embedded in daily practice in line with Trust risk policies and current NHS England/NICE guidance.

5.1.5 Near-miss management includes following any near-miss fall, reassess physical, cognitive, behavioural, and environmental risk factors, and adjust the care plan as clinically appropriate.

5.1.6 Escalation and care planning, including, escalate clinical concerns immediately to the relevant healthcare professional. Review at the next MDT and falls huddle.

5.1.7 Enter or update the Falls Care Plan in Rio under "MDT – Recovery & Discharge Action Plan," and align with DIALOG+ and any other action planning.

6.0 Medicines optimisation to reduce the risk of falls

6.1 All identified patients who have fallen at least once must undergo monthly or quarterly medication reviews (according to clinical need, particularly older adults or those on multiple psychotropics (**Appendix 5**).

7.0 Management of Falls

7.1 For any witnessed fall, or when a service user is found on the floor with a presumed fall, staff must follow the Immediate Post-Fall Care pathway in **Appendix 3.** If the fall was unwitnessed or a head injury is suspected, follow NICE guidance for frequent neurological observations (for example, every 15 minutes initially).

7.2 Before moving, complete and document red-flag screening for head/spine/fracture; if red flags present, do not move and escalate; if no red flags and safe, proceed with the least-risk

recovery method. Keep the person warm, comfortable, and monitored until a full assessment is completed (see **Appendix 3**).

7.3 Report all falls on ECLIPSE (describe what happened, where and when, observed impacts, and immediate actions taken) and document in Rio. Review the current FPRA and update risks and actions accordingly (see **Appendix 7**).

7.4 Where a formal "falls huddle" is not feasible, apply the same multifactorial considerations immediately to guide decisions, referrals, and ongoing care after a fall. This approach aligns with NICE and PHE guidance and must be recorded within the falls risk assessment. A scheduled or ad hoc MDT review may still be held where local practice allows, but the Priority is timely care using the huddle's multifactorial template as a practical checklist (see **Appendix 3**, **Appendix 4** and **Appendix 5**).

8.0 Transfers & Discharges

8.1 Ensure continuity of falls prevention and safe handling across care settings. Applies to all internal transfers and external discharges.

8.2 Minimum handover content (record in Rio and share with the receiving team or GP):

- Falls history and recent events (including near-misses) and current physical health status.
- Latest Multifactorial Falls Assessment (FPRA) and the personalised Falls Prevention Care Plan (risks and mitigations).
- Manual-handling requirements (level of supervision, gait aids, sit-to-stand assistance, and whether equipment-assisted floor retrieval may be indicated).
- Observation plan (including neurological observations if head-injury risk is present).
- Medication review summary (psychotropics, hypotensive agents; pending actions).
- Equipment provided/required (for example, walking aid, hip protectors; note that equipment-based floor retrieval is Advanced Practice).
- Key contacts and follow-ups (named clinician, next of kin/carer, target dates).

8.3 Onward referrals (offer, agree, action):

- Consider and action referrals to Community Falls Services, Physiotherapy, Occupational Therapy, Pharmacy, and Fracture Liaison (if fracture suspected/confirmed), and Safeguarding where indicated.
- Send a GP notification with explicit requests (for example, medication review, vitamin D consideration, orthostatic blood-pressure monitoring). Provide written information to the person/carer and confirm understanding.

9.0 Escalation (non-punitive):

9.1 Where there is any concern about falls risk or complex handling needs, staff must escalate to the Trust Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) for advice. Trends and system issues should be raised to the Falls Steering Group.

10.0 Training and competence

10.0 Falls prevention and management training is mandatory for all relevant clinical staff.

10.1 Moving and Handling Level 2 mandatory practical training is required for all relevant clinical staff.

10.2 **Hybrid training delivery and assurance**: The Trust e-learning package is the baseline reference for all staff and must be used for updates. Local induction must include face-to-face practical input where available; where face-to-face delivery or Advanced-trained staff are unavailable, services must use e-learning as the interim method and escalate the gap for prioritised practical support. Services must maintain a cohort of Advanced-trained senior clinicians, authorised by the Trust Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert, who provide on-ward coaching, cascade knowledge and training within teams, and deliver refresher and update sessions at least every 24 months, and sooner where policy, equipment, or risk themes change.

10.3 **Authorisation to practise**: Staff must hold current Moving and Handling Level 2 mandatory training and complete the Trust advanced retrieval course before undertaking, instructing, or supervising equipment-assisted floor retrieval. The Trust Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert, as
the legally competent person, authorises and signs off practitioners.

11.0 Falls prevention in community settings.

11.1 While this policy primarily addresses inpatient services, some Trust teams support service users in community and residential settings. Apply these principles in line with NICE NG249 (2025).

11.2 **Where relevant, teams must:**

- Identify people at risk of falls in line with NICE NG249 (sections 1.1.2 to 1.1.6).
- Liaise with the GP or an appropriate healthcare professional for a medication review and consideration of vitamin D supplementation in line with local protocols and clinical judgement.
- Offer or refer for indicated interventions, which may include strength and balance training, vision assessment and correction, footcare and footwear advice, and home environment checks completed by appropriately trained staff (for example, occupational therapists), in liaison with care home staff where relevant.
- Make onward referrals to specialist services within the Integrated Care System (for example, community falls services, rehabilitation teams, and fracture liaison services) as appropriate.

Note: routine remote monitoring and telecare are not covered for falls prevention within this policy.

12.0 Responsibilities

Post/Team	Falls prevention — policy	Management of falls and advanced practice	Out of hours (OOH)	Ref
All staff (including bank/agency and temporary staff)	Follow the policy; complete FPRA within six hours of admission; embed daily checks in safety huddles; provide person-centred advice; document in Rio; complete mandatory training. TILEO is documented in Rio before handling; if an incident occurs, summarise the TILEO rationale in ECLIPSE. Ordering of PUWER/LOLER rated and specialist must be authorized by Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) and via the SHUB central trust ordering system. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	Default to backward chaining were safe. Do not use floor-based equipment unless authorised. Stabilise, observe, escalate to a senior clinician; call 999 if delay risks harm. Record the incident in ECLIPSE.	Apply the same standards; escalate to the senior nurse/clinician and on-call rota. No equipment retrieval unless an authorised practitioner attends.	§§3.2, 3.1, 3.3.2, 3.4
Ward/team manager	Ensure admission screening (FPRA), care-plan updates, daily huddles; send Transfers and Discharges pack; track actions and referrals; roster appropriate competence mix; ensure Moving and Handling and Falls mandatory training compliance. Ensure	Maintain an authorised-staff list for equipment-assisted floor retrieval; verify currency; ensure equipment availability and servicing; review incidents and learning with the Moving & Patient-	Ensure the OOH escalation tree is visible; ensure access to authorised cover (or a clear 999 plan); review OOH incidents on the next working day.	§§3.2, 3.3.1–3.3.4

	TILEO is documented before any handling. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	Handling, Falls Prevention/Management Subject Matter Expert and Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.		
Senior nurse/clinician (shift lead)	Oversee prevention during the shift; respond to deterioration; initiate MDT and safety-huddle actions; confirm documentation quality. Ensure TILEO is recorded before any handling. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	Triage post-fall; confirm no red flags before any move. If advanced retrieval is needed, call an authorised practitioner; otherwise, do not proceed. Ensure Rio and ECLIPSE are completed; initiate Duty of Candour if indicated.	First escalation point; liaise with on-call medics and authorised practitioners; authorise 999 when required.	§§3.3, 3.4
Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person)	Advise on complex prevention related to handling interfaces; contribute standards and training content; support audits. Conduct quarterly audits of risk assessments and compliance with TILEO. Collaborate with all staff. Provide education and training for levels of Patient Handling and Falls training. Audit Eclipse incidents and produce quarterly and annual reports. Investigate a quarterly sample of incidents and provide support and advice. Own the prevention programme: set Trust-	Train, assess, and sign off advanced practitioners; maintain the Trust-wide authorised register; advise live cases; audit advanced retrievals; pause and re-authorise as needed (supportive, non-punitive). Interface with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert on post-fall pathways; ensure prevention learning feeds retrieval practice and PSIRF actions. Does not	Provide advice via on-call or arranged escalation where feasible; review OOH cases for learning and sign-off. Provide strategic advice; ensure OOH incidents are thematically reviewed on the next working day, and learning is fed back into prevention actions.	§§3.3.2, 3.3.4, 3.4

