Acacium Group
Falls Prevention Policy

Policy Reference | CLIN 34

Version | V2.0

Policy Name	Falls Prevention Policy
Purpose of Document	To ensure that the correct preparation, procedure and outcome are achieved by implementing a consistent, and systematic, approach to the effective assessment and management of falls
Target Audience	All Acacium Group Workers
Version	V2.0
Author	Kate Nicholson-Florence
Date of Approval	November 2014
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Lead Director	Karen Matthews-Shard
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Last Reviewed	July 2023
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Risk and Resource Implications	Client injury Potential claims and litigation.
Associated Strategies and SOPs	CLIN 03 Medicines Management Policy CLIN 06 Consent Policy CLIN 17 Safe Use of Bed Rails Policy ORG 03 Health and Safety Policy ORG04 Incident Reporting Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Nov 2014	Signed off by Karen MS.	KMS
V1	Jan 2015	Published.	KNF
V1	Jan 2016	Annual review.	KNF/SJ
V1	Jan 2017	Annual review.	KNF/SJ
V1	Feb 2017	Updated with guidance from NICE.	KNF/VM
V1	Nov 2017	Updated to include new TCS bio brand description page.	LB / MS
V1	Jan 2018	Annual review.	KMS/VM
V1	Feb 2018	Updated front sheet to include new review frequency date.	KMS
V1	May 2018	Updated CSSIW to CIW	LW
V1.1	Apr 2019	Implementation of new Policy template	CCR/KG
V1.2	Feb 2020	Update to new Policy template	CCR/CC
V1.3	Oct 2020	Update re Rebrand	CCR/CC
V1.4	Jan 2021	3 yearly review	Clinical Advisory Group
V1.5	Jan 2021	Update re Rebrand	CC
V1.6	Apr 2021	Added CHS brand	CC
V1.7	Jul 2021	Review	Clinical Advisory Group
V1.8	Jul 2023	Reviewed and updated	Clinical Advisory Group
V2.0	Jan 2024	Rebrand	Clinical Advisory Group

Table of Contents

1. Introduction

1.1 A fall can be defined as “An unplanned or unintentional descent to the floor with or without injury, regardless of cause”. (NRLS) “An unintentional or unexpected loss of balance resulting in coming to rest on the floor, ground, or an object below knee level” (NICE 2017).

1.2 Falls are among the most common and serious problems facing elderly clients, falls can

1.3 also affect clients of any age with any illness or disability.

1.4 Falls occur in 30% of adults aged over 65 years annually, for whom the consequences are more serious, despite concerted efforts of researchers and clinicians to understand, assess and manage their risks and causes (Ganz 2020). In addition to personal distress, falls and fall-related injuries are a serious health care problem because of their association with subsequent morbidity, disability, hospitalisation, institutionalisation and mortality. (James et all 2020)

1.5 Falls generally result from an interaction of multiple and diverse risk factors and situations and can occur in many different environments/settings.

1.6 Falls are estimated to cost the NHS and social care an estimated £6 million pounds a day (Age UK 2016). The human cost of falls includes distress, pain, injury, loss of confidence, increase in anxiety about future falls and potential loss of independence and mortality.

1.7 However client safety has to be balanced with independence, rehabilitation, privacy, and dignity – a client who is not allowed to walk alone will very quickly become a client who is unable to walk alone (www.patientsafetyfirst.nhs.uk).

2. Scope of Policy

2.1 This Policy is for all healthcare professionals working for Acacium Group who care for clients who at risk of falling.

2.2 This Policy is to provide guidance in assessment, falls prevention and management post falls. This guidance is to be followed in conjunction with guidance from statutory services.

2.3 The aim of this Policy is to manage the risk of, reduce the incidence of, and thereby reduce the harm clients experiencing falls whilst under the care of Acacium Group staff in their own homes and other community and acute settings.

3. Definitions

Table 1: Definitions in relation to this Policy

Definition	Explanation
Fall	An unintentional or unexpected loss of balance resulting in coming to rest on the floor, ground, or an object below knee level (NICE 2017).
Assessment	A comprehensive look into the client’s condition coupled with associated risk factors leads to an assessment of the client’s condition at the time and assists in predicting future complications.

