Northern Care Alliance
NHS Foundation Trust

Falls Prevention Policy

Lead Author:	Sally Hulmes Falls Prevention Lead Nurse,
Additional author(s)	Previous contribution to earlier version - Rachel Pyburn Consultant Physician, Deborah Hindle Dep. DDN ICD, Angela Winstanley ADNS MCCN
Division/ Department:	Falls Prevention Service, Safeguarding Team - Corporate
Applies to:	Salford Care Organisation Oldham Care Organisation Bury Care Organisation Rochdale Care Organisation
Approving Committee	NCA Safeguarding Committee
Date approved:	21/03/2023
Review date:	21/03/2028

Contents

1. Overview (What is this policy about?)

This policy describes what must be done for the assessment and management of patients at risk of falling or who have fallen whilst in hospital.

If you have any concerns about the content of this document please contact the author or advise the Document Control Administrator.

2. Scope (Where will this document be used?)

- This document should be used by; all staff who assess, plan, deliver and evaluate patient care at the Northern Care Alliance for Inpatients. This includes Registered Nurses, Non-Registered Nurses, AHPS, Medics, Pharmacy Students; Student Nurses, Medical Students, AHP Students and any other students on placement in the Trust and temporary staff working within the NCA Group Foundation Trust e.g. NHS Professionals or Agency Staff.
- This policy applies to all adult patients over the age of 18 years admitted to the Trust.

Associated Documents

- Intentional Rounding Policy SCO TWGOP1(12)
- Intentional Rounding Policy NES EDN051
- Moving and Handling Policy EDH021
- Guidelines for the Manual Handling of People with Bariatric Needs NCAG041(22)
- Measurement of Lying and standing Blood pressure (Royal College of Physicians).

- Delirium and dementia assessment (EPR and assessment and guideline - GSCMEC04(16) *Assessment and Management of Dementia, Guideline GSCMEC04(16)*
- Adult transfer Policy EF002 (v1)
- Safe and Appropriate Use of Bed Rails NCASG019(22)
- Mental Capacity Act Policy NCASG015(22)
- Enhanced Patient Observation Policy (NCASG018(22)
- Head Injury Policy (CPME133)
- Deprivation of Liberty Safeguards Policy EDN037/TWGOP08(15)

3. Background (Why is this document important?)

Patients, whether they normally have problems with their mobility or not, can suffer falls in hospital due to physiological responses to illness, side effects of interventions or new medications, and lack of familiarity with their environment or confusion. Patient falls can cause significant harm to patients, impacting on hospital length of stay, morbidity and mortality, and independence. National guidance is available to assist practitioners in recognising predisposing factors to falls and set out recommended actions to reduce falls risk whilst balancing the need to promote independence.

4. What is new in this version?

- Policy is an amalgamation of Salford RM27(06) and NES CPME176 and will replace both documents to create an NCA document.
- Links to the Falls Prevention Web page for local processes to support staff in making accurate risk assessments and implementing appropriate care plans.
- Clinical Frailty Score
- Enhanced patient observation process/policy, as this is being adopted at Salford Care Organisation.
- Lying/standing blood pressure to be completed on all patients over the age of 18 years old at Salford CO, rather than just on patients over the age of 65 years old as per National Guidance. This has been in place at the Northeast Sector since 2018 and supports identifying a postural drop in any adult patient to be able to treat and minimise risk as there is a large percentage of patients under 65 years old fall in hospital.
- Falls Risk Assessment to be completed within 6 hrs of admission to a ward/dept. at the Northeast Sector in line with the other risk assessments and being standardised across the NCA.
- Removal of RAG rating of falls using a scoring system at Salford CO as per national guidance following the National Falls Inpatient Audit 2017. Patients will be identified as at risk of falls or not at risk.

- Falls Leaf symbol will be used on the patients bed board to identify increased falls risk rather than a red/amber/green circle to standardise the process across the NCA.

5. Policy

Definition of a Fall

A fall is defined as *'an unexpected or unintentional loss of balance whereby an individual comes to rest on the ground or another lower level'* (The World Health Organisation).

Falls are often multifactorial in origin and may result from environmental factors as well as factors intrinsic to a particular person.

Older patients, and hospitalised patients, have an increased risk both falling and of injury from falling as a result of multiple factors e.g., muscle weakness, skin and bone fragility, conditions causing cognitive impairment and use of certain medications e.g. anticoagulants which may increase the risk of bleeding

Falls cannot always be prevented, and the falls policy must be considered alongside the need to enable mobility and independence for the patient along with rehabilitation goals. Since many falls are multifactorial in nature, a multidisciplinary approach is needed in prevention and management of falls.
It is our responsibility to minimise the risk as much as possible and ensure appropriate care plan is in place to maintain patient safety whilst in our care.

5.1 Completion of patient risk assessments

A falls risk assessment must be undertaken, and care plan created, as part of the risk assessment process, when a patient is admitted to or transferred from another ward area and always within 6 hours of arrival to the ward/unit area. The risk assessment forms the basis of the nursing care plan and should enable the nurse to determine if the patient has any difficulty with normal walking, transferring to and from bed or chair, or toileting and bathing . Previous history of falls or balance difficulties should also be recorded.
Any patient returning to the ward from hospital leave must have a review of their fall's risks undertaken within 6 hours of returning to the ward, the assessment should take into account any falls sustained whilst absent from the ward.
Risk assessment should be completed, on admission to a ward/Dept., following a change in condition (deterioration or improvement), following surgery, and always repeated after any fall or near miss, or weekly as per normal 'Risk Assessment Process'.

Examples of "condition change" that would require a repeat assessment include:

- Patient has undergone a procedure under general anaesthetic/sedation.
- Patient's medical/surgical condition has declined e.g. may have developed confusion/delirium due to an infection.

- Patient's mental status or capacity has declined, increasing risk of falling.
- A decline in the patient's mobility or balance.
- A patient who was initially assessed as immobile or "unlikely to move unless assisted", has now improved and now mobilising, but is "unsafe" and requires supervision.
- Some patients may require continuous risk factor review on a daily basis. Changes in a patient's mental capacity must be documented. These examples are not exhaustive, and staff must use clinical judgement.

Patients who routinely require the use of an aid to walk should have this with them- if they do not; liaise with family or therapist so this can be provided.

When a patient is identified to clinically to be at an increased risk of falling this should be highlighted behind on the bed board behind the bed with the 'Falls Symbol – Yellow Leaf'. All relevant staff must be informed via the nursing handover and patient safety huddle of patient specific risks and the necessary actions within the action plan, including Enhanced Patient Observation. https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?open=22100

5.1.2 Consideration should be paid to the following risk factors as part of the Falls Risk Assessment:

- **Age:**

  30% of people over the age of 65 years old, are more likely to fall once a year, this increases to 50% for people over the age of 80 years old and injury & harm is more likely due to contributing factors of brittle bones, multiple co-morbidities and polypharmacy along with general aging factors such as impairment of vision/hearing and cognition issues.