	wide standards aligned to NICE NG249; design FPRA and care-plan templates; lead pathways for strength and balance, vision/footwear, orthostatic hypotension, hip protectors, and near-miss learning; coordinate Transfers and Discharges content; run education and compliance dashboards; theme medicines risk with Pharmacy; co-chair the Falls Steering Group. Ordering of PUWER/LOLER rated and specialist must be authorised by Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) and via the SHUB central trust ordering system. Receive and review ECLIPSE notifications defined in section 4.3, theme risks, trigger proportionate support, and feed learning into the Falls Steering Group and PSIRF processes.	authorise equipment-based retrieval.		
Physiotherapists	Assess strength, balance, gait, and orthostatic tolerance; prescribe graded exercise and assistive devices; contribute to FPRA and care plan; teach backward chaining. Simple test: time to complete 5 times sit-to-	Attend post-fall when requested; advise the safest pathway; support authorised retrievals with clinical input (not a substitute for authorisation). Simple test in the notes: record 5xSTS times or failure (low	On-call or next-day review per rota; provide written advice to shift leads within scope of practice.	§§3.2, 3.3

	stand and measure popliteal (knee) height; document both in Rio and note footwear. Document a legally required dynamic risk assessment, recorded using TILEO before any patient handling, ensure all assessments are documented in Rio, and refer any concerns to the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert. Ordering of PUWER/LOLER rated and specialist must be authorized by Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) and via the SHUB central trust ordering system. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	risk≤12 s; medium risk 13–15 s; high risk >15 s/unable) and popliteal height to inform bed/egress set-up.		
Occupational therapists	Assess environment, function, cognition, and equipment needs; implement adaptations; lead discharge home and environment checks; update plans in Rio. Record TILEO before any handling, ensure all assessments are documented in Rio, and refer any concerns to the Moving & Patient-Handling, Falls	Advise within scope of practice, on positioning, surfaces, and environment during retrieval; participate when an authorised practitioner leads equipment use.	As per service hours, prioritise next-day review after OOH incidents.	§§3.2, 3.3

	Prevention/Management Subject Matter Expert. Ordering of PUWER/LOLER rated and specialist must be authorized by Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) and via the SHUB central trust ordering system. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.			
Medical staff (doctors/ACP/physician associates)	Review reversible risks (delirium, infection, hypotension); optimise medicines; set observation plans; consider vitamin D per protocol; document in Rio. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	Examine immediately if serious injury is suspected; otherwise within six hours. Order imaging; initiate Duty of Candour where required.	Provide urgent review via on-call; document interim plans; hand over to the day team.	§§3.3, 3.4
Pharmacy	Review medicines with focus on psychotropics, hypotension, and sedatives; support deprescribing and alternatives; communicate with GP at discharge; contribute to Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert theming.	Provide rapid advice post-fall when medicines are implicated (for example, hypotension); support incident learning themes.	OOH advice via on-call if available; then, action next day.	§§3.2, 3.4

	Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.			
Patient Safety Team	Educate on LFPSE and quality of prevention records; theme recurrent risks with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert; support improvement cycles. Ordering of PUWER/LOLER rated and specialist must be authorized by Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert (legally competent person) and via the SHUB central trust ordering system. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert. Maintain ECLIPSE notification rules and distribution lists so the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert receives the incident set defined in section 4.3, and provide a daily digest where automated routing is not feasible.	Quality-check ECLIPSE submissions; harm grading (physical/psychological); coordinate PSIRF responses; track Duty of Candour evidence; ensure closure standards are met.	Monitor Serious OOH incidents; initiate early actions; coordinate next-day reviews.	§3.4
Service, clinical, and	Ensure services meet prevention standards; resource training and	Ensure safe access to authorised practitioners Trust-	Ensure on-call cover and clear	§4; §§3.2–3.4

corporate directors	staffing; monitor KPIs; report assurance to Board; support the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert programme. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	wide; support equipment procurement and maintenance; remove barriers to escalation (non-punitive).	escalation pathways.	
Executive director (quality/safety)	Sponsor the policy; ensure resources and governance; champion a just culture.	Oversee serious incidents and PSIRF; ensure enterprise-level learning is implemented.	Provide executive on-call oversight for severe or fatal harm.	§4; §3.4
EBME, estates, and facilities	Ensure a safe environment (lighting, flooring, clutter control); maintain bed heights and rails per policy; perform routine checks. Cooperate and collaborate with the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.	Service and verify retrieval equipment (Raizer, HoverJack, floor hoists, slings); quarantine faults; maintain logs accessible to wards and the Trust Moving and Patient Handling Risk Mitigation Lead.	Provide urgent make-safe or swap-out; escalate major faults to on-call.	§3.3.2
Learning and development (L&D)	Deliver and track Moving and Handling mandatory training and Falls Prevention and Management modules; report compliance to managers; support the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert with curriculum. Cooperate and collaborate with the Moving & Patient-	Deliver the Advanced Practice training pathway; record Clinical Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert sign-off; schedule refreshers; coordinate spot-checks with the Clinical Moving & Patient-Handling, Falls	Maintain access to e-learning; record OOH completions where applicable.	§3.3

	Handling, Falls Prevention/Management Subject Matter Expert.	Prevention/Management Subject Matter Expert and the Trust Moving and Patient Handling Risk Mitigation Lead.		

13.0 Development and Consultation process:

Consultation summary		
Date policy issued for consultation	December 2025	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	Date(s)	
Falls steering group	June, July, September 2025	
Equipment working party (SHUB development)	August, September 2025	
Where received	Summary of feedback	Actions / Response

14.0 Reference documents

Primary legislation (England & Wales)

1. Health and Safety at Work etc. Act 1974, s.2 (general duties of employers to employees).
2. Management of Health and Safety at Work Regulations 1999, reg.3 (risk assessment).
3. Provision and Use of Work Equipment Regulations 1998 (PUWER).
4. Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).
5. Manual Handling Operations Regulations 1992 (MHOR).
6. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 — Reg.12 (Safe care and treatment); Reg.17 (Good governance); Reg.20 (Duty of Candour).
7. Mental Capacity Act 2005 — best-interests framework for care/treatment decisions.
8. Mental Health Units (Use of Force) Act 2018 ("Seni's Law") — restraint, recording, training, and transparency duties; statutory guidance (2021).

B. Regulators and national frameworks

9. Care Quality Commission (CQC) — Reg.12: Safe care and treatment (guidance); Reg.17: Good governance (guidance); Reg.20: Duty of Candour (guidance).
10. NHS England — Patient Safety Incident Response Framework (PSIRF) (replaces the Serious Incident Framework).
11. NHS England — Learn from Patient Safety Events (LFPSE) service overview and recording portal.

C. Clinical guidance (NICE)

12. NICE NG249 (Apr 2025) — *Falls: assessment and prevention in older people and in people 50+ at higher risk*. (Overview + full guideline PDF).
13. NICE NG232 (May 2023) — *Head injury: assessment and early management* (incl. observation, imaging, discharge/GP letter timelines).
14. NICE QS86 Falls Quality standard Reference number:QS86 Published: 25 March 2015 Last updated: 29 April 2025

15. CQC Regulation 18 Staffing. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18
16. Section 3 of the Health and Safety at Work Act (HSWA) 1974

Note: NG249 supersedes CG161. Use NG249 for current falls prevention standards.

D. National audit and quality improvement

14. Royal College of Physicians — National Audit of Inpatient Falls (NAIF) 2024 (2023 data) — report + infographic; programme hub.
15. Royal College of Physicians — NAIF 2023 (2022 data) — report and KPI supplement.

E. Public health and prevention resources

16. Office for Health Improvement and Disparities (OHID) — *Falls: applying All Our Health* (formerly PHE "All Our Health").
17. All Our Health — programme collection (context for prevention curricula, workforce training).

F. HSE Approved Codes of Practice (ACoP) & guidance (safe equipment, lifting, handling)

18. HSE L23 — *Manual Handling: Guidance on Regulations* (MHOR) + INDG143 summary leaflet.
19. HSE LOLER overview and ACoP (safe planning, competent person, inspection/examination).
20. HSE PUWER — overview and ACoP L22 (*Safe use of work equipment*).

G. Key common-law authorities (reasonableness, "reasonably practicable," emergency risk-balancing)

21. Edwards v National Coal Board [1949] 1 All ER 743 (CA) — the leading authority on "reasonably practicable" (weighing risk vs. time/cost/trouble).
22. Latimer v AEC Ltd [1953] AC 643 (HL) — standard of care; practicality and cost of precautions; factory floor risks.
23. Watt v Hertfordshire CC [1954] 1 WLR 835 (CA) — emergency context and social utility in balancing risk (relevant to urgent retrieval decisions).