Risk factors	Factors that increase the client's risk of falling, these can include medical and environmental factors.
Balance and gait	Balance is the ability to stand and gait is a rhythmic stepping movement for travel (locomotion).
Postural hypotension	A client has a drop-in blood pressure when they stand up which can result in a fall.
Risk	Risk is the chance that an event will occur. It is measured in terms of likelihood (the frequency or probability that an event will happen) and severity (the consequence or effect of the event happening). In the context of the company's activities, risk encompasses anything that has an impact on the care of a service user/client, or which impacts upon the ability of Acacium Group to fulfil its objectives.
Risk management	The term applied to a logical and systematic method of establishing the context, and identifying, analysing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process, in a way that will enable organisations to minimise losses and maximise opportunities. Risk management is as much about identifying opportunities, as avoiding or mitigating losses.
Dignity and respect	The uniqueness and intrinsic value of individual clients is acknowledged, and each person is treated with respect.
Independence	Clients have as much control as possible over their lives, whilst being protected against unreasonable risks.
Rights	Clients' individual and human rights are safeguarded and actively promoted within the context of services delivered by Acacium Group workers.

4. Roles & Responsibilities

4.1 The overall organisational roles and responsibilities are set out in ORG1, the Policy on Policies for drafting, approval and review of policies and standard operating procedures (SOPs).

4.2 The following table outlines the responsibilities of key people involved in the care of a service user, and their family, after their death.

Table 2: Roles and responsibilities in relation to this Policy

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Line Managers / appropriate others	Operationally responsible for ensuring: • compliance with this Policy within their area of responsibility

	• that this Policy is supported by appropriate training, policy distribution and awareness.
Individual workers	Have a responsibility to: • undertake this procedure when they have been assessed as understanding the cultural and sensitive needs and are able to provide last offices using best practice • adhere to professional codes of practice and ensure their clinical competence.
Clinical Advisory Group (CAG)	Review polices associated documents and training content for the Group. To support high clinical standards and quality improvement agendas in line with the Groups vision, strategic aims

5. Risk Factors

5.1 There are many risk factors associated with falling, and the risk of falling appears to increase with the number of risk factors a client has. Being aware of these risk factors allows for intervention to be targeted at specific risk factors to help prevent future falls.

Falls risk factor	Explanation
Cognitive impairment	Cognitive impairment is when a person has trouble remembering, learning new things, concentrating or making decisions that affect their everyday life, this can lead to an increase risk of falling.
Continence problems	When the client has problems maintaining control of their bladder and bowels.
History of falls	Previous falls, the causes and consequences (such as injury and fear of falling) can increase the likelihood of future falls.
Footwear	Footwear that is unsuitable or missing can increase the likelihood of falls.
Health problems	Certain health problems may increase the risk of falling e.g.: vertigo, neurological and muscular skeletal conditions.
Medication	Some medications and poly pharmacy can have side effects which increase the risk of falling. Greater number of side effects associated with multiple medication use and the side effects can be more intense. Interactions between medications can also cause side effects.
Alcohol and/ or recreational drugs	Consider if alcohol/recreational drugs may be taken or consumed – consider the amount and how this may interact with prescribed medications
Postural instability	Impaired postural stability – inability to maintain an upright posture. Can be either sitting, standing or walking.
Mobility problems	Impaired physical mobility represents a complex healthcare problem.
Muscle weakness	A decrease in muscle strength.

Syncope syndrome	Syncope syndrome is a condition that makes the Client faint on a regular basis.
Visual impairment	A decrease in the client's sight, visual impairment covers a broad spectrum from mild impairment through to registered blind. With visual impairment the risk of a fall increases significantly particularly if the client is in unfamiliar surroundings.

5.2 Environmental factors can have a significant impact on the risk factor of falling. Environmental factors such as poor lighting, furniture, loose carpets, rugs, children's toys, household pets. This is particularly relevant in the community setting and should be considered as part of the environmental risk assessment.

6. Falls Prevention

6.1 It is recommended by NICE that clients should be asked routinely whether they have fallen in the past year and asked about the frequency, context and characteristics of the fall/s.

6.2 Within the community divisions of Acacium Group, a Falls Risk Assessment this should be completed as part of clinical or social assessment and during care reviews.

6.3 NICE recommend that clients at risk of falling, and their carers should be offered information on the following:

- What measures they can take to prevent further falls
- How to stay motivated if referred for falls preventions strategies that include exercise or strength and balancing components
- The preventable nature of some falls
- The physical and psychological benefits of modifying falls risk
- Where they can seek further advice and assistance e.g. Community OT, falls clinic
- How to cope if they have a fall, including how to summon help.