- **Cognition:**

  There are many conditions that's cause a person to have a cognitive impairment. This could affect the way their brain or mind functions to make decisions around maintaining their own safety. In line with the Mental Capacity Act 2005, a capacity assessment should be completed for the specific decision 'Can the patient maintain their own safety whilst in hospital'. If the patient lacks capacity to maintain their own safety in hospital, then a specific plan of care should be in place to support the patient to minimise risk of harm whilst in our care. The Enhanced Patient Risk Assessment must be completed to identify specific risks of harm and an appropriate plan of care put in place to support the patient.

  Cognitive Impairment/underlying neurological conditions can be at increase a person's risk of falling, due to inability to understand risk and follow advice, and may

experience worsening of weakness, disorientation and balance problems during concurrent illnesses.
Thorough risk assessments and support from Specialist Teams e.g. Dementia Specialist Nurses, Mental Health Team, Parkinson's Team, Alcohol Team, Learning Disability Team, Neurology, Geriatricians etc, to ensure the patient has an appropriate care plan in place will minimise the risk of the person falling and sustaining harm:

- **Dementia**

  AMTS should be completed on all patients over the age of 65 years at the point of admission. If a patient has AMTS score of below 7 the Management of Dementia Guideline should be followed and support sort from the Dementia Specialist Team. https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?open=4403

- **Delirium**

  Appropriate Delirium Assessment (CAM- Confusion Assessment Method) should be carried out by the Medical Team and the Diagnosis and Management of Delirium Policy followed. https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?open=4404

- **Alcohol/Substance abuse**

  If the patient maybe suffering from alcohol, substance abuse or other medication withdrawal such as sedative medications this is likely to increase the risk of falls. Follow guidance with regard to prescription and administration of medications as per CIWA (- Clinical Institute Withdrawal Assessment score)for alcohol withdrawal. Liaise with medics/ pharmacists for suspected substance usage or withdrawal of prescribed medications .
  Audit C Tool (CIWA Score) should be completed and if a patient has a score above 8, referral to the Alcohol Team must be made for management and support of the patient and the Alcohol Withdrawal Policy followed https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?open=2117

- **Learning Disability/Autism**

  Refer to the Learning Disability Team for support and follow the Learning Disability and Autism Policy https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?open=23100

For any other specific conditions leading to a cognitive impairment refer to the appropriate specialised policies on the NCA Policy Hub including Stroke, Brain Injury, Parkinson's Disease etc.

Ensure the Enhanced Patient Observation Policy is followed for all patients with a cognitive impairment in line with the Mental Capacity Act 2005.

- **Mobility:**

  On admission to NCA, all patients must receive a moving and handling assessment. As part of the assessment, each patient will be assessed for their physical capability and mobility and what activities they would be expected to undertake in a toilet or bathroom to ensure the risk of falls is minimized. Refer to Moving & Handling policy (EDH 021).
  The patient's usual mobility, any self-reported difficulties with mobility, recent deterioration to their mobility or self-reported fear of falling should be recorded.
  Consider the rehabilitation of patients who have suffered falls or have experienced fear of falls and refer to therapy as required.
  All patients experience loss of muscle strength after bedrest, which may have particular impact on the mobility of older persons who may have been managing prior to an illness but who have low strength reserves. Patients may need supervision for their initial practice at walking following a period in bed.
  Physiotherapy staff will review patients who require balance, mobility and strength assessment upon request/referral. Patients who are unsteady walking, unsafe transferring, have any gait disorder or reduced confidence will benefit from physiotherapy and this will often be combined with an occupational therapy assessment. Mobility aids will be provided as appropriate, and advice given to both patients and staff of plans to reduce the risk of falls.

- **Communication/language:**

  Assessment of a person's communication is important to ensure they can understand information and advice being provided around Falls Prevention in hospital. If a person has any communication difficulties or language barrier all appropriate steps must be taken to support them in being able to communicate including use of communication aids e.g., pictures etc, interpreter service – 24hr telephone interpretation service, interpretation apps on mobile devices, family to support with everyday communication, note interpreters must be used for clinical decisions.
  Ensure the patient has a communication care plan in place.

- **Postural Hypotension/Lying Standing Blood Pressure:**

  Falls can be caused by dizziness as a result of a fall in blood pressure on standing; postural hypotension/postural drop. It is therefore recommended that all patients over the age of 18 years old have a lying and standing blood pressure recording checked on admission (as soon as physically possible), however all patients over the age of 65y years of age must have a lying and standing blood pressure recording checked, as this is one of the biggest contributing risk factors of over 65s falling. Issues can therefore be identified and treated to minimise the risk of falls and harm.

A positive result (drop of 20mmHg of systolic blood pressure on standing or a systolic of below 90mmHG), must be referred to the medical team for review and other members of the MDT as a multifactorial review to identify the drop in blood pressure and treat. Patients who have capacity should be advised on the safe management of postural hypotension and patients who lack capacity to understand this information; the staff delivering their care must be informed of the safe management to minimise risk of falling. For patients with a positive postural hypotension the lying/standing BP should continue to be monitored & recorded until resolved.

- **Medications:**

  Medications may increase a risk of a patient suffering falls, dizziness, reduced reaction time, drowsiness and extra monitoring may be required if new medications have been administered.eg. Cardiac medicines designed to lower blood pressure, anticonvulsant medications, analgesics and anaesthetic agents.
  Patients taking multiple medications who have a history of falling should have a targeted medications review by medical or pharmacy staff. Refer to the Medicines Guidance sheet for advice of 'Falls Risk Medications' and their effects Appendix no.1.
  Communicate the effects to all staff to plan care around the risk. Ensure the patient is aware of the risks of the medications and how to manage them.

- **Conditions:**

  There are many conditions that can increase a person's risk of falling including. Respiratory Conditions, Stroke, Cardiac Conditions, Neurological Conditions and many more, it is important to highlight if any of these are relevant in the Falls Risk Assessment and include them in the care planning for the patient and refer to appropriate specialist teams to ensure the patient care is optimised to minimise risk of falls and harm.

- **Footwear:**

  It is important patients have good fitting safe footwear to wear in hospital due to the hard slippy floors. If the patient does not have any appropriate footwear with them 'None Slip Socks' should be provided. Please note these are a temporary measure and do not replace the patient's own footwear. The socks should be a good fit and should be worn for a maximum of 72hrs as the grip will wear, making them slippy and unsafe.

  Ensure patients feet are also checked regularly for pressure damage, long toenails etc, or damage to toes, refer to podiatry for assessment. These can all impact on gait pattern and increase risk of falls.

