Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

In-Patient Falls Risk-Reduction and Management Policy

Department / Service:	Clinical Effectiveness
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Approved by:	Clinical Governance Group
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Trust Wide

Purpose of this Policy:
To provide information and guidance on the prevention, reduction and management of inpatient falls within Worcestershire Acute Hospitals NHS Trust.

Key amendments to this Document:

Date	Amendment	By:
May 2021	Document creation	Alice Elderton, Dr Ruma Dutta, Sarah Craister and Sarah Pittaway
July 2025	Updated – NICE [NG249]	Donna Kruckow, Victoria Sturdy, Dr. Susan Powell, Sarah Craister, Sarah Pittaway, Karen Apps, Sarah Troth,

Contents

1.0 Introduction

Falls among older adults remain a significant concern in the UK. Recent data shows that approximately one-third of individuals aged 65 and over, and half of those aged 80 and over, experience at least one fall annually. These incidents are closely associated with increased mortality, morbidity, and long-term loss of independence. Falls are a major cause of disability and are the leading cause of injury-related mortality in older people in the UK (Office for Health Improvement and Disparities, 2022). The prevalence of medical comorbidities in this population further increases both fall risk and the likelihood of serious injury.

In acute care settings, falls are the most frequently reported patient safety incident, with an estimated 247,000 to 250,000 inpatient falls occurring each year in England and Wales (NPSA, 2010; GOV.UK, 2024). Approximately 30–50% of these result in physical injury, and 1–3% in fractures. Beyond physical harm, falls are linked to delayed recovery, prolonged hospital stays, reduced confidence, and increased risk of institutionalisation. Nearly 350,000 patients remain in acute hospitals for more than three weeks annually, which increases the risk of falling and contributes to complications such as sleep disturbance, infection, and both mental and physical deconditioning (NHS England, 2019).

It is important to recognise that the risk of falling may temporarily increase during the recovery process as patients regain independence and autonomy following acute illness. However, in line with NICE guidance (2025), patients should be encouraged to remain as active and mobile as safely possible throughout their hospital stay to prevent deconditioning and support recovery. Falls prevention should never be achieved at the expense of patient mobility and functional ability.

Falls are not random events; they occur due to identifiable and modifiable risk factors. National guidance recommends that all inpatients aged 65 and over—and those aged 50–64 with risk factors—undergo a multi-factorial falls risk assessment. This assessment should guide the implementation of person-centred, evidence-based interventions tailored to the individual.

The Falls and Fragility Fracture Audit Programme (FFFAP, 2019) estimated that an 800-bed hospital could experience around 1,500 inpatient falls per year, with each fall costing the NHS approximately £2,600. Falls are associated with increased length of stay, the need for additional surgery, and unplanned treatments. Although falls cannot be entirely eliminated, risk should be minimised as far as reasonably practicable.

A growing body of evidence shows that a coordinated, multidisciplinary approach to falls prevention—tailored to individual patient needs—can reduce inpatient falls by 20–30% (PMC, 2024; FFFAP, 2019). Effective fall prevention requires collaboration across clinical teams, early identification of risks, and delivery of targeted interventions within a culture of safety. In the event that a fall does occur, timely and effective post-fall care is essential. In alignment with the Patient Safety Incident Response Framework (PSIRF), responses should be proportionate to the potential for learning, with a focus on identifying contributory factors and preventing recurrence.

2.0 Scope of the Policy

The purpose of this policy is to outline the approach taken by Worcestershire Acute Hospitals NHS Trust (WAHT) to minimise the risk of falls as far as is reasonably practicable and to reduce harm associated with falls. This approach aims both to lower the occurrence of falls and to mitigate the severity of any harm should a fall occur. The policy adopts a comprehensive, evidence-based approach to falls risk reduction and management. It addresses medical, environmental, and other contributing factors in alignment with current best practices and clinical guidelines.
This policy applies to all personnel carrying out duties for or on behalf of WAHT acute services, as well as all patients, visitors, and others present on any of the Trust sites. Specifically, it applies to all adult inpatients. The following groups must undergo a Falls Risk Assessment:

- Inpatients aged 65 years or over.
- Inpatients aged 50 to 64 years who are identified by a Clinician or Nurse as being at higher risk of falls due to an underlying condition (i.e. PC of fall, Neurodegenerative condition, Stroke / pre-existing disability).

By ensuring consistent assessment and management of falls risk, this policy supports safer care and contributes to the overall well-being of patients during their hospital stay.

3.0 Aims and Objectives

- To outline the processes to identify people at risk of falling.
- To recommend proactive measures to reduce the risk of falling in hospital.
- To guide the management of patients who fall in hospital.
- To describe the actions for reporting and learning from falls incidents as described by the Patient Safety Incident Response Framework.