6.4 Avoiding falls at home: NHS Choices present tips for preventing falls in the home as shown below:

Tips for avoiding falls at home

- ✓ Mopping up spillages straight away
- ✓ Removing clutter, trailing wires and frayed carpet
- ✓ Using non-slip mats and rugs
- ✓ Using high-wattage light bulbs in lamps and torches so clients can see clearly
- ✓ Organising the home and the location of belongings so that climbing, stretching and bending are kept to a minimum and to avoid bumping into things
- ✓ Getting help to do things that the clients are unable to do safely on their own
- ✓ Not walking on slippery floors in socks or tights
- ✓ Not wearing loose fitting trailing clothes that might trip them up
- ✓ Wearing well-fitting shoes or slippers that are in good condition and support the ankle
- ✓ Taking care of their feet by trimming their toenails (if prescribed or commissioned) regularly and seeing a GP or chiropodist about any foot problems

7. Slips, Trips and Falls in Children

7.1 Falling is part of normal childhood development when acquiring independent standing balance, stepping and walking.

7.2 However there are three broad categories of children where falling is outside the normal parameters:

a. Children who, pre-school, show delay with their mobility and may present with increased falling, tripping when developing independent mobility at a later age. This does not require therapeutic intervention and should be managed through adapting activities and environment.

b. Children with co-ordination difficulties, usually school age up to early teenage years, who may report increased falling, tripping etc. when participating in activities requiring more advanced levels of balance and co-ordination. This may require assessment of co-ordination difficulties to rule out any underlying long term pathologies and intervention, preferably in an MDT context.

c. Falls in children with deteriorating conditions (diagnosed or undiagnosed) due to regression in their mobility and functional skills. This requires timely diagnosis and therapeutic intervention.

7.3 If any child continues to fall outside normal development then further investigation should be undertaken, Acacium Group workers should raise these concerns with the Service User/Client MDT for further assessment as required.

7.4 The risk of falling and strategies for the management of the falls risks in children are assessed on an individual basis as part of weighing up benefits and risks of therapeutic intervention and discussed with the child and their parents/carers as part of gaining consent.

8. Falls Assessment

8.1 There are numerous assessments that can be completed to assess the risk of falls in conjunction with the Falls Risk Assessment Tool (FRAT) (see Appendix D).

8.2 The risk assessment tool (Appendix D) may vary from location to location if Acacium Group workers are placed within the hospital setting. All workers should FAMILIARISE themselves with the documentation in use and complete when necessary and follow the local policy.

8.3 Further assessment may be required by professionals such as the falls clinic/falls team, occupational therapist, GP etc. The table below illustrates referral options and interventions, NB. for commissioned care packages any referral would be required to come via the commissioner and concerns relating to possible falls or falls that have occurred should be escalated as detailed within the clients care plan and escalation process.

Risk Factor Present	Further Assessment	Referral Options	Interventions
1) History of falling in the previous year	• Review incident(s) identifying precipitating factors	• OT • Physiotherapist • Falls clinic	• Discuss fear of falling and realistic preventative measures
2) Four or more medications per day.	• Identify types of medication prescribed	• GP • Falls clinic	• Review medications particularly sleeping tablets. For more information please follow the link : https://www.yumpu.com/en

	• Ask about symptoms of dizziness		/document/view/47584881/falls-risk-assessment-tool-frat-bhps.org.uk • Discuss changes in sleep patterns and sleep promoting behavioral techniques
3) Balance and gait problems	• Can they talk while walking? • Do they sway significantly on standing? • Do basic balance test such as timed up and go test	• OT • Physiotherapist • Falls Clinic	• Teach about risk. And how to maneuver safely, effectively and efficiently. • Physiotherapy evaluation for range of movement, strength, balance and/or gait exercises • Transfer exercises • Evaluate for assistive devices • Consider environmental modifications a) to compensate for disability and to maximize safety, b) so that daily activities do not require stooping or reaching overhead • Consider motivation of the client to maintain and improve their independence
4) Postural hypotension (low blood pressure)	• Ask the client to lie down for 5 mins. • Measure BP after 5 minutes • Ask the client to stand. • Measure BP after standing in the first minute. • Measure BP again after client has been standing for 3 minutes. • Repeat recording if BP is still dropping. This process will need to be adjusted for sitting if clients are unable to stand. -Ask the person to lay down flat for 5 minutes -Take a blood pressure measurement, whilst laying down. -Ask the person to sit up right, can be with the assistance of the	• District Nurse • Practice Nurse • GP • Falls Clinic	• Offer extra pillows or consider raising head of bed if severe. • Review medications • Teach to stabilize self after changing position and before walking • Avoid dehydration