Note: These cases underpin "so far as is reasonably practicable" in HSWA/MHSWR risk assessments, analyses and support proportionate decision-making in urgent falls retrieval (e.g., pausing vs. proceeding; 999 escalations; competent planning for lifting operations).

H. Useful cross-checks (for governance packs)

24. NICE NG232 — Discharge & GP communication requirements after head injury (48-hour GP letter; written patient/carer advice).
25. NAIF 2024 KPI highlights — post-fall management, safe method of moving from the floor, and timeliness of medical assessment (to benchmark local practice).

Notes for BSMHFT policy custodians

- Replace old PHE citations with OHID for "All Our Health" falls resources.
- Anchor "advanced practice" equipment retrieval to LOLER/PUWER/MHOR and Trust authorisation (competent person, planned lifting operations, inspection/maintenance).
- Embed PSIRF/LFPSE in incident-response sections; use CQC Regs 12/17/20 for governance, safe staffing/competence, and Duty of Candour

15.0 Glossary:

- DoC = Duty of Candour
- FPRA = Multifactorial Falls Risk Assessment (Rio)

- LFPSE = Learn from Patient Safety Events
- PSIRF = Patient Safety Incident Response Framework
- OOH = Out of Hours
- TILEO (task, individual, load, environment, other)
- SHUB (Safe Handling Universal Board) is the Trust's new centralised ordering and governance platform for patient-handling PUWER/LOLER related equipment. It is currently in pilot; once fully integrated, training will be delivered to senior staff.

16.0 Audit and assurance:

Element to be monitored	Lead	Tool	Frequency	Reporting committee
Spot-check of Rio/ECLIPSE entries for FPRA quality, care plans, and handover information	Matrons and Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert	Rio, ECLIPSE, AMaT	Quarterly	Local CGG meetings
Review of Advanced Practice (equipment) activities	Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert	AMaT QI data	Quarterly	Physical Health Committee
Review and lessons learnt from ECLIPSE falls data	Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert with the Falls Steering Group	ECLIPSE	Quarterly	Physical Health Committee
Maintain continuous improvement cycles to review falls trends and emerging patterns; empower staff at all levels to engage in proactive, data-driven solutions	Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert and the Falls Steering Group and local leadership (Matrons)	ECLIPSE	Weekly first, then monthly	Local CGG meetings
Share best practice (areas of notable reductions in falls); teams present data to support replication of successful strategies	Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert and the Falls Steering Group and local leadership (Matrons)	QI methodology	Quarterly	Local CGG meetings; Physical Health Committee
Completeness and timeliness of ECLIPSE notification routing to	Patient Safety Team with the Trust Moving and Patient Handling,	ECLIPSE alert logs or	Monthly for first 3 months	Physical Health Committee

the Trust Moving and Patient Handling, Falls Prevention/Management Subject Matter Expert (per 4.3).	Falls Prevention/Management Subject Matter Expert.	daily digest record.	post-ratification, then quarterly.	and Falls Steering Group.

17.0 Appendices

APPENDIX 1 - Equality Analysis Screening Form

APPENDIX 2 - Falls Prevention Process Flowchart

APPENDIX 3 - Immediate Post-Fall Care Flowchart

APPENDIX 4 - Multidisciplinary Team (MDT) Falls Huddle Guideline

APPENDIX 5 – Falls Risk Increasing Drugs (FRIDs)

APPENDIX 6 - Screenshot of Falls Prevention assessment (Rio)

APPENDIX 7 - Falls Incident Eclipse Reporting Template (With Rationale)

APPENDIX 8: PREVENTING DETERIORATING HEALTH (PDH) 8 DAILY SIGNS

APPENDIX 1 - EQUALITY ANALYSIS SCREENING FORM

A word version of this document can be found on the HR support pages on Connect

Title of Policy	**Falls Prevention and Falls Management Policy (CG18)**		
Person Completing this policy	Dr Louis Watson	**Role or title**	Trust Clinical Lead – Moving & Patient-Handling and Falls Risk Mitigation
Division	AHP	**Service Area**	Corporate
Date Started	December 5th 2025	**Date completed**	February 1st 2026
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
To provide clear, evidence-based guidance and legislative direction for preventing falls and reducing harm if a fall occurs, supporting Trust-wide patient safety and harm reduction ambitions.			
Who will benefit from the policy?			
Service users at risk of falls-related harm and staff supporting or managing a person who has fallen.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
Yes. It affects service users (inpatient and community settings) and employees by setting requirements for assessment, care planning, escalation, documentation, and safe retrieval processes. Data used and how it reduces inequality: Age: the policy sets explicit processes for older adults and those with risk factors (e.g., multifactorial risk assessment within 6 hours for people aged 65+ and those 50–64 with risk factors).			

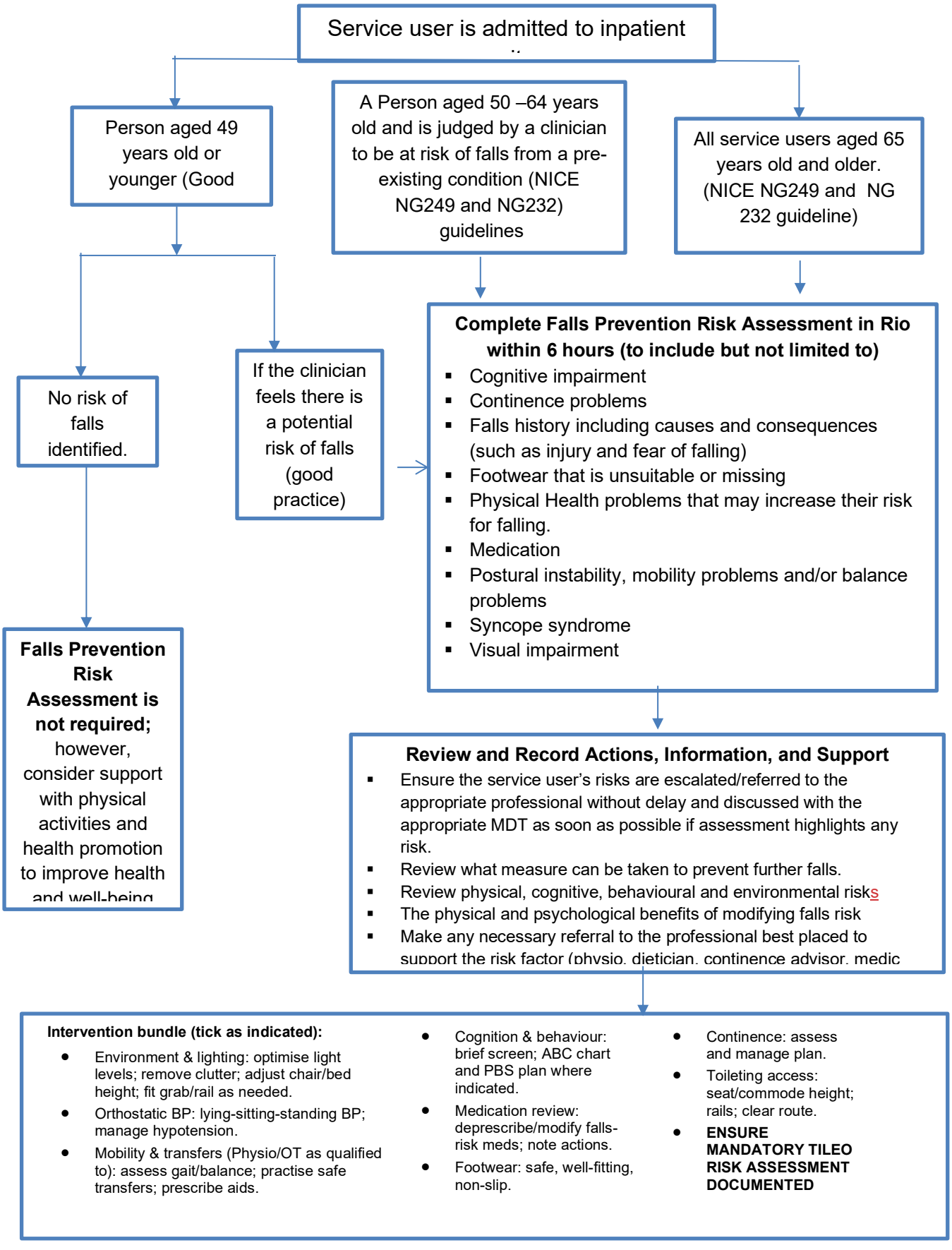
Disability: the policy explicitly recognizes increased falls risk linked to mobility and sensory impairment and expects reasonable adjustments through personalized risk assessment and care planning.				
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***				
Yes. It standardized admission screening, multifactorial assessment, post-fall response, escalation, referral, and documentation expectations across services. This reduces unwarranted variation in care for high-risk groups.				
Does it involve a significant commitment of resources? ***How will these reduce inequality?***				
Moderate. Resource implications include staff training/competence requirements and access to appropriate equipment and governance arrangements. These reduce inequality by ensuring staff can deliver safe, dignified care for people with higher physical risk and/or complex needs.				
Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
Yes. Falls risk is concentrated in older adults and people with physical/sensory impairment; the policy is designed to reduce avoidable harm in these higher-risk groups.				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? *Eliminate discrimination?* *Eliminate harassment?* *Eliminate victimisation?*				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	Age: Positive impact (promotes a positive plan of action for older adults at highest risk).

Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	Positive impact (recognises mobility/sensory impairment and expects risk assessment/adjustments).
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	X			
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation into pregnancy and maternity?				
Race or Ethnicity	X			
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			

Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights			X	Positive impact (supports safe retrieval with dignity and respect).
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No X**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X
If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required.				

If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
No negative impact identified. Maintain focus on reasonable adjustments, accessible communication, and consistent application of the policy.
How will any impact or planned actions be monitored and reviewed?
Use existing audit and assurance routes (e.g., spot checks of FPRA documentation quality and review of falls trend data) and governance forums to identify any differential impact and implement improvement actions.
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Share best practice through falls governance routes and learning systems, including replication of approaches linked to reductions in falls and falls-related harm.
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

APPENDIX 2 - FALLS PREVENTION PROCESS FLOWCHART



APPENDIX 3 - IMMEDIATE POST-FALL CARE FLOWCHART

Updated to Align with NICE NG232 and TILEO Protocol

Initial Check and Scene Safety

- The staff member who witnesses the fall or finds the service user on the floor first assesses the environment for safety (for example, no continuing hazards, cords, spills).
- If the setting is safe, summon help (use personal alarm if necessary).

Encourage Independent Rising (if Safe)

- If the service user spontaneously rises without apparent pain or difficulty, escort them to a place of comfort and privacy, continuing to observe for any delayed onset of symptoms.
- If the service user appears injured or reports pain, do not move them. Await additional staff or equipment support (for example, mechanical falls retrieval aid, slide sheets) to ensure safe handling.

Immediate Mandatory and legally required dynamic TILEO risk assessment, documented in RiO.

- **T (Task):** Establish the nature of the fall and the need for further assistance (for example, do you need additional staff, hoisting equipment, or an ambulance?).
- **I (Individual):** The staff member should assess their own ability to help, considering training (e.g., hybrid Level 2 Handling) and the presence of further staff.
- **L (Load):** Evaluate the service user's condition (for example, are they conscious, complaining of pain, or showing signs of confusion?).
- **E (Environment):** Confirm the area is safe (dry floors, ample lighting) before intervening.
- **O (Other):** Consider extra resources needed, such as calling 999 if you suspect serious injury, using any mechanical falls retrieval device or slide sheets, or providing immediate CPR if necessary.

Systematic Assessment (include neurological observations and NEWS2)
Initial safety and approach

- Ensure scene safety, introduce yourself, and gain consent where possible.
- Use the ABCDE approach. If there are immediate threats to life, escalate and treat first.

Level of consciousness

- Assess responsiveness using ACVPU: alert, new confusion, responds to voice, responds to pain, unresponsive.
- If head injury is suspected or the person is not at their normal baseline, perform a Glasgow Coma Scale assessment and repeat as per neuro-observation schedule.

Physical observations (NEWS2)

- Record the six NEWS2 parameters: respiratory rate, oxygen saturation (and whether supplemental oxygen is in use), systolic blood pressure, pulse rate, temperature, and level of consciousness/new confusion.
- Calculate the aggregate NEWS2 score and follow the local escalation thresholds (for example, urgent clinical review for any single parameter scoring 3, aggregate 5 or more, or any acute change in consciousness).
- Recheck any abnormal parameter to confirm, then act—do not delay escalation while repeating if the patient appears unwell.

Neurological observations (how to perform)

- Indications: any unwitnessed fall, suspected head impact, anticoagulation, post-fall confusion, seizure, or any change from baseline.
- What to record each round: GCS (E, V, M), pupils (size and reactivity), limb movement and power, new focal deficits (face, arm, speech), nausea/vomiting, headache severity, seizure activity, and vital signs.
- Frequency (minimum): start immediately. If concern persists, observe at least every 15 minutes initially until clinically stable and reviewed; then follow your local schedule (for example, 30-minutely for 2 hours, hourly for 4 hours, then 2-hourly for up to 6 hours, or as a clinician specifies).
- Red flags requiring urgent medical review or transfer: drop of ≥2 in GCS, unequal or non-reactive pupils, new weakness, repeated vomiting, severe/worsening headache, new confusion or agitation, seizure, or any clinical deterioration.

Head-to-toe check

- Inspect for visible injury: reddening, bruising, lacerations, swelling, deformity.
- Palpate gently only if safe and consented; stop if pain, deformity, or crepitus is detected.
- Suspected fractures: look for limb shortening or external rotation (suggestive of hip fracture) and inability to weight-bear. Immobilise, keep warm, and escalate.

Hands-off observations (when the person declines touch or contact is unsafe)

- Consciousness: assess ACVPU verbally; ask orientation questions (name, place, date).
- Breathing: count visible chest rise for one minute; note effort, use of accessory muscles, audible breath sounds, and cyanosis.
- Circulation and skin: observe colour, sweating, capillary refill proxy (if visible), and any bleeding.
- Neurology: ask the person to smile, show teeth, lift arms and legs, and squeeze hands against gravity (no manual resistance). Check speech for slurring or word-finding difficulty.
- Pain and function: ask location and severity of pain, ability to move, and ability to stand or transfer.

- Document precisely which measurements were unobtainable and why (for example, “hands-off only—patient declined contact”). If you cannot obtain core NEWS2 parameters, escalate based on clinical concern and ACVPU.

Documentation and escalation

- Record all findings and times in Rio, including NEWS2 (or partial NEWS2 with “not obtained” fields), neuro-observation entries, and any red flags or escalation actions.
- If a fall occurred, submit an ECLIPSE report and update the care plan.
- Share concerns immediately with the senior clinician. Call emergency services if delay would increase harm.

Ongoing review

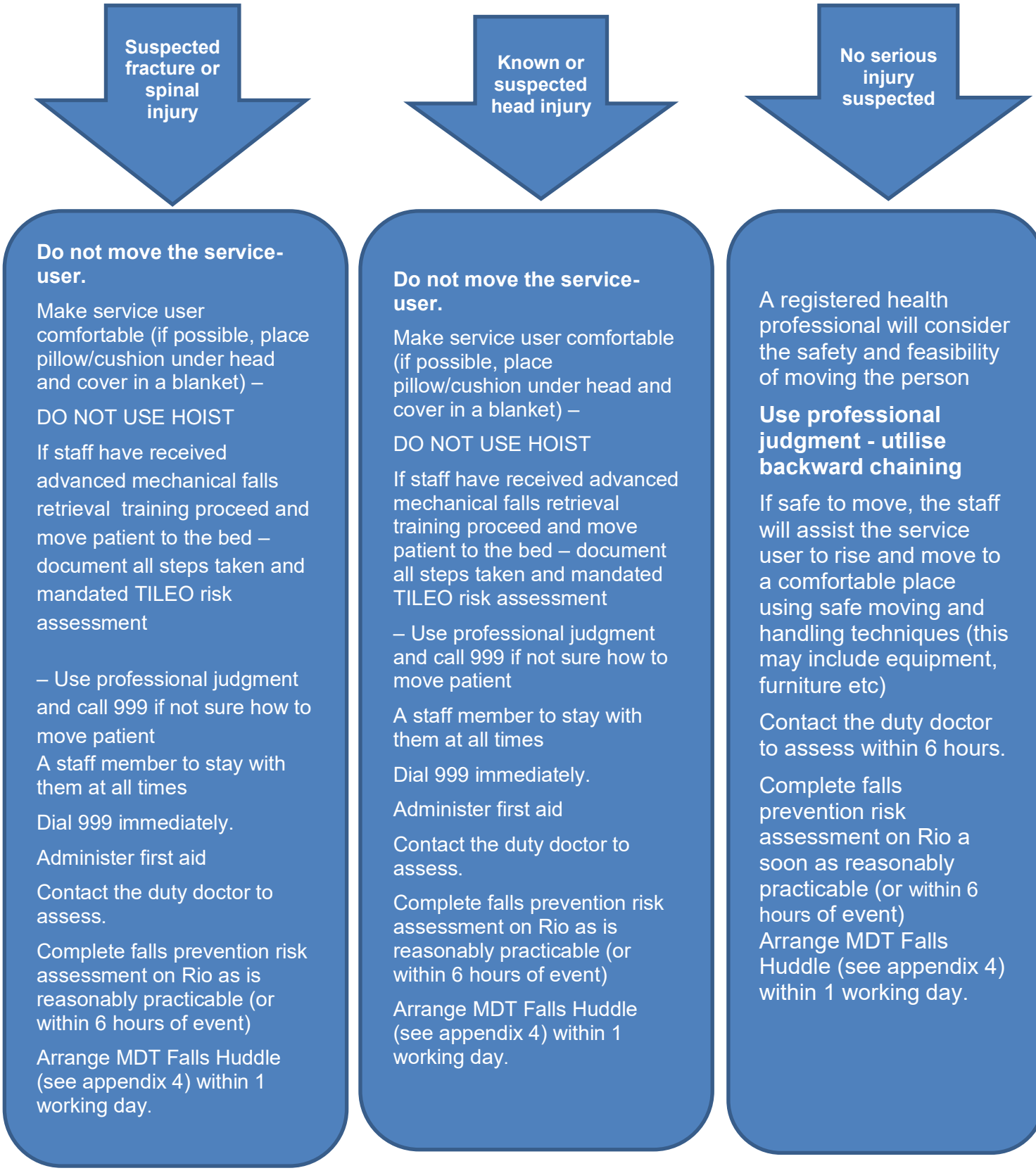
- Continue observations at the prescribed frequency until a clinician deems them no longer required.
- Reassess after any change in condition, transfer, procedure, or analgesia/sedation.
- Update the falls care plan and make referrals (medical, physiotherapy, occupational therapy, pharmacy) as indicated.