- **Vision/Hearing:**

  Ensure all conditions relating to vision and hearing are identified. If a person wears glasses, please ensure they have the appropriate glasses they need e.g., for vision or reading.
  Refer to the Royal College of Vision Assessment Tool Appendix no.2, to assess peripheral vision and put an appropriate plan in place.
  Ensure hearing aids are in good working order.
  'Say what you mean'- in a language the patient can understand and ask the patient to feedback the information you have given them to provide assurance they have understood you.

- **Anxiety:**

  Anxiety about falling, especially if a patient has had a previous fall will impact on their confidence and will increase their risk of falling again.
  Identify the patients concerns and provide a plan of care to support them and reassure them their risk will be minimised with the plan.

- **Continence:**

  If patient needs to use the toilet frequently, locate the patient as close to the bathroom as possible. Discuss with the individual patient whether they wish a staff member to remain present and consider the use of a curtain for dignity. Use the teach back technique to discuss with patients their particular needs relating to toileting Consider patients without capacity as above.
  Consider the safety of leaving the patient in a bathroom alone or behind the curtain alone on a commode. Weigh up the risk of harm v privacy and dignity. If a patient lacks capacity to understand instructions/advice, follow the Enhanced Patient Observation policy and act in their best interest e.g., remain in the bathroom with them to minimise risk of falls/harm.

5.2 Environment

All patients must be orientated to the bed, toilet, and bathroom and ward area on admission. Drinks, food, walking aid and belongings must be placed within easy reach of the patient whether in bed or sitting in the chair. There should be clear signs to make it easy for patients to see where bathrooms and toilets are.
The Ward Environment - Must be Clutter Free and Clear from Obstacles. Floors should be even, clean and no slip. Reviewing the journey that a patient is required to make, for example from the bed to the toilet, avoiding obstacles such as trolleys, chairs and trailing wires are important measures in minimising risk of falls.
Patients must be warned of the potential risk of tripping up over items of equipment e.g., catheters, drips and drains, when mobilising and request assistance if required. Appropriate lighting, use of night lights, accessible toilets and bathrooms with handrails and space to stand

and turn safely, availability of chairs and perching stools all contribute to an environment that reduces the risk of a patient falling.

5.3 Intentional Rounding

Maintaining a safe environment; at each intentional rounding the following checks should be completed:

- If a normal bed is in use, then ensure that the bed is at the most appropriate height for safe transfers and that the brakes are on.
- Ensure the bed rails are in the correct position as per the Bed Rail Risk Assessment recommendation.
- Ensure that the bed is free from hazards e.g., clutter, wet floors, trailing wires.
- Ensure that the patient's belongings and any aids/equipment are within easy reach, as per intentional rounding policy EDN051(v1.2)/TWGOP112 (v4.1).
- Ensure all patients who have capacity have been shown how to use the nurse call system and use teach-back technique to ensure patients have understood and this is documented in the nursing/medical records.
- Ensure that patients who lack capacity have an Enhanced Patient Observation Risk Assessment completed and appropriate care plan for the level of care in place.

5.4 Enhanced patient observation

An enhanced level of observation is required when staff have assessed that the risk harm to self or risk to others is increased, either within the ward environment and/or if the patient were to leave the ward. This may require additional support from staff for example if the source of harm is an increased risk of falls; this needs to be risk assessed by using the Enhanced Patient Observation Risk Assessment and a detailed care plan in place to minimise the risk of falls and or any other harm that may occur.

If there is reason to doubt the patient's mental capacity, then a mental capacity assessment must be completed to identify if the patient can 'maintain their own safety; understanding advice and instructions to minimise risk of falls in hospital'. If the patient lacks capacity to maintain their own safety whilst in hospital, then they will need to have the 'Enhanced Patient Observation Risk Assessment' completed and an appropriate care plan in place in their best interest to support maintaining their safety. Follow Enhanced Patient Observation Policy NCASG018(22)v1 https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policy-document?search=1&view=all&sortBy=&sortDirection=&applicable_to=&category=&keywords=&document_type=&ref_id=+NCASG018%2822%29&owner=#list-25794

5.5 Sensor Equipment

The use of pressure sensor equipment as a fall's prevention strategy can potentially reduce the risk of a patient falling, if trying to move from the bed or chair without requesting assistance. A chair and/or bed sensor is used to alert staff when a patient is mobilising independently but has been assessed as unsafe to do so. An alarm is emitted when the patient moves from the bed or

chair. However, it must be highlighted that there is no guarantee that by using these sensors that a patient will not fall.
The use of these kits needs to be assessed on an individual patient basis as they are not appropriate for all patients deemed at risk of falling. The use of sensor equipment must be supported by the Enhanced Patient Observation Risk Assessment and Care Plan.
Sensor equipment must only be used in areas agreed by the Director of Nursing for the Care Organisation and discussed with the Falls Steering Group for appropriateness.
All staff must be trained how to use the equipment by the company supplying the equipment and must be assessed as being competent.
All equipment must be registered with the Medical Devices Team and a maintenance contract in place.
Wards should only purchase agreed equipment via the procurement team, Wards must not under any circumstances buy their own equipment from other sources.

5.6 Use of bed rails for patients at risk of falling from bed

Bed safety rails should not routinely be used, especially for confused and agitated patients. Bed rails should only be used if a patient is at risk of slipping, sliding rolling out of/or off the bed. However, if staff believe it may be appropriate to use bed safety rails, then a comprehensive bed rails risk assessment must be conducted and a relevant care plan in place to minimise the risk of the patient falling from the bed.
Patients must have the mental capacity to consent to the use of bed rails understanding both the benefits and the risks of bed rails. Guidance can be found in the Policy document 'Safe Use of Bed Rails' If a patient lacks the mental capacity to consent to the use of bed rails but staff believe they are at risk of slipping, sliding, rolling off the bed the 'Enhanced Patient Observation' process must be followed. https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policydocument?search=1&view=all&sortBy=&sortDirection=&applicable_to=&category=&keywords=&document_type=&ref_id=NCASG019%2822%29&owner=#list-25794

Consideration must be used to the type of bed rails used for each individual patient's needs.