	profiling bed) for three minutes -After the 3 minutes take another blood pressure reading. Postural hypotension | The BMJ https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjropex9JTzAhUMV8AKHS7KDhQQFnoECDYQAQ&url=https%3A%2F%2Fwww.rcplondon.ac.uk%2Fprojects%2Foutputs%2Fmeasurement-lying-and-standing-blood-pressure-brief-guide-clinical-staff&usg=AOvVaw3viF8nA9vIpa5woJeMbipw		
5) Cognitive Impairment	Ability to retain and understand information and follow instructions	• District Nurse • Practice Nurse • GP • Falls Clinic	• Follow the care plan • Review and follow impairment/falls assessment/capacity, MCA and DoLs
6) Alcohol consumption	Amount of alcohol consumed daily. Is the client amenable to abstaining/reducing intake?	• GP • Substance abuse/alcohol liaison service	• Assessment • Assistance to stop. • Consider treatment for withdrawal. • Involvement of the person purchasing the alcohol

9. Severity Rating of the Fall

9.1 The severity of the fall should be defined in accordance with the National Reporting and Learning System (NRLS) categories:

- No fall: the client did not experience a fall
- No harm: fall occurred but with no harm to the patient
- Low harm: client required first aid, minor treatment, observation or medication
- Moderate harm: the client is likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital
- Severe harm: permanent harm, such as brain damage or disability

- Death: where death was the direct result of the fall.

10. Management of the Client after a Fall

10.1 If a client falls or a fall related near miss occurs, check the client for signs of Injury. If a severe injury is evident or suspected dial 999/2222 dependant on the care setting for emergency assistance.

10.2 If the client is assessed as having a fall without a severe injury return the client to bed/chair using appropriate moving and handling techniques and refer to GP/111. If unable to safely use the moving and handling technique – dial 999 or raise the alarm for help, in accordance with local policy and as detailed within their care plan.

10.3 All incidents must be reported and then documented on DATIX, or the local incident reporting system, to include client details, time, location and circumstances of the fall.

10.4 Reassess risk and document any actions required. If indicated initiate referral medical review, medication review, falls services, community therapy Services or specialist nurse assessment and document. Document any Changes in the clients care plan and risk assessments as appropriate.

11. Reporting and Recording of Incidents

11.1 In the NHS although falls are the most commonly reported patient safety Incidents, some trusts have undertaken case note review using the Global Trigger Tool and have found that there is still significant under reporting. (Seil Et Al 2007).

11.2 No harm falls are the most likely to go unreported (Hanesel et al 2009). It is Important to record all falls so analysis and improvement plans can be put in Place if required.

11.3 All falls causing significant injury (e.g. fractured neck of femur) require a full Root cause analysis (RCA) investigation to identify underlying causes and creation of action plans to prevent similar incidents. Acacium Group will work with other providers and within contractual requirements for any investigation that is lead externally .

11.4 Falls involving Acacium Group staff or clients are analysed per division and reported to internal Quality and Safety meetings.

12. The Use of Bed Rails

12.1 In general, manufacturers intend their bed rails to be used to prevent or reduce the risk of bed occupants from falling and sustaining injury. They are not designed or intended to limit the freedom of people by preventing them from intentionally leaving their beds; nor are they intended to restrain people whose condition disposes them to erratic, repetitive or violent movement.

Bed rails: management and safe use - GOV.UK (www.gov.uk)

12.2 Bedrails are designed to reduce the risk of clients accidentally slipping, Sliding, falling or rolling out of bed. It must be remembered that all clients may not be suitable for bed rails. Where bed rails are in use a risk assessment must be undertaken and reviewed and re-assessed on a regular basis

12.3 The national Patient Safety Agency Report (2007) states that ‘’The prevailing opinion in most nursing literature is that bed rails do not prevent falls and may increase the likelihood of injury in falls from

bed''. Deaths from bedrail entrapment in England and Wales have been recorded but remain extremely rare.