Determine Appropriate Pathway

- Use clinical judgement to decide if urgent escalation (for example, contacting on-call doctor, calling 999) is warranted.
- Ensure the service-user or patient is comfortable, safe and continuously reassessed for any emerging symptoms (for instance, head injury with delayed presentation).
- **Record all incidents in Eclipse** and document thoroughly in the patient’s records (Rio & Inpatient Portal), referencing any immediate actions & next steps (post-fall plan, neurological observation schedule).

Note:

- If the fall was unwitnessed or a head injury is suspected, NG249 recommends repeated neurological observations in defined intervals (for example, every 15 minutes initially) until the risk is ruled out. Every set of observations to be immediately documented in their entirety.
- Provide information or comfort measures as needed, always prioritizing the patient’s well-being.


Suspected fracture or spinal injury
Do not move the service-user.
Make service user comfortable (if possible, place pillow/cushion under head and cover in a blanket) –
DO NOT USE HOIST
If staff have received advanced mechanical falls retrieval training proceed and move patient to the bed – document all steps taken and mandated TILEO risk assessment
– Use professional judgment and call 999 if not sure how to move patient
A staff member to stay with them at all times
Dial 999 immediately.
Administer first aid
Contact the duty doctor to assess.
Complete falls prevention risk assessment on Rio as is reasonably practicable (or within 6 hours of event)
Arrange MDT Falls Huddle (see appendix 4) within 1 working day.
Known or suspected head injury
Do not move the service-user.
Make service user comfortable (if possible, place pillow/cushion under head and cover in a blanket) –
DO NOT USE HOIST
If staff have received advanced mechanical falls retrieval training proceed and move patient to the bed – document all steps taken and mandated TILEO risk assessment
– Use professional judgment and call 999 if not sure how to move patient
A staff member to stay with them at all times
Dial 999 immediately.
Administer first aid
Contact the duty doctor to assess.
Complete falls prevention risk assessment on Rio as is reasonably practicable (or within 6 hours of event)
Arrange MDT Falls Huddle (see appendix 4) within 1 working day.
No serious injury suspected
A registered health professional will consider the safety and feasibility of moving the person
Use professional judgment - utilise backward chaining
If safe to move, the staff will assist the service user to rise and move to a comfortable place using safe moving and handling techniques (this may include equipment, furniture etc)
Contact the duty doctor to assess within 6 hours.
Complete falls prevention risk assessment on Rio a soon as reasonably practicable (or within 6 hours of event)
Arrange MDT Falls Huddle (see appendix 4) within 1 working day.

APPENDIX 4 – MULTIDISCIPLINARY TEAM (MDT) FALLS HUDDLE GUIDELINE

1. Purpose and Scheduling of the MDT Falls Huddle

- The Huddle aims to identify new or existing risks, review recent fall incidents, and ensure timely interventions in line with NICE's recommended multifactorial assessment (NG249, 2025).
- Every ward or service area should schedule a regular, structured MDT Falls Huddle at an agreed time and frequency that suits local operations (for example, daily on high-risk wards, or at least weekly for other units).

2. Criteria for Including Service Users in the Falls Huddle

- **At-Risk Individuals:** Any service user flagged as "at risk of falling" following a new or repeat Falls Prevention Risk Assessment (for example, older adults, people aged 50 and over with underlying risk factors, as per NG249).
- **Post-Fall Review:** Any inpatient who has experienced a fall (including unwitnessed falls) within the ward.

3. *Suggested* MDT Membership

Core attendance (where possible):

- Doctor (medical perspective, medication review)
- Registered Nurse (clinical oversight)
- Occupational Therapist (environmental adaptation, functional assessment)
- Pharmacist (medication review, polypharmacy)
- Physiotherapist (mobility, gait, balance)

Additional specialists (as warranted by the person's needs):

- Dietitian (nutrition, dehydration)
- Diabetes Specialist (glycaemic control)
- Podiatrist (footwear, foot deformities)
- Psychologist or Mental Health Practitioner (behavioural interventions, cognitive issues)
- Other relevant professionals (for example, Speech and Language Therapist in cases of swallowing risk, moving and handling specialist, or Falls Champions).

4. Focus of the MDT Falls Huddle in relation to each patient discussed

Review Key Risk Factors (from the Falls Prevention Risk Assessment),

Risk Identified	Common Considerations
Cognitive Impairment	Dementia, delirium, depression, TBI, orientation deficits
Physical Health Problems	Frailty, neuropathy, foot deformities, hypotension, CVD, dehydration, osteoporosis
Syncope/Fainting	Orthostatic hypotension, transient loss of consciousness, inadequate fluid intake
Continence Issues	Frequency/urgency, nocturia, BPH, overactive bladder
Falls History	Frequency, causes, consequences (injuries, fear of falling)
Footwear	Unsuitable or missing footwear, incorrect size
Medication	Polypharmacy (≥4 medicines), sedatives, psychotropics, analgesics

Mobility issues/ Postural Instability or Balance	Mobility problems, gait abnormalities, reduced muscle strength, prolonged inactivity
Visual Impairment	Poor sight, need for correct glasses prescription, macular degeneration
Behaviour	Confusion, lack of insight, agitation, or non-adherence to safety advice
Environment	Lighting, furniture arrangement, assistive technology, clutter

1. **Review physical health problems** which elevate the risk of serious injury e.g. anticoagulant treatment, osteoporosis, bony metastases; this can support conversations with patients to gain informed consent re interventions and also help guide decision regarding investigations (especially imaging) after a fall.

2. **Identify and Document planned actions/ Interventions:** Each identified risk factor should lead to a clear, practical intervention (for example, medication review for psychotropics, physiotherapy referral for balance training, occupational therapy for environmental modifications).

3. **Documentation and Follow-Up**
    - **Recording in Rio**: Assign a single professional (for example, the NiC or an appointed nurse) to document the discussion and decisions from each Huddle in Rio.
    - **Action Planning**: All agreed interventions must be appropriately documented within the Dialog+ Action Plan. Use SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound) to track progress.
    - **Review Cycle**: At each subsequent MDT meeting or daily/weekly Huddle, update individual patient's Action plan if new risks emerge or existing interventions need adjusting. Continue the cycle for each patient until risk is minimized and stable, at which point they may come off the list for discussion at the Huddle.

4. **Key Principles**
    - **Person-Centred Care**: Engage the service user (and carers/family, where possible) in decisions about managing falls risk.
    - **No Numeric Risk Prediction Tools**: Align with NICE NG249 by avoiding simplistic "RAG" scoring; focus on multifactorial assessments.
    - **Continuous Learning**: Incorporate lessons learned from each fall event, share findings Trust-wide if patterns emerge (e.g., repeated medication-related falls).