5.7 Low profiling beds

For patients at risk of rolling, slipping, sliding out of bed but bedrails are inappropriate or unsafe, e.g. if a patient is confused/distressed, consideration can be given to the use of low profile beds or the bed positioned at its lowest height. Patients should be assessed individually to ensure that this is the safest and appropriate method of preventing a patient potentially falling from their bed. Crash mats must be used in conjunction with this process and the Enhanced Observation Policy NCASG018(22)v1 https://www.northerncarealliance.nhs.uk/our-policy-hub/search-for-a-policydocument?search=1&view=all&sortBy=&sortDirection=&applicable_to=&category=&keywords=&document_type=&ref_id=+NCASG018%2822%29&owner=#list-25794

There are a number of regular beds on the wards that lower to near the floor level, if one is not available contact the current Trust Bed Hire Company to order one and the crash mats**.**

5.8 Relatives and Carers

Relatives and carers often know the patient's normal routine and can give NCA staff vital information in helping prevent them from falling e.g. night time toileting routine. If a patient is identified at risk of falling, discuss plan of care with both the patient and relatives/or carers explaining the risk and prevention measures being taken.
If a patient has a cognitive impairment a 'This is me' document / Traffic Light Passport Alzhiemer's Society- This is me document / Traffic Light Hospital Passport, or other appropriate passport of care, must be completed with this information by family/carers and left at the end of the bed for staff to access.
Encourage relatives of patients who have a cognitive impairment to be involved in their care to achieve the best possible outcome and minimise risk. Use the 'Relatives/Carers Care Plan found in the Enhanced Patient Observation Policy to support relatives/carers and have an appropriate understanding/agreement of responsibility and communication between them and staff.
Relatives/carers must be informed of an inpatient fall at the earliest opportunity (with the patient's consent) and be given time to discuss the incident and an explanation of interventions that have been implemented to mitigate further falls occurring.
If it is felt inappropriate to contact family during the night, it is the responsibility of the nurse caring for the patient to contact the family/carer before finishing their shift at 8am. This ensures any relevant information can be provided and questions answered appropriately.

5.9 Positioning and observation of patients

Patients identified as being a risk of falls must be nursed in the most appropriate area of the ward/unit, where they can safely be observed, and their needs met.
On some occasions a patient may need to be nursed in a side room for a number of reasons e.g., infection control or being over stimulated in a bay. Patients with cognitive impairment need to be assessed as to the appropriateness of being cared for in a side room, this can be isolating and distressing and may increase the risk of falls. Enhanced observation must be considered therefore refer to Enhanced Observation Policy link.
The patient must be moved back to an appropriate bed as soon as medically possible. Ensure the Infection Control team are liaised with regularly to offer advice on the greater risk; infection control or risk of harm, and communication when the patient can be moved out of the side room as soon as safe.

5.10 Medical management of patients at risk of falls

- A medication risk assessment should be completed.
- If the history of fall is suggestive of syncope and this is first 'simple faint', check L+S BP if possible (lying BP, standing BP,) at one and three minutes, and ECG if any possibility of rhythm disturbance of cardiac disease.
- If patient has recurrent syncope or single syncope with injury, referral to an interested clinician (Geriatrician, Cardiologist, Neurologist dependant on age) may be

appropriate. This is not an emergency referral usually.(unless features of cardiac compromise e.g. bradycardia)

- Patients who experience injurious falls should be assessed for potential osteoporosis as treatment may reduce their risk of fracture injury. Prescription of calcium/Vitamin D, Bisphosphonate therapy and other bone therapies are individual decisions taking into account the patients risk factors, preferences and overall life expectancy. A FRAX score can be used to guide treatment decisions.
- If the patient has risk factors for osteoporosis, then checking calcium and vitamin D levels is appropriate. For older patients DEXA scanning is not always required before initiation of treatment can be considered. If these therapies/investigations are to be considered, perhaps discussion with the patients consultant or other relevant expert should be undertaken electively (Elderly/ Orthogeriatric or Rheumatology dependant on age).

5.11 Post fall actions – Nursing Staff

- Carry out top to toe assessment of the patient for injury prior to moving patient, include assessment for head injury, possible fracture or potential spinal injury.

- If no injury, assess the patient's condition and safely transfer the patient to an appropriate environment. Staff must have undertaken patient manual handling training and ensure safe manual handling techniques are used.

- If a harm injury is suspected particularly in relation to suspected fracture or spinal injury the emergency lifting equipment should be used to manoeuvre the patient to safety minimising the risk of further harm (training provided as part of the mandatory 'Moving and Handling Training, Training videos can be accessed on the Moving and Handling Web Page and the Falls Prevention Web Page).

- Complete clinical observations and National Early Warning Score (NEWS) and complete a full body assessment to review for injury or skin damage

- If fall unwitnessed by a healthcare professional or potential head injury sustained, commence neurological observations following Post falls review and record on Patientrack/EPR. Follow the Head Injury Policy CPME133(v1).

  □ Half-hourly for 2 hours.

  □ Then 1-hourly for 4 hours.

  □ Then 2-hourly thereafter.

  □ Should the patient with Glasgow Coma Scale (GCS) deteriorate at any time after the initial 2-hour period, observations should revert to half-hourly and follow the original frequency schedule.

 Any of the following examples of neurological deterioration should prompt urgent reappraisal by the supervising doctor.

 Development of agitation or abnormal behaviour.

 A sustained (that is, for at least 30 minutes) drop of 1 point in GCS score (greater weight should be given to a drop of 1 point in the motor response score of the GCS).

 Any drop of 3 or more points in the eye-opening or verbal response scores of the GCS, or 2 or more points in the motor response score.

 Development of severe or increasing headache or persisting vomiting.

 New or evolving neurological symptoms or signs such as pupil inequality or asymmetry of limb or facial movement

 If any of the changes are confirmed, an immediate CT scan should be considered, and the patient's clinical condition re-assessed and managed appropriately.

 In the case of a patient who has had a normal CT scan but who has not achieved GCS equal to 15 after 24 hours' observation, a further CT scan or MRI scanning should be considered and discussed with the radiology department.

Refer to Medical Team/Advanced Clinical Practitioner (ACP), for review according to clinical assessment. All patients should be reviewed within 12 hours of a fall- even if they are well to assess for any injuries. In cases where serious injury is possible a referral for fast track 30-minute review should be made- e.g. potential head injury, hip fracture, spinal injury, deterioration to NEWS, new onset confusion, patient on anticoagulants or any new clinical concerns.

Ensure the fall is appropriately documented in the patient’s health record, complete a post falls review document and undertake a repeat falls risk assessment.

Ensure the adverse incident is reported onto the DATIX system. Harm of moderate and above should be escalated to a Senior Nurse (Lead Nurse/Site Co-ordinator and the Governance Team). Falls Review must take place immediately.

Inform Next of Kin (NOK) if the patient has capacity to consent.

Ensure the surrounding environment is safe and clutter free

Post fall checklist to be completed, to identify root cause of fall enabling actions to be put in place to prevent further fall for patient or other patients.

5.12 Post fall Actions – Medical Staff

Following a fall the patient should have a medical review as soon as possible, continue to monitor the patient and escalate for an urgent review if there is a change to their condition or development of apparent injuries.