4.0 Definitions

Fall
A fall is defined as an event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event (such as a stroke) or overwhelming hazard. (OHID, Feb 2022).
Falls are commonly defined as “inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest on furniture, a wall or other objects”. (WHO 2007)

Falls with harm
The degree of harm relates to the actual impact on a patient from the particular incident being reported (PSIRF 2023) – NHS England » Policy guidance on recording patient safety events and levels of harm.

5.0 Governance

The falls work stream provides a weekly highlight report for the CNO Production Board. Monthly data is provided to an integrated performance report for the Quality Governance Committee. A bi-monthly report on Falls and Mobility is presented to the Fundamentals of Care Committee.

The Trust measures falls data against the Royal College of Physicians (RCP) national benchmark of falls per 1000 bed days.

All processes, procedures and quality improvement are aligned with:

- National Institute of Clinical Excellence (NICE) clinical guidance (NG249 & QS086)
- NICE Quality standard ((NG249 & QS086)
- RCP National Audit of Inpatient Falls (NAIF)

6.0 Falls Risk Management

6.1 Multifactorial Falls Risk Assessment (MFFA)

A Multifactorial Falls Risk Assessment (MFFA) is a comprehensive evaluation of an individual's risk of falling. An MFFA is not a single assessment or form. Instead, it is the collated output of multiple professional assessments undertaken by the multidisciplinary team (for example, nursing, medical, therapy, and pharmacy staff). Together, these components form the complete MFFA.
The purpose of the MFFA is to ensure that all relevant risk factors are identified and acted upon, with findings linked to a clear, documented care plan. In line with NICE NG249 (2025), the MFFA should be person-centred, multidisciplinary, and regularly reviewed to reduce the likelihood of falls and fall-related harm.

The following patients must be assessed for their risk of falls:

- All patients aged 65 years or older
- Patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

A comprehensive falls assessment should be completed for all hospitalised adults over 65 years of age and those aged 50 to 64 with one or more factors which increase the risk of falling to identify individual risk factors and appropriate interventions to reduce risk of falls (National Institute for Health and Care Excellence [NICE], 2025). This should be reviewed if there is a change in an individual's condition or if the individual experiences a fall (British Geriatrics Society, 2022).

The following assessments and examinations (where appropriate) should be included in the comprehensive falls assessment to identify the person's individual fall risk factors:

- Alcohol misuse.
- Cardiovascular examination (including a lying and standing blood pressure test).
- Cognition and mood.
- Delirium.
- Diet, fluid intake and weight loss.
- Dizziness: ask about the presence and nature of any dizziness; if the person reports symptoms of rotational vertigo, consider performing a Dix–Hallpike manoeuvre.
- Footwear and foot condition.

- Functional ability: assess the person's perceived functional ability and explore any concerns about the individual's fear of falling.
- Gait, balance and mobility, and muscle strength assessment.
- Hearing impairments.
- Long-term conditions that affect the person's daily life: for example; arthritis, dementia, diabetes or Parkinson's disease.
- Medication review (**see below**).
- Neurological examination.
- Osteoporosis risk assessment.
- Urinary continence.
- Visual impairments (Please note: If the person has visual impairment caused by cataracts, consider referral to an ophthalmologist).

Further information

- Medication Review:
  Consider carrying out a structured medication review:
- to identify any medicines that may increase the person's risk of falls **and**
- consider adjusting their medicines to reduce that risk.

- For people taking psychotropic medicines:
  - review any psychotropic medicines **and**
  - discuss the increased risk of falls associated with psychotropic medicines with the person **and**
  - plan withdrawal as appropriate and consider liaising with specialist mental health services.

- Vitamin D supplements
  Although there is insufficient evidence to support taking vitamin D supplements specifically to lower the risk of falls, encourage individuals to follow NHS advice on taking vitamin D to maintain bone and muscle health.

- **N.B.** If the person has experienced falls with an unexplained cause:
- Investigate possible cardioinhibitory carotid sinus hypersensitivity as a cause **and**
- Consider cardiac pacing if indicated.

Falls risks are identified through use of the Falls Risk Assessment tools available on Sunrise EPR (found within the Nursing Admission flowsheet for initial assessment and within the Nursing Risk Assessment flowsheet for repeat assessments) and align with NICE Guidance NG249 - (See Appendix A for examples of Sunrise EPR assessments).

- A Falls Risk assessment must be completed within 4 hours of admission. This should involve both the patient and their next of kin where possible, to provide a broader perspective and guide the decision-making process of the Multi-Disciplinary Team (MDT).
- The patient should be re-assessed weekly, or sooner if required e.g. on transfer, post fall and if a change in the patient's condition is identified.
- Lying and standing blood pressure must be completed as part of the falls risk assessment on admission or at the earliest opportunity when the patient is able. A Lying and Standing Blood Pressure measurement is recommended for all patients at risk of falls (NAIF, 2022). If an alternative assessment or no assessment is completed, reasoning for not completing

the assessment should be clearly documented on Sunrise in the patient's record by an Allied Healthcare Professional (AHP), Registered Nurse (RN), Physiotherapist or Healthcare Support Worker (HCSW).