By systematically implementing this MDT Falls Huddle approach, the Trust can ensure timely, individualised, and evidence-based interventions.
This will substantially be reducing the likelihood of recurrent falls and improving overall patient safety consistent with current NICE guidelines and best-practice standards.

Updated 01/11/2025 to Reflect NICE **NG249** and Best Practice

APPENDIX 5 – FALLS RISK INCREASING DRUGS (FRIDS)

This appendix has been adapted from NFPCG Medicines and Falls (1), please refer to the full guideline alongside other references & tools such as STOPPFall (2), NICE Guideline NG249 Falls: assessment and prevention in older people and in people 50 and over at higher risk (3), NICE Guideline NG5 Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes (4), PrescQIPP 300 Medication and Falls (5), when carrying out medication reviews.

There is evidence that certain medicines increase falls risk in older adults, referred to as Falls Risk Increasing Drugs (FRIDs). The Falls Risk Prevention Assessment includes a requirement to identify medications that may lead to falls and, as part of the patient-centred multifactorial interventions, referral for a review of these medications may help to significantly reduce falls risk.

Falls can be caused by almost any drug that acts on the brain or on the circulation and usually the mechanism leading to a fall is one or more of:

- Sedation, with slowing of reaction times and impaired balance.
- Hypotension, including the 3 syndromes of paroxysmal hypotension – orthostatic hypotension, vasovagal syndrome and vasodepressor carotid sinus hypersensitivity.
- Bradycardia, tachycardia or periods of asystole.

Falls are often caused by medicines that have been administered for some time but may be the consequence of recent medication changes or dose changes. In the Falls Risk Increasing Drugs List in Table 1, medications in **bold** type are considered to have a high potential to cause a fall – high-risk FRIDs, all other drugs in this list are considered to have medium potential to cause a fall – medium-risk FRIDs.

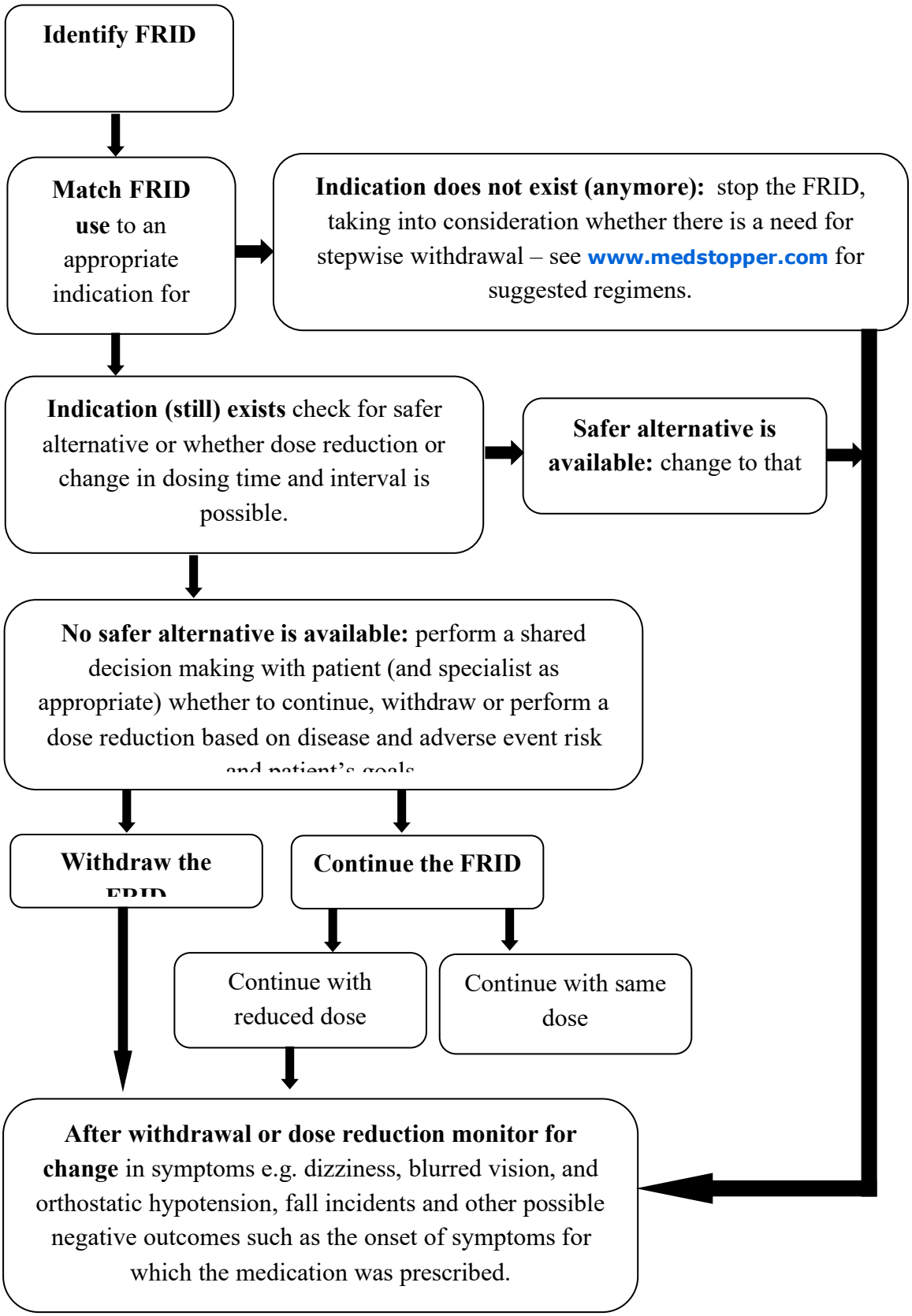
- Service users prescribed high-risk FRIDs, either alone or in combination, should be referred for a review of their medication and any adverse effects regardless of whether they have already had a fall.
- Service users prescribed medium-risk FRIDs, especially if they are being used in combination, should be referred for a review of their medication after consideration of any other risk factors that may cause a fall.

The potential for medication related falls may be increased for service users with multiple physical and mental health co-morbidities, older age and/or frailty, who are prescribed multiple FRIDs. No list is comprehensive, and medication review requires a balance between the risks and benefits of treatments and should be tailored to the needs of an individual service user. See Figure 1 for a suggested decision tree for management of FRIDs. Before prescribing potential FRIDs to older adults, enquire about falls and consider the relative benefits and risks of initiating therapy and any monitoring that may be required. FRIDs will be identified on prescribing templates in the ePMA Formulary by the following icon:

Table 1: Falls Risk Increasing Drugs (FRIDs) List

Name of medication	Name of medication	Name of medication
ALFUZOSIN	FLUPHENAZINE	PRAZOSIN
ALIMEMAZINE	FLURAZEPAM	PREGABALIN
AMIODARONE	FOSINOPRIL	PROCHLORPERAZINE
AMISULPRIDE	FUROSEMIDE	PROMAZINE
AMITRIPTYLINE	GABAPENTIN	PROMETHAZINE
AMLODIPINE	GALANTAMINE	PROPRANOLOL
ARIPIPRAZOLE	GLYCERYL TRINITRATE	QUETIAPINE
ATENOLOL	HALOPERIDOL	QUINAPRIL
BACLOFEN	HYDROXYZINE	RAMIPRIL
BENDROFLUMETHIAZIDE	HYOSCINE BUTYLBROMIDE	RISPERIDONE
BETAHISTINE	HYOSCINE HYDROBROMIDE	RIVASTIGMINE
BISOPROLOL	IMIPRAMINE	SERTRALINE
BUMETANIDE	INDAPAMIDE	SODIUM VALPROATE
BUPRENORPHINE	INDORAMIN	SOLIFENACIN
CANDESARTAN	IRBESARTAN	SOTALOL
CAPTOPRIL	ISOCARBOXAZID	SULPIRIDE
CARBAMAZEPINE	ISOSORBIDE MONONITRATE	TAMSULOSIN
CARVEDILOL	LACIDIPINE	TELMISARTAN
CHLORDIAZEPOXIDE	LAMOTRIGINE	TEMAZEPAM
CHLORPHENAMINE	LERCANIDIPINE	TERAZOSIN
CHLORPROMAZINE	LEVETIRACETAM	TIMOLOL EYEDROPS
CHLORTALIDONE	LISINOPRIL	TOLTERODINE
CINNARIZINE	LOFEPRAMINE	TOPIRAMATE
CITALOPRAM	LORAZEPAM	TRAMADOL
CLOMIPRAMINE	LORMETAZEPAM	TRANDOLAPRIL
CLONAZEPAM	LOSARTAN	TRANYLCYPROMINE
CLONIDINE	METOLAZONE	TRAZODONE
CLOZAPINE	METOPROLOL	TRIFLUOPERAZINE
CODEINE	MIANSERIN	TRIHEXPHENIDYL
DANTROLENE	MIRTAZAPINE	TRIMEPRAZINE
DIAZEPAM	MORPHINE	TRIMIPRAMINE
DIGOXIN	MOXONIDINE	VALSARTAN
DIHYDROCODEINE	NICORANDIL	VENLAFAXINE
DIPHENHYDRAMINE	NIFEDIPINE	VERAPAMIL
DILTIAZEM	NITRAZEPAM	ZOLPIDEM
DONEPEZIL	NORTRIPTYLINE	ZOPICLONE
DOSULEPIN	OLANZAPINE	
DOXAZOSIN	OLMESARTAN	
DOXEPIN	ORPHENADRINE	
DULOXETINE	OXAZEPAM	
ESCITALOPRAM	OXYBUTYNIN	
ENALAPRIL	OXYCODONE	
EPROSARTAN	PAROXETINE	
FELODIPINE	PERINDOPRIL	
FENTANYL	PHENELZINE	
FLECAINIDE	PHENOBARBITAL	
FLUOXETINE	PHENYTOIN	