- Document a history of the event, a patient account or eyewitness account if possible. Please include the following:

  - Document observations - and any deterioration since the fall
  - Document if any loss of consciousness occurred, any signs of confusion and if this is a new feature
  - Examine the patient- document injuries identified or lack of injuries. Assess for symptoms or signs of for signs of bony injuries especially spinal and hip fractures or any head injuries.
  - Order bone radiographs as necessary.

Later assessment to consider causes of falling should include:

- Consider syncope or seizure as a cause and undertake neurological and cardiology examination
- Review medications- especially any new medications as potential cause medications and amend /review with usual team as deemed appropriate.

- Compare mental state/cognition to previously noted levels.

- If new onset confusion is present consider the causes of delirium (new drugs, biochemical derangement, infection, vascular event, retention of urine or constipation etc.).

5.13 Staff training

Staff allocated on ESR with, 352 Falls Awareness Training will be compliant with the Training and will remain competent within the framework of the Care Organisation.
Training resources available on the Falls Prevention Service Web Page or via L&D Web Page on the intranet.

5.14 Staff awareness / lessons learned

Staff will be made aware of incidents (concise/serious) via the established Governance framework; the Care Organisation Falls Steering Group meets regularly to oversee the cross Divisional sharing of lessons learnt and action plans.

6. Roles & responsibilities

6.1.1 **The Board and Chief Executive Officer (CEO) have ultimate responsibility for patient safety**.

6.1.2 **Divisional Directors (DDN'S), Associate Director of Nursing (ADNS), Divisional Lead nurses (DLD'S), Ward/Departmental Managers (WM'S):** You are responsible for ensuring that all staff are aware of and have access to this guidance. You are also responsible for ensuring that any accidents, incidents or complaints relating to a failure to follow this policy are investigated and followed up, identifying actions and lessons learned to share with the whole team.

6.1.3 **All health care professionals:** You have a professional responsibility to ensure adherence to this guidance when caring for patients. You must report any accidents incidents or near misses in relation to the practice within this guideline as per the Trusts Incident Reporting & Investigation Policy (EDQ008) and notify your line managers of any issues or concerns you have in implementing this guideline.

7. Monitoring document effectiveness

7.1.1 A summary/ evaluation of care delivered must be recorded in the nursing evaluation at least every duty period by the patient's designated nurse.

7.1.2 The designated nurse will review the plans of care for patients within his/ her remit and liaise with the nurse in charge regarding re-assessment and the level of observation required every 24hrs unless the patients risk/condition changes then a further review should take place.

7.1.3 The reviews set out above are a minimum requirement and must be held more frequently if the patient's risk/condition changes or a significant incident occurs.

7.1.4 Review is not limited to the formal measures above, but is a continuous process of assessment, planning, implementation and evaluation so that a formal review can be held as soon as practicable if this is considered necessary.

7.1.5 The falls policy will be owned, monitored and overseen by the Northern Care Alliance Care Organisations Falls Steering Groups.

7.1.6 Audits of documentation and process will be carried out by the Senior Nursing Team, monthly on the wards, and Falls Prevention Service, quarterly to ensure compliance is maintained and processes are appropriate to minimise risk of falls/harm for patients.

8. Abbreviations and definitions

CD -	Clinical Directors
CEO -	Chief Executive Officer
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
DD -	Divisional Directors
DLD -	Divisional Lead nurses
DND -	Divisional Nurse Directors
DoLs -	Deprivation of Liberty Safeguard
EPO-	Enhanced Patient Observation
EPO	Enhanced Patient Observation.
FRAX	Fracture Risk Assessment
HDU -	High dependency Unit
MCA	Mental Capacity Assessment
MCA-	Mental Capacity Assessment
MFRA	Multifactorial Risk Assessment
NCA	Northern Care Alliance
NICE	National Institute for Health and Care Excellence
RCA	Root cause analysis
RCP	Royal College of Physicians
WM -	Matrons and Ward/Departmental Managers

8.1 Terms used:

- Mental Capacity Assessment: If there is reason to doubt the patient's capacity under the Mental Capacity Act 2005, a patient should have their capacity assessed – specific decision; 'Can the patient maintain their own safety whilst in hospital'.
- Enhanced Patient Observation: A process used to provide extra observation for patients who are unable to maintain their own safety in hospital.

9. References

Royal College of Physicians – Implementing FallSafe – Royal College of Physicians 2012
NICE Guidance 161 – Falls in Older People – NICE Clinical Guideline 12 June 2013
Mental Capacity Act (2005) – Legislation.gov.uk 2005
Deprivation of Liberty Act (2007)

10. Document Control Information

Part 1 Must be fully completed by the Author prior to submission for approval			
Name of lead author:	Sally Hulmes		
Job Title:	Falls Prevention Lead Nurse		
Contact number:	07870 511965		
Email address:	sally.hulmes@nca.nhs.uk		
Consultation: List persons/groups included in consultation. **N.B** Include Pharmacy/PADAT/D&T/MMG for documents containing drugs. Indicate whether feedback used (FU), not used (FNU) or not-received (NR)			
Name of person or group	**Role / Department / Service / Committee / Corporate Service**	**Date**	**Response: FU / FNU / NR**
Falls Steering Group	All Care Organisations	February groups	NR
Salford QPE	All Care Organisations.	23/02/2023	FU
Angela Winstanley	ADNS/Chair Salford Falls Steering Group	30.01.2023	NR
Deborah Hindle	Dep. DDN	30.01.2023	NR
Rachel Pyeburn	Consultant Geriatrician	30.01.2023	NR
Claire Stott	Deputy Directory of Nursing	30.01.2023	FU
Emma Pickavance	Consultant Geriatrician	30.01.2023	FU
Wiebke Wentzlau	Consultant Geriatrician	30.01.2023	FU
Sarah Ingleby	DDN Tertiary Medicine	10/03/2023	FU
Richard Bulman/ Lorna Beswick	DDN/Chair of Bury Falls Steering Group	30.01.2023	FU
Karen Archibald	Lead Nurse.	30.01.2023	NR
Shona McCallum	Consultant Physician	30.01.2023	NR
Safeguarding Adults Committee	All Care Organisations	February 2023 groups	NR
NAAS Team	NAAS Team	30.01.2023	NR
Kirsty MacDonald	Patient Safety Team	30.01.2023	NR
Stephanie Mills	Health and Safety Team	30.01.2023	NR
Paula Beech	Governance Team	30.01.2023	NR
Amy Burton	EPO Team	30.01.2023	FU
Beverly Drogan	Dementia Team	30.01.2023	NR
Catherine Wickham	Alcohol Team	30.01.2023	FU
EqIA sign off: See Appendix 11			
Name:		**Date:**	
Shain Miah		Date: 10/03/2023	
Communication plan:			
This will be taken back to both the Falls Steering Group and Learning Panels to be cascaded to the Clinical workforce It will be on the Divisional QPE for each Division and presented there for awareness and dissemination and taken through CECDAM for awareness and further cascade. There will be a 'roll out' programme via the safety huddles to the ward and department-based teams			