- Following completion of the risk assessment, a Falls Management plan must be completed as part of the care planning process. For patients identified as being at risk of falls an enhanced level of observation may be required (See Trust In-patient Enhanced Observation Guideline – Adults for further information).
- Individualised interventions must be recorded in the Falls Evaluation and Progress report and reviewed on a weekly basis alongside a falls risk reassessment.
- A physical copy of the Trust risk alert must be placed within the bed space for these patients (Xerox - Xerox061).
- An electronic falls risk icon is added automatically to Sunrise EPR for patients identified at risk of falling.
- Falls risks must be communicated at handovers, safety huddles and on transfer/discharge.
- All patients identified as being at risk of falls should have interventions implemented that are tailored to the individual, so they promptly address any falls risk factors. It should be considered whether the risk factors can be improved or managed during the patient's expected stay.
- Individually tailored education sessions that the person can engage with and participate in should be provided. The Trust leaflet 'Falls Prevention in Hospital' (Xerox - WAHT-PI-0122) should be given to the patient as part of this discussion with the patient (**See 6.11 below**).
- The patient's next of kin must be informed that the patient is at risk of falling, if the patient wishes their next of kin to be involved, or if the patient lacks capacity to make decisions about falls prevention. The next of kin should be involved in decisions about implementing risk reduction measures.
- At discharge from hospital, consider referring the individual to community services so that risk factors identified during their hospital stay that would also be relevant in their discharge destination can be addressed.

6.2 Patient Falls in the Emergency Department (ED) and short stay areas

For adult patients presenting to the Emergency Department (ED) or short stay areas, the Falls Risk Assessment within the Nursing Initial Assessment on Sunrise EPR should be completed by a Registered Nurse or Nursing Associate on admission to a cubicle or bedspace (See Appendix A for Sunrise EPR assessments).

Any identified falls prevention interventions should be clearly documented in the patient's healthcare record, and patients at high risk of falls should be appropriately escalated to senior staff members. If a decision to admit is made or where patients remain in ED or Short stay areas for more than 12 hours, a full Falls Risk Assessment should be completed in Sunrise EPR.

6.3 Patient Falls in Paediatrics

Generally, babies, children and young people accessing paediatric services are at low risk of falls in hospital. Some children may be at an increased risk of falls e.g., those with complex needs, sensory or motor impairment and those without a resident parent or carer present. Very young children who are still learning to stand, walk or run will often experience developmental falls as a natural part of the development process of acquiring these skills (Staggs et al, 2015).

A mobility assessment and assessment of developmental stage is completed for paediatric patients as part of the nursing admission assessment, which ensures appropriate moving and handling for the child during their hospital stay. Parents/carers are encouraged to bring in

children's usual equipment e.g., orthotics, specialised footwear, walking aids and helmets (which may reduce risk of falls while mobilising or injury caused by falls).

All parents/carers of paediatric inpatients are provided with an explanation on how to use cot sides/bed rails safely and are reminded to leave cot sides/bed rails in a safe position depending on the age and developmental stage of the child.

There should be appropriate care and supervision of each child whilst they are an inpatient, which may be from parents/carers and staff. Parents are reminded to inform staff if they are leaving their child unsupervised for any reason.

In the event of a patient fall in paediatrics the following procedure should be followed:

- Ensure safety of the responder. Assess for signs of injury and respond appropriately, calling for help as required.
- Any child or young person who is suspected of having a serious injury **must not** be moved until assessed by the medical team.
- Use safe moving and handling techniques to move the child or young person to a place of safety.
- The child or young person should be assessed by a paediatric doctor and the assessment, and any actions documented in the medical notes.
- Complete a DATIX incident report, informing child or young person's NOK.

6.4 Patient Falls in Maternity

Patients accessing Maternity services are generally well and at a low risk of falls. However, there are some known risk factors which may increase the risk of falls which may be more prevalent due to changing health needs of the Maternity population.

Patients admitted to hospital for maternity care who are identified as being at significant risk of falls during the antenatal, intrapartum or postnatal stage should have an appropriate plan of care documented and implemented.

The following minimum standards should be implemented for all patients in maternity care:

- Ensure bed height is set appropriately for each individual and bed brakes are on
- Encourage patients to wear appropriate footwear in hospital.
- Give clear instructions on how to use the call bell system to call for help.
- Encourage patients to ask for help if needed.
- Minimise clutter in the room.
- For patients with impaired mobility, ensure essential items e.g., call bell, bedside table are within reach.
- Safe sleeping practices should be reiterated to parents
- Make appropriate referrals e.g., to physiotherapists as required.