Figure 1: A suggested decision tree for Falls Risk Increasing Drugs (FRIDS) management:



References & Tools

1. Đula Alićehajić-Bečić and Heather Smith (July 2023), NFPCG Medicines and Falls. Available **HERE**
2. Seppala et al (December 2020),STOPPFall (Screening of Older Persons Prescriptions in older adults with high fall risk): A delphi study by the EuGMS Task and Finish Group on Fall Risk Increasing Drugs. Available **HERE**
3. NICE Guideline NG249 Falls: assessment and prevention in older people and in people 50 and over at higher risk (April 2025). Available **HERE**
4. NICE Guideline NG5 Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes (March 2015). Available **HERE**
5. PrescQIPP 300 Medication and Falls (February 2025). Available **HERE**

APPENDIX 6 - SCREEN SHOT OF 'FALL PREVENTION RISK ASSESSMENT' FORM (RIO)

Continence problems

Does the service user have any continence problems? (i.e. Frequency or benign prostatic hyperplasia, overactive bladder, urgency, nocturnal)?	○ Yes ○ No

Falls history

Has the service user previously had a fall?	○ Yes ○ No

Footwear

Is the service user wearing suitable footwear?	○ Yes ○ No

Medication

Does the service user take 4 or more medications per day?	○ Yes ○ No
Does the service user take medication with side effects which can cause falls?	○ Yes ○ No
Does the service user take medication which can cause dizziness, drowsiness or drop in blood pressure?	○ Yes ○ No

Postural instability

Does the service user have any problem with the following (Mobility problems, balance problems, abnormal gait, reduced muscle strength or uses a walking aid)?	○ Yes ○ No
Has the service user recently has any acute episode of illness which could effect their mobility?	○ Yes ○ No

Continence problems

Does the service user have any continence problems? (i.e. Frequency or benign prostatic hyperplasia, overactive bladder, urgency, nocturnal)?	○ Yes ○ No

Falls history

Has the service user previously had a fall?	○ Yes ○ No

Footwear

Is the service user wearing suitable footwear?	○ Yes ○ No

Medication

Does the service user take 4 or more medications per day?	○ Yes ○ No
Does the service user take medication with side effects which can cause falls?	○ Yes ○ No
Does the service user take medication which can cause dizziness, drowsiness or drop in blood pressure?	○ Yes ○ No

Postural instability

Does the service user have any problem with the following (Mobility problems, balance problems, abnormal gait, reduced muscle strength or uses a walking aid)?	○ Yes ○ No
Has the service user recently has any acute episode of illness which could effect their mobility?	○ Yes ○ No

Continence problems

Does the service user have any continence problems? (i.e. Frequency or benign prostatic hyperplasia, overactive bladder, urgency, nocturnal)?	○ Yes ○ No

Falls history

Has the service user previously had a fall?	○ Yes ○ No

Footwear

Is the service user wearing suitable footwear?	○ Yes ○ No

Medication

Does the service user take 4 or more medications per day?	○ Yes ○ No
Does the service user take medication with side effects which can cause falls?	○ Yes ○ No
Does the service user take medication which can cause dizziness, drowsiness or drop in blood pressure?	○ Yes ○ No

Postural instability

Does the service user have any problem with the following (Mobility problems, balance problems, abnormal gait, reduced muscle strength or uses a walking aid)?	○ Yes ○ No
Has the service user recently has any acute episode of illness which could effect their mobility?	○ Yes ○ No

APPENDIX 7 - FALLS INCIDENT ECLIPSE REPORTING TEMPLATE (WITH RATIONALE)

Use this template guidance in ECLIPSE. Keep language factual and non-judgmental. Attach supporting evidence

A. Event header (who/when/where)
- Patient identifier & ward/location:
- Date/time of fall (or found on floor):
- Witnessed / unwitnessed:
- Staff present / responders: (names/roles)
- Immediate risk to others/environment controlled: yes/no (how)

Rationale. Clear provenance enables reliable governance and PSIRF theming; NAIF and CQC require time-stamped, person-centred records of care.

B. What happened (brief objective description)
- **Plain description:** (e.g., "Patient stood from low chair, stumbled, sat to floor." Avoid speculation.)
- **Activity at time:** (toileting, mobilising to dining room, etc.)
- **Assistance level at the time:** independent/supervised/assisted/1:1

Rationale. A neutral narrative supports systems learning and avoids hindsight bias (PSIRF).

C. Immediate clinical assessment (before any movement)
- **Red-flag check completed before movement:** head injury / suspected fracture / potential spinal injury → **yes/no (detail)**
- **Neurological observations indicated (NG232) & commenced:** yes/no (schedule recorded)
- **Pain assessment & analgesia given** yes/no (what/when)

Rationale. NAIF and NICE require injury checks **before** moving; NG232 sets observation/escalation thresholds for head injury.

D. Method of moving from the floor (select one, detail)
- ALL STAFF MUST Document legally mandated TILEO risk assessment conducted before any patient handling activities.
    - **Backward-chaining (guided self-recovery):** yes (steps taken) / no (why unsafe)
    - **Equipment-based floor retrieval (Advanced Practice):**
        - Device/technique: floor hoist / Raizer / HoverJack / other
        - **Authorised practitioner present:** name/role & **Trust sign-off** (Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert)
        - **Dynamic risk assessment documented:** yes/no – if not why.
        - **Equipment pre-use checks passed:** yes/no
- **Not moved pending clinical review** / **999 ambulance** (reason)

Rationale. Safe retrieval is a NAIF standard; equipment use must meet MHOR/LOLER/PUWER competence and planning, restricted to authorised staff signed off by the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert.

E. Injuries & investigations
- **Observed/suspected injury:** none / soft tissue / laceration / head injury / suspected fracture (site) / other
- **Medical examination:** immediate / within 12 h / within 1 working day (clinician & time)
- **Imaging/tests ordered & results (if known):**

- **Safeguarding concerns / capacity issues noted:** yes/no (actions)

Rationale. NAIF tracks **timely medical assessment**; CQC Reg 12 demands proportionate investigation and mitigation.

F. Observations & contributory factors (multifactorial)
- **Postural (lying standing) BP** at 1 and 3 min: values & symptoms
- **Pharmacology present:** yes/no (list classes/agents; dose/timing changes in last 72 h)
  - **Amber Early Escalation Response (AEER) started** (if FRIDs): yes/no; pharmacist review ≤24 h booked/done
- **Mobility/balance & gait aid and status (Physio/OT if qualified to prescribe otherwise refer to patient handling trust lead):**
  - Equipment prescribed – provide TILEO risk assessment, strength test and rationale for prescription along with follow up/reassessment cadence schedule.
  - **Footwear:** safe/unsafe (action)
- **Cognition/delirium screen (e.g., 4AT) & behaviour triggers:** result/actions
- **Environment:** lighting, clutter, floor surface, chair/bed height, rails/grab-rails
- **Continence & toileting access:** plan in place yes/no
- **Other factors:** dehydration, infection, hypotension, vision, recent RT/IM meds

Rationale. NICE NG249 mandates multifactorial assessment; national audits highlight orthostatic BP and medication review gaps—your AEER/Red pathway operationalises this.