Part 2 Must be fully completed by the Author following committee approval. Failure to complete fully will potentially delay publication of the document. Submit to Document Control/Policy Support for publication.		
Approval date:	**Method of document approval:**	
21/03/2023	Formal Committee decision Yes	Chairperson's approval
Name of Approving Committee	NCA Safeguarding Adults Committee	
Chairperson Name/Role	Jill Stott - Group Director of Nursing, Quality and Governance	
Amendments approval: Name of approver, version number and date. Do not amend above details.		
Part 3 Must be fully completed by the Author prior to publication		
Keywords & phrases:	Falls, Harm, Prevention, Management	
Document review arrangements	Review will occur by the author, or a nominated person, within five years or earlier should a change in legislation, best practice or other change in circumstance dictate.	
Special requests	Ward Managers/Lead Nurses across all Care Organisations	

11. Equality Impact Assessment (EqIA) screening tool

- The below tool must be completed at the start of any new or existing policy, procedure, or guideline development or review. **N.B.** For ease, all documents will be referred to as 'Policy*'. The EqIA should be used to inform the design of the new policy and reviewed right up until the policy is approved and not completed simply as an audit of the final Policy itself.
- All sections of the tool will expand as required.
- EqIAs must be sent for review prior to the policy* being sent to committee for approval. Any changes made at committee after an EqIA has been sign off must result in the EqIA being updated to reflect these changes. Policies will not be published without a completed and quality reviewed EqIA.

Help and guidance available:

- Click here for the Policy*EqIA Tips for Completion QRG
- Email the Group EDI Team: eqia@pat.nhs.uk for advice or training information.
- Submission of policy* documents requiring EqIA sign off to: eqia@pat.nhs.uk. Allowing an initial four week turnaround.
- Where there is a statutory or significant risk, requests to expedite the review process can be made by exception to the Group Equality & Inclusion Programme Manager tara.hewitt@pat.nhs.uk

1. Possible Negative Impacts			
Protected Characteristic	**Possible Impact**	**Action/Mitigation**	
Age	Understanding with regard to sensory deterioration, acute delirium/dementia.	Use of physical aids and assessment of safety by Physiotherapist;	

		multidisciplinary assessment of falls risk Completion of capacity assessments, safety prescriptions, risk assessments. Use of 'teach back' technique	
	Deprivation of Liberty	DOLs assessments as indicated in line with Trust policy	
	Medication	Ensure medication is reviewed in line with risk assessment	
	Recording Lying and Standing Blood pressure	Enhances risk assessment process and may increase risk level identified	
Disability	Mobility constraints	Use of physical aids and assessment of safety by Physiotherapist; multidisciplinary assessment of falls risk Completion of capacity assessments, safety prescriptions, risk assessments. Use of 'teach back' technique	
	Understanding of need for compliance with assistance due to communication/learning disability	Utilisation of communication/physical aids and techniques such as reflection to assure understanding. Involve carers and family	
	Impact on independence	Utilisation of physical aids to minimise impact in partnership with OT and Physiotherapists protecting independence as far as possible, balancing risk.	

Ethnicity	Potential language barrier	Utilisation of the interpreting services and to support family members to remain with patients during their stay to minimise distress	
Gender	None		
Marriage/Civil Partnership	None		
Pregnancy/Maternity	In the later stage of pregnancy mobility can become more difficult	Risk assessment undertaken around mobility and involvement of Physiotherapy and OT to support and assess intervention required.	
Religion & Belief	None		
Sexual Orientation	None		
Trans	None		
Other Under Served Communities (Including Carers, Low Income, Veterans)	None		

2. Possible Opportunity for Positive Impacts

Protected Characteristic	Possible Impact	Action/Mitigation
Age	None	
Disability	Understanding of need for this intervention due to communication/learning disability	Use of the communication book – alternative method of pictorial communication
Ethnicity	None	
Gender	None	
Marriage/Civil Partnership	None	
Pregnancy/Maternity	None	
Religion & Belief	None	
Sexual Orientation	None	
Trans	None	
Other Under Served Communities (Including Carers, Low Income, Veterans)	None	

3. Combined Action Plan

Action *(List all actions & mitigation below)*	Due Date	Lead *(Name & Job Role)*	From Negative or Positive Impact?
Robust completion of multifactorial risk assessment and care plan within 6 hours of admission to a ward/dept.	December 2023	1.Sally Hulmes Falls Prevention Lead Nurse.	Negative Impact, not 100% compliant in all areas.

		2.All Ward Managers	
Falls Prevention information to be available in the top 5 languages used in the Trust.	August 2023	1.Sally Hulmes Falls Prevention Lead Nurse.	Negative Impact. Currently not available.
>95% compliance of the Mental Capacity Act to identify patients who cannot maintain their own safety to ensure a safe plan of care is in place to minimise risk of falling.	December 2023	1.Sally Hulmes Falls Prevention Lead Nurse. 2.Safeguarding Adults Team. 3.All Ward Managers.	Negative Impact. Not 100% compliant in all areas.

4. Information Consulted and Evidence Base *(Including any consultation)*

Protected Characteristic	Name of Source	Summary of Areas Covered	Web link/contact info
Age	Royal College of Physicians	Patients over the age of 65 years in hospital are more likely to fall and suffer harm.	www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original
Disability			
Ethnicity			
Gender			
Marriage/Civil Partnership			
Pregnancy/Maternity			
Religion & Belief			
Sexual Orientation			
Trans			
Other Under Served Communities (Including Carers, Low Income, Veterans)			

5. EqIA Update Log

(Detail any changes made to EqIA as policy has developed and any additional impacts included)

Date of Update	Author of Update	Change Made

6. Have all of the negative impacts you have considered been fully mitigated or resolved? *(If the answer is no please explain how these don't constitute a breach of the Equality Act 2010 or the Human Rights Act 1998)*

Impact has been mitigated as described above in sections 1 & 2
7. Please explain how you have considered the duties under the accessible information standard if your document relates to patients? As stated in section1 & 2 The policy will be available to staff in different formats, including large print, enlarged on computer screen and/or on different colour paper
8. Equality Impact ~~A~~ssessment completed and signed off? *(Insert named lead from EDI Team below). Please also add this information within Section 11.* **Name: Shain Miah** **Date: 10/03/2023**

12. Appendices

Appendix 1. Falls Medication Guidance Sheet

Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Foundation Trust

Medicines Guidance Sheet
Preventing Falls in Hospital

Medicines and Falls in Hospital: Guidance Sheet

All patients should have their drug burden reviewed with respect to its propensity to cause falls.
The history should establish the reason the drug was given, when it started, whether it is effective and what its side effects have been.
An attempt should be made to reduce the number and dosage of medications, and ensure they are appropriate and not causing undue side effects.
Falls can be caused by almost any drug that acts on the brain or on the circulation.
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 may be the consequence of recent medication changes, but are usually caused by medicines that have been given for some time.