12.4 The only appropriate use of bed rails is to reduce the risk of client's accidentally slipping, sliding, falling or rolling out of bed. Where bedrail bumpers or additional mattresses are in place height extension rails may be required

12.5 The use of bed rails must not be considered as a form of restraint which can deprive a client of their dignity and autonomy. DoLS – (Deprivation of Liberty) is required to allow the use of bed rails in the community. It is the responsibility of Acacium Group staff to check that the correct documentation is in place for the safe use of bed rails, but it isn't the company's responsibility to implement the DoLS.

12.6 Bed rails are 'medical devices', which fall under the authority of the Medicines and Healthcare Products Regulatory Agency (MHRA). Manufacturers and suppliers of bedrails also have a duty to ensure that equipment is safe for use and staff should refer to their instructions.

13. Record Keeping

13.1 All records must be kept in accordance with national requirements, such as The Data protection Act 2018, and with Acacium Group information governance and Records management policies.

13.2 Recording in the client care records must be according to the best practice Developed by Acacium Group and within local policy guidelines

13.3 When Acacium Group are the commissioned provider ,all records remain the property of Acacium Group. Acacium Group is responsible for the storage and retention of the Records in line with the Care Standards Act 2000

14. Reporting Breaches in Policy

14.1 Acacium Group supports the use of a thorough, open and multi-disciplinary approach to Investigating adverse events, where improvements to local practice can be discussed, identified and disseminated.

14.2 It is important that an open culture exists in order to encourage the immediate reporting of errors or incidents.

14.3 All errors and incidents require a thorough and careful investigation at a local level, taking full amount of the context and circumstances and the position of the practitioner involved. Such incidents require sensitive management and a comprehensive assessment of all the circumstances before a professional and managerial decision is reached on the appropriate way to proceed.

14.4 If any Acacium Group staff members makes or identifies an error or incident, they should inform their line manager as soon as possible after the event.

14.5 All errors (client safety incidents) and near misses should be reported through the Acacium Group incident reporting system (DATIX) or the system used in the location of staffing provision

14.6 The relevant management team would then make the decision to report the incident to the Care Quality Commission in line with requirements.

14.7 When considering allegations of misconduct, the manager investigating the incident will identify if the error was the result of reckless or incompetent practice, and/ or was concealed. If it is identified that

this was the case it may result in disciplinary action and external reporting to the professional bodies, DBS or the police.

14.8 For errors or incidents that resulted from other causes, such as the serious pressure of work, Acacium Group may still suspend the worker or take local disciplinary action where it is considered to be necessary, even where there was immediate, honest disclosure in the client's interest.

14.9 All lessons learned from errors and incidents will be reviewed and disseminated across the organisation.

15. Training

15.1 Acacium Group will enable staff to participate in training in falls management and assessment. The training will be proportionate, and relevant, to the roles and responsibilities of each staff member.

15.2 Staff must attend training to ensure that they are competent and have reached an agreed standard of proficiency in the management of falls.

15.3 The Group Global Clinical Director & Group Chief Nurse will be responsible for ratifying the policy, standard operating procedures (SOP) and levels for competency.

15.4 The delivery of training is the responsibility of the operational teams.

15.5 It is the responsibility of the central training team to organise and publicise educational sessions, and to keep records of attendance.

15.6 All training provided will be mapped to the requirements of individual care packages, the appraisal process, and noted in the personal development plan where appropriate.

16. Audit / Monitoring

16.1 Processes for monitoring the effectiveness of the Policy include:

- Assessment of satisfaction through questionnaires developed for the client's use.
- Case records review and audit by Acacium Group community nurses/clinical auditors on an agreed basis. The audit should be completed and returned to the line manager with an action plan, if appropriate.
- Incident reporting procedure.
- Appraisal and Personal Development Plan (PDP)

17. Associated Policies / SOPs

Policies
CLIN 03 Medicines Management Policy
CLIN 06 Consent Policy
CLIN 17 Safe Use of Bed Rails Policy
ORG 03 Health and Safety Policy
ORG04 Incident Reporting Policy

18. References

- National Institute for Health and Care Excellence, June 2013. Reviewed May 19 Falls in older people: assessing risk and prevention. Guideline CG161. NICE. Available at: https://www.nice.org.uk/guidance/cg161
- National Institute for Health and Care Excellence, March 2015. Last updated Jan 2017 Falls in older people. Quality standard. NICE. Available at: https://www.nice.org.uk/guidance/qs86
- https://www.nice.org.uk/guidance/cg161/resources/2019-surveillance-of-falls-in-older-people-assessing-risk-and-prevention-nice-guideline-cg161-6784064895/chapter/Surveillance-decision?tab=evidence
- https://www.gov.uk/guidance/bed-rails-management-and-safe-use March 2020
- National Patient Safety Agency, 2007. Slips, trips and falls in hospital. NPSA.
- Public Health Outcomes Framework (PHOF)

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DRA DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. This Policy is supported by legislation and national guidance, as set out in the table below.