G. Documentation & candour
- **Rio post-fall note completed** (title/time): yes/no
- **Falls care plan/risk plan updated:** yes/no (what changed)
- **Duty of Candour** (moderate+ physical/psych harm): discussion held/written info sent (attach)
- **ECLIPSE harm grading applied (physical & psychological):** none/low/moderate/severe/death (with rationale)

Rationale. CQC Reg 12/17/20 require accurate records, governance, and candour; LFPSE needs consistent harm grading (incl. psychological).

H. Learning response (PSIRF) & actions
- **Learning response indicated:** None / Hot debrief (date) / After-Action Review / PSII / Thematic review
- **Key contributory themes:** (bullet list)
- **Immediate actions taken today:**
- **Follow-up actions with owners/dates:**
- **How learning will be shared:** ward huddle / Falls Steering Group / dashboard / teaching

Rationale. PSIRF requires proportionate, systems-focused learning with agreed timelines and sharing routes.

I. Closure checklist (manager sign-off)
- Injury check before movement evidenced (Section C)
- Safe retrieval method documented; authorisation evidenced if equipment used (Section D)
- Medical exam timeliness meets standard (Section E)
- Orthostatic BP recorded or reason not possible; FRIDs review started; AEER/Red bundle actions recorded (Section F)
- Rio note & care-plan update attached (Section G)
- LFPSE harm grading (physical & psychological) applied with rationale (Section G)
- DoC completed (if required) and attached (Section G)
- Learning response chosen, owners/dates recorded; sharing route stated (Section H)

Rationale. Aligns closure to national expectations (NAIF timeliness, PSIRF learning, CQC governance) and Trust standards.

J. Attachments (tick & upload)

- Rio post-fall note (PDF)
- Updated Falls Care Plan (PDF)
- Orthostatic BP chart/flowsheet
- Imaging/report
- Hot debrief/AAR notes
- Pharmacy review or AEER checklist
- DoC letter/record
- Photos/diagrams (if relevant)

Rationale. “Document once, use many times” supports audit, safety improvement and external assurance.

Why this template (evidence & governance fit)

- **NAIF standards** emphasise checking for injury before movement, choosing the safest method of moving from the floor, and ensuring timely medical assessment — Sections C–E make these explicit data points.
- **NICE NG249** requires a multifactorial approach; Section F hard-codes orthostatic BP, environment, mobility, cognition and medication review into every report.
- **Pharmacology bundle (AEER/Red)** closes the national gap on FRIDs and postural hypotension identified in audits, with pharmacist/prescriber review times captured for assurance.
- **Head injury (NG232)** prompts are embedded to start neuro-observations and escalate appropriately.
- **Equipment-based floor retrieval** is flagged as Advanced Practice requiring authorisation by the Moving & Patient-Handling, Falls Prevention/Management Subject Matter Expert, meeting MHOR/LOLER/PUWER competence and planning duties while protecting staff (non-punitive).
- **LFPSE/PSIRF/CQC**: the template forces correct harm grading (including psychological), Duty of Candour capture, and a proportionate learning response with owners/dates to satisfy Reg 12/17/20 and PSIRF.

APPENDIX 8: PREVENTING DETERIORATING HEALTH (PDH) 8 DAILY SIGNS

Purpose and position in the falls pathway

Preventing Deteriorating Health (PDH) is the Trust's daily early recognition and action process for emerging deterioration linked to falls risk. It supports Trust Policy CG18 and NICE NG249.
PDH does not use a numerical falls score or red-amber-green grading. Instead, staff check for eight daily signs, identify whether there is no PDH trigger, a Tier 1 trigger, or a Tier 2 trigger, and take the required action in the same shift.

PDH is intended to turn routine observations, ward knowledge, and assessment findings into clear action.

Core rule

The PDH action rule is as follows:

a. If no PDH signs are present, continue routine care and routine observation. No additional PDH action is required.
b. If one or more Tier 1 PDH signs are present, escalate to the nurse in charge or other appropriate senior clinician and hold a falls huddle in the same shift.
c. If a Tier 2 trigger is present, escalate immediately to the MDT and request urgent clinical review in line with local physical health escalation processes.

For the purposes of PDH, a Tier 2 trigger is a NEWS2 score of 3 or more.

The PDH Daily 8 signs

The following are the eight PDH daily signs to be checked and considered:

1. A fall or near fall today, or since the last review.
2. Increased assistance required, for example independent to one assist, one assist to two assist, or newly requiring a hoist.
3. Slowed or changed behaviour, for example increased sleep, withdrawal, refusal, new isolation, reduced engagement, or appearing more slumped than usual.
4. New handling or support equipment ordered, introduced, or upgraded, for example a hoist, stand aid, transfer aid, low bed, or other falls-related equipment.
5. Another physical health concern noted, for example faint, seizure, collapse, chest pain, choking, dizziness, or acute unsteadiness.
6. NEWS2 score of 3 or more.
7. A physiological red flag, for example systolic blood pressure below 100 mmHg, heart rate above 100 beats per minute, temperature 38.0°C or above, respiratory rate 22 breaths per minute or above, or oxygen saturation below baseline where not otherwise explained.
8. Weight change of 2 kg or more within the previous 7 days.

PDH tiers

Tier 1: Falls deterioration concern

Required action:

a) Escalate to the nurse in charge or appropriate senior clinician.
b) Hold a falls huddle in the same shift.

c) Review the patient's current falls risks, recent changes, supervision needs, transfer method, mobility status, environment, and equipment.
d) Update the care plan and risk controls as required.
e) Record the PDH sign or signs identified, the discussion held, and the actions taken in the clinical record.

Tier 2: MDT escalation
Tier 2 applies where the patient has a NEWS2 score of 3 or more.

Required action:
a) Escalate immediately to the MDT and seek urgent clinical review.
b) Follow local physical health escalation processes without delay.
c) Review for reversible causes of deterioration and falls risk, including acute illness, medication effects, orthostatic symptoms, hydration, infection, pain, or neurological change.
d) Record the NEWS2 score, time of escalation, who was contacted, and the outcome in the clinical record.

Where a patient is acutely unwell or an emergency response is required, staff must act immediately in line with emergency procedures and must not delay escalation pending a falls huddle.

Relationship to the falls pathway
PDH sits within the wider Trust falls management process as follows:
a) On admission, or when risk is identified, staff complete the multifactorial falls assessment in line with Trust Policy CG18.
b) PDH is then used daily to identify whether new deterioration signals are present.
c) Where one or more Tier 1 signs are present, staff escalate to senior staff and complete a falls huddle in the same shift.
d) Where Tier 2 is present, staff escalate to the MDT immediately.
e) PDH does not replace the multifactorial falls assessment, post-fall review, medical review, or incident reporting requirements. It supports earlier recognition and earlier action between those points.

Documentation requirements
The following must be documented where PDH applies:
a) Which PDH sign or signs were identified.
b) Whether the patient was no trigger, Tier 1, or Tier 2.
c) Who the concern was escalated to.
d) Whether a falls huddle was completed.
e) What immediate actions were taken.
f) Any changes to observation level, assistance required, transfer plan, equipment, or care plan.
g) For Tier 2 cases, the NEWS2 score, time of escalation, MDT response, and clinical outcome.

Where a fall or near fall has occurred, Eclipse and Rio documentation must be completed in line with Trust policy.

Staff roles under PDH

- Nurses and HCAs identify PDH signs during routine care, escalate concerns promptly, and ensure actions are documented.
- The nurse in charge or senior clinician reviews Tier 1 concerns and ensures a falls huddle is completed in the same shift.
- The MDT responds to Tier 2 escalation, reviews the patient's clinical status, and agrees further management.
- Medical staff review acute deterioration, investigate reversible causes, and document treatment decisions.
- Pharmacy, physiotherapy, occupational therapy, and mental health practitioners contribute to targeted intervention planning according to the patient's presentation and identified risks.
- The Trust Clinical Lead for Moving and Patient Handling sets standards for safe transfer practice, equipment use, training, and governance assurance relevant to falls prevention and post-fall management.

Alignment with NICE NG249 and Trust Policy CG18

- NICE NG249 defines the national standard for multifactorial assessment and targeted falls prevention.
- Trust Policy CG18 defines the local process, timescales, documentation standards, and governance requirements.
- PDH operationalises these requirements day to day by providing a simple action rule:
- No PDH signs: routine care.
- One or more Tier 1 signs: escalate to senior staff and hold a falls huddle.
- NEWS2 score of 3 or more: escalate immediately to the MDT.