Key to Table below

Red: High Risk- can commonly cause falls alone or in combination.

Amber: Moderate Risk- Can cause falls, especially in combination.

Yellow: Possibly causes falls, particularly in combination.

Green: National Institute for Health and Clinical Excellence (NICE) guidelines.

Medicines and Falls in Hospital: Guidance Sheet

Drug	Medication Group	Risk Level	Effect on Falls Risk
Alfluzosin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
All opioid analesics	Opiate analgesics	High	Sedate, slow reactions, impair balance, cause delirium.
Amiodarone	Other antidysrhythmics	Medium	May cause bradycardia and other arrhythmias.
Amitriptyline	Sedating antidepressants (tricyclics and related drugs)	High	All have some alpha blocking activity and can cause orthostatic hypotension.
Amlodipine	Calcium channel blockers that only reduce blood pressure	Medium	Cause hypotension and paroxysmal hypotension.
Atenolol	Beta blockers	High	Renally excreted. May accumulate. Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Baclofen	Muscle relaxants	Medium	Sedative. Reduced muscle tone. No falls data on muscle relaxants. Tend to be used in conditions associated with falls.
Bendroflumethiazide	Thiazide diuretics	High	Cause orthostatic hypotension, weakness due to low potassium. Hyponatraemia.
Betahistine	Vestibular sedatives Antihistamines	Possible Cause	Sedating. No evidence of benefit in long term use.
Bisoprolol	Beta blockers	High	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Bumetanide	Loop diuretics	Medium	Dehydration causes hypotension. Low potassium and sodium
Candesartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Captopril	Angiotensin converting enzyme inhibitors (ACEIs)	High	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.

Carbamazepine	Anti-epileptics	High	Sedation, slow reactions. Excess blood levels cause unsteadiness and ataxia.
Carvedilol	Beta blockers	High	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Chlordiazepoxide	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Chlorphenamine	Sedating antihistamines for allergy	Possible Cause	No data but sedation likely to contribute to falls. Long half lives.
Chlorpromazine	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Chlorthalidone	Thiazide diuretics	High	Cause orthostatic hypotension, weakness due to low potassium. Hyponatraemia.
Cinnarazine	Vestibular sedatives Antihistamines	Possible Cause	Sedating. No evidence of benefit in long term use.
Citalopram	Selective serotonin reuptake inhibitor (SSRI) antidepressants	Medium	Cause falls as much as other antidepressants in population studies. Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause orthostatic hypotension and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.
Clomipramine	Sedating antidepressants (tricyclics and related drugs)	High	All are antihistamines and cause drowsiness, impaired balance and slowreaction times.
Clonazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Clonidine	Centrally acting alpha 2 receptor agonists	High	May cause severe orthostatic hypotension. Sedating.

Codeine	Opiate analgesics	High	Sedate, slow reactions, impair balance, cause delirium.
Dantrolene	Muscle relaxants	Medium	Sedative. Reduced muscle tone. No falls data on muscle relaxants. Tend to be used in conditions associated with falls.
Diazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Digoxin	Other antidysrhythmics	Medium	May cause bradycardia and other arrhythmias. Data on digoxin and falls probably spurious due to confounding by indication.
Diltiazem	Calcium channel blockers which slow the pulse and reduce blood pressure	Medium	May cause hypotension or bradycardia.
Donepezil	Acetylcholinesterase inhibitors (for dementia)	Possible Cause	Cause symptomatic bradycardia and syncope.
Dosulepin	Sedating antidepressants (tricyclics and related drugs)	High	All have some alpha blocking activity and can cause orthostatic hypotension.
Doxazosin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
Doxepin	Sedating antidepressants (tricyclics and related drugs)	High	All have some alpha blocking activity and can cause orthostatic hypotension.
Duloxetine	Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants A combination of an SSRI and a noradrenaline re-uptake inhibitor	High	As for SSRIs but also commonly cause orthostatic hypotension (through noradrenaline re-uptake blockade).
Enalapril	Angiotensin converting enzyme inhibitors (ACEIs)	High	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.

Eprosartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Felodipine	Calcium channel blockers that only reduce blood pressure	Medium	Cause hypotension and paroxysmal hypotension.
Flecainide	Other antidysrhythmics	Medium	May cause bradycardia and other arrhythmias.
Fluoxetine	Selective serotonin reuptake inhibitor (SSRI) antidepressants	Medium	Cause falls as much as other antidepressants in population studies. Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause orthostatic hypotension and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.
Fluphenazine	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Flurazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Fosinopril	Angiotensin converting enzyme inhibitors (ACEIs)	High	Excreted by liver and kidney.
Furosemide	Loop diuretics	Medium	Dehydration causes hypotension. Low potassium and sodium
Gabapentin	Anti-epileptics	Medium	Some data on falls association.
Galantamine	Acetylcholinesterase inhibitors (for dementia)	Possible Cause	Cause symptomatic bradycardia and syncope.
Glyceryl trinitrate (GTN)	Antianginals	High	A common cause of syncope due to sudden drop in blood pressure.
Haloperidol	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.

Hydroxizine	Sedating antihistamines for allergy	Possible Cause	No data but sedation likely to contribute to falls. Long half lives.
Imipramine	Sedating antidepressants (tricyclics and related drugs)	High	All have some alpha blocking activity and can cause orthostatic hypotension.
Indoramin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
Irbesartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Isocarboxazid	Monoamine oxidase inhibitors (MAOIs)	High	MAOIs are little now used; all (except moclobemide) cause severe orthostatic hypotension.
Isosorbide mononitrate	Antianginals	High	Cause hypotension and paroxysmal hypotension.
Lamotrigine	Anti-epileptics	Possible Cause	Insufficient data to know if these newer agents cause falls.
Lercanidipine	Calcium channel blockers that only reduce blood pressure	Medium	Cause hypotension and paroxysmal hypotension.
Levatiracetam	Anti-epileptics	Possible Cause	Insufficient data to know if these newer agents cause falls.
Lisinopril	Angiotensin converting enzyme inhibitors (ACEIs)	High	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.
Lofepramine	Sedating antidepressants (tricyclics and related drugs)	High	All are antihistamines and cause drowsiness, impaired balance and slowreaction times.
Lorazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Lortemazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Losartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.