Act, policy, guidance	Explanation
Health and Safety at Work Act 1974, England, Scotland, Wales and Northern Ireland	All workers have the right to work in places where risks to their health and safety are properly controlled. The Health and Safety at Work Act creates legal obligations for staff and employers on ensuring this, including undertaking risk assessments to identify risks and to put in place preventative measures.
Management of Health and Safety at Work Regulations 1999	The main requirement of the Management of Health and Safety at Work Regulations is that employers must carry out risk assessments to eliminate and reduce risks. Employers with five or more employees need to record the significant findings of a risk assessment.
Management of Health and Safety at Work (Amendment) Regulations 2003	As above, with amendments.
Manual Handling Operations Regulations 1992	These regulations require employers to minimise the health risks associated with manual handling activities which involve lifting, carrying, moving, holding, pushing, lowering, pulling or restraining an object or person.
Manual Handling Operations Regulation 1992, Northern Ireland	As above, amended for Northern Ireland.
Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013	Under these regulations, certain work-related accidents are reportable by law to the Health and Safety Executive (HSE).
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, HSE Northern Ireland	As above, amended for Northern Ireland.
CQC care standards	The independent regulator of all health and social care services in England. They stipulate 28 outcomes for all providers to comply with.
SCI	The independent regulator of social care and social work services across Scotland. They regulate, inspect and support improvement of care, social work and child protection services for the benefit of the people who use them.
RQIA	'The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and

	encouraging improvements in the quality of those services'.
CIW	The independent regulator of social care and nurse agencies in Wales.

2. Equality and diversity

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: Falls Risk Assessment Tool (FRAT)

FALLS RISK ASSESSMENT TOOL (FRAT)	Client name: Client DOB: Business Unit

PART 1: FALL RISK STATUS

Risk Factor	Level	Risk Score
Recent Falls	None in last 12 months…….. One or more between 3 and 12 months…….. One or more in last 3 months…… One or more in last 3 months whilst inpatient in hospital…….	**2** **4** **6** **8**
Medications (Sedatives, anti-depressions, anti-Parkinson's, diuretics, anti-hypersensitives, hypnotics)	Not taking any of these…… Taking one…… Taking two…… Taking more than two……..	**1** **2** **3** **4**
Psychological (Anxiety, Depression, ↓Cooperation, ↓insight, ↓judgement)	Does not appear to have any of these… Appears mildly affected by one or more… Appears moderately affected by one or more….. Appears severely affected by one or more…….	**1** **2** **3** **4**
Cognitive Status	Intact…….. Mildly impaired…….. Moderately impaired…….. Severely impaired……..	**1** **2** **3** **4**
(Low risk: 5-11, Medium risk: 12-15 High risk: 16-20) RISK SCORE		/20

Automatic High-Risk Status
□ Recent change in functional status and/or medication affecting safe mobility (or anticipated)
□ Dizziness / postural hypotension

FALL RISK STATUS: (Circle): LOW / MEDUIM / HIGH Ensure to list fall status on Care Plan

PART 2: FALLS HISTORY

Document recent falls including known circumstances and consequences

PART 3: RISK FACTOR CHECKLIST

		Y/N
Vision	Reports/observed difficulty seeing – objects/signs/finding way around	

Mobility	Mobility status unknown or appears unsafe/impulsive /forgets gait aid	
Transfers	Transfer status unknown or appears unsafe	
Behaviours		
Activities of daily living	Observed risk-taking behaviours, or reported from MDT	
	Observed unsafe use of equipment	
	Unsafe footwear / inappropriate clothing	
Environment	Difficulties with orientation to environment	
	Cluttered / untidy environment	
	Multiple equipment required	
Nutrition	Underweight / low appetite	
Continence		
Other		

PART 4: ACTION PLAN

(for risk factors identified in part 1+3, list strategies below to manage falls risk)

Problem list	Intervention strategies required

REVIEW

Review date	Risk Status	Revised care plan Y/N	Signed