Metolazone	Thiazide diuretics	High	Cause orthostatic hypotension, weakness due to low potassium. Hyponatraemia.
Metoprolol	Beta blockers	High	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Mianserin	Sedating antidepressants (tricyclics and related drugs)	High	Double the rate of falling.
Mirtazapine	Sedating antidepressants (tricyclics and related drugs)	High	Double the rate of falling.
Morphine	Opiate analgesics	High	Sedate, slow reactions, impair balance, cause delirium.
Moxonidine	Centrally acting alpha 2 receptor agonists	High	May cause severe orthostatic hypotension. Sedating.
Nicorandil	Antianginals	High	Cause hypotension and paroxysmal hypotension.
Nifedipine	Calcium channel blockers that only reduce blood pressure	Medium	Cause hypotension and paroxysmal hypotension.
Nitrazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Nortriptyline	Sedating antidepressants (tricyclics and related drugs)	High	All are antihistamines and cause drowsiness, impaired balance and slowreaction times.
Olanzapine	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Olmesartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Oxazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Oxybutinin	Anticholinergics acting on the bladder	Possible Cause	No data but have known Central Nervous System (CNS) effects.

Paroxetine	Selective serotonin reuptake inhibitor (SSRI) antidepressants	Medium	Cause falls as much as other antidepressants in population studies. Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause orthostatic hypotension and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.
Perindopril	Angiotensin converting enzyme inhibitors (ACEIs)	High	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.
Phenelzine	Monoamine oxidase inhibitors (MAOIs)	High	MAOIs are little now used; all (except moclobemide) cause severe orthostatic hypotension.
Phenobarbitone	Anti-epileptics	High	Sedation, slow reactions. Excess blood levels cause unsteadiness and ataxia.
Phenytoin	Anti-epileptics	High	Phenytoin may cause permanent cerebellar damage and unsteadiness in long term use at therapeutic dose. Excess blood levels cause unsteadiness and ataxia.
Pramipexole	Parkinson's disease (PD): Dopamine agonists	High	May cause delirium and orthostatic hypotension.
Prazosin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
Pregabalin	Anti-epileptics	Possible Cause	Insufficient data to know if these newer agents cause falls.
Prochlorperazine	Vestibular sedatives Phenothiazines	Possible Cause	Dopamine antagonist – may cause movement disorder in long term use. Alpha receptor blocker and antihistamine.
Promethazine	Sedating antihistamines for allergy	Possible Cause	No data but sedation likely to contribute to falls. Long half lives.

Propranolol	Beta blockers	High	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Quetiapine	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Quinapril	Angiotensin converting enzyme inhibitors (ACEIs)	High	Excreted by liver and kidney.
Ramipril	Angiotensin converting enzyme inhibitors (ACEIs)	High	These drugs rely almost entirely on the kidney for their elimination and can accumulate in dehydration or renal failure.
Risperidone	Drugs for psychosis and agitation	High	All have some alpha receptor blocking activity and can cause orthostatic hypotension. Sedation, slow reflexes, loss of balance.
Rivastigmine	Acetylcholinesterase inhibitors (for dementia)	Possible Cause	Cause symptomatic bradycardia and syncope.
Ropinirole	Parkinson's disease (PD): Dopamine agonists	High	May cause delirium and orthostatic hypotension.
Selegiline	Parkinson's disease (PD): MAOI-B inhibitors	High	Causes orthostatic hypotension. The subject of drugs and falls in PD is difficult, as falls are so common, and orthostatic hypotension is part of the disease. In general only definite drug related orthostatic hypotension would lead to a change in medication.

Sertraline	Selective serotonin reuptake inhibitor (SSRI) antidepressants	Medium	Cause falls as much as other antidepressants in population studies. Several population studies have shown that SSRIs are consistently associated with an increased rate of falls and fractures, but there are no prospective trials. The mechanism of such an effect is unknown. They cause orthostatic hypotension and bradycardia only rarely as an idiosyncratic side effect. They do not normally sedate. They impair sleep quality.
Sodium valproate	Anti-epileptics	Medium	Some data on falls association.
Solifenacin	Anticholinergics acting on the bladder	Possible Cause	No data but have known Central Nervous System (CNS) effects.
Sotalol	Beta blockers	High	Renally excreted. May accumulate. Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Tamsulosin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
Telmesartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Temazepam	Sedatives: Benzodiazepines	High	Drowsiness, slow reactions, impaired balance. Caution in patients who have been taking them long term.
Terazocin	Alpha receptor blockers	High	Used for hypertension or for prostatism in men. They commonly cause severe orthostatic hypotension. Stopping them may precipitate urinary retention in men.
Timolol eye drops	Beta blockers	High	Can cause bradycardia, hypotension, carotid sinus hypersensitivity, orthostatic hypotension and vasovagal syndrome.
Tolterodine	Anticholinergics acting on the bladder	Possible Cause	No data but have known Central Nervous System (CNS) effects.

Topiramate	Anti-epileptics	Possible Cause	Insufficient data to know if these newer agents cause falls.
Tramadol	Opiate analgesics	High	Sedate, slow reactions, impair balance, cause delirium.
Trandolapril	Angiotensin converting enzyme inhibitors (ACEIs)	High	Excreted by liver and kidney.
Tranylcypromine	Monoamine oxidase inhibitors (MAOIs)	High	MAOIs are little now used; all (except moclobemide) cause severe orthostatic hypotension.
Trazodone	Sedating antidepressants (tricyclics and related drugs)	High	Double the rate of falling.
Trimeprazine	Sedating antihistamines for allergy	Possible Cause	No data but sedation likely to contribute to falls. Long half lives.
Trimipramine	Sedating antidepressants (tricyclics and related drugs)	High	All are antihistamines and cause drowsiness, impaired balance and slowreaction times.
Valsartan	Angiotensin receptor blockers (ARBs)	Medium	May cause less orthostatic hypotension than ACEIs. Excreted by liver and kidney.
Venlafaxine	Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressants A combination of an SSRI and a noradrenaline re-uptake inhibitor	High	As for SSRIs but also commonly cause orthostatic hypotension (through noradrenaline re-uptake blockade).
Verapamil	Calcium channel blockers which slow the pulse and reduce blood pressure	Medium	May cause hypotension or bradycardia.
Zolpidem	Sedatives: ' Z Drugs'	High	Drowsiness, slow reactions, impaired balance.
Zopiclone	Sedatives: ' Z Drugs'	High	Drowsiness, slow reactions, impaired balance.

This document was created based upon national guidance prepared by:

Dr Adam Darowski, Consultant Physician, Clinical Lead, The FallSafe Project
Dr Jeremy Dwight, Consultant Cardiologist
Dr John Reynolds, Consultant in Clinical Pharmacology
John Radcliffe Hospital, Oxford, March 2011
This guidance has been approved by the British Geriatrics Society.

Appendix 2. Vision Tool – Royal College of Physicians

www.northerncarealliance.nhs.uk/application/files/9116/6783/2921/Bedside_Vision_Check.pdf