For patients who receive care in theatres, a Health Care Support Worker (HCSW) or Operating Department Practitioner (ODP) should remain with the patient in theatre until the appropriate anaesthesia has been administered and until they are positioned safely on the operating table.

Midwifery and support staff should be aware of the risk of accidental baby drops. To minimise this risk, staff must remain vigilant, particularly with mothers identified as high risk, and ensure appropriate monitoring and preventative strategies are in place.

6.4a Risk Factors for Falls in Maternity

The following are identified as risk factors for falls in patients in maternity units (Department of Health, Aus):

Antenatal falls risk factors:

- Pre-existing medical conditions
- Seizure disorder, e.g., epilepsy
- Acute/Chronic Illness e.g., Eclampsia / Antepartum haemorrhage
- Mobility impairment
- Developmental delay
- Mental health conditions

Conditions such as gestational diabetes, hyperemesis gravidarum and low back pain have also been shown to increase the risk of falls during pregnancy (Hrvatin & Rugelj, 2022)

Intrapartum falls risk factors:

- Epidural/spinal analgesia
- Opioid analgesia
- Severe fatigue
- Falls and trip hazards:
    - Cardiotocography (CTG) monitor
    - Drip stands
    - Fluid spills

Postnatal falls risk factors:

- Fatigue / tiredness following birth
- Post caesarean section
- On-going effects of analgesia e.g. epidurals (weakness, reduced sensation in lower extremities)
- Medications (affecting level of consciousness, balance, cognition and sleep patterns)
- Blood loss following postpartum haemorrhage (PPH)
- Hypotension

6.4b Risk Factors for Newborn Falls

Newborn falls in hospital are a rare event in which a neonate falls to floor accidentally, as a result of errors in judgement of the hospital staff or carer, or environmental factors (Paul et al, 2011).

The risk of newborn falls is increased in the following situations:

- During delivery – risk of baby slipping through the hands of the health care professional delivering the baby, compounded by quick delivery and blood/fluid
- During transport – in an insecure cot on an unsteady surface or in the arms of someone who may trip or fall themselves.
- During Postpartum period – when a mother may fall asleep cradling their newborn, risk increased by analgesia, limited mobility post caesarean section or maternal risk factors.

6.5 Management of Falls in Outpatient areas

There is a relatively low risk of falls in outpatient areas, meaning there is no mandated requirement to complete a Falls Risk Assessment for patients attending Outpatient appointments. However, the individual needs of patients should be taken into consideration to assess risks and manage any immediate risk during an outpatient appointment. People aged 50 to 64 with 1 or more factors that could increase their risk of falls and people aged 65 and over should be asked about the details of any falls when they attend appointments or assessments in community or hospital settings (NICE 2025).

6.6 Use of Mobility Aids

Patients who normally use a mobility aid should be provided with one for use in hospital if their own has not been brought to hospital with them.

6.7 Bed Rails Risk Assessment

All medical beds used across WAHT acute sites (currently various versions of the Hillrom HR900) are fitted with integral, non-removable bed rails. Bed rails must only be used following an individual risk assessment that considers both the potential risks and benefits for the specific patient.

Patients who have mental capacity have the right to make their own decisions about the use of bed rails. Bed rails must never be used to restrain a patient's movement. Their use is associated with significant risks, including entrapment and patients attempting to climb over them. Bed rails are not a substitute for close nursing supervision and must not replace appropriate levels of observation for patients at risk of harm. Refer to the Inpatient Enhanced Observation Guidelines (WAHT-NUR-085) for further guidance. Alternative resources should also be considered, such as the use of ultra-low beds/trolleys and electronic falls monitoring systems if available to reduce the risk of harm from falling.

The following patients **must** be assessed for the appropriate use of bedrails:

- Impaired/restricted mobility
- Dementia/cognitive impairment
- Learning disabilities
- Visual impairment
- Fragile skin

The initial assessment is found in the Nursing Admission document & must be completed within 4 hours of admission. Weekly repeat assessments must be completed within the Nursing Risk Assessment Document – See Appendix B – or sooner if required e.g. on transfer, post fall and if a change in the patient's condition is identified.

Decisions about the use of bed rails should be discussed with patients, relatives or carers and shared with members of the multi-disciplinary team (MDT) and documented in the additional comments section of the assessment.

6.8 Ultralow Beds

The use of low beds can pose additional risks, particularly for mobile patients who may struggle to rise safely from a low height. Crash mats or mattresses placed beside low beds may also create trip hazards or affect the balance of unsteady patients.

If the use of ultralow beds or bed rails introduces further risk to a patient who is already at risk of falling, increased levels of supervision should be considered as an alternative safety measure.

The ultralow bed position is designed to reduce the risk of injury in the event of a patient falling or climbing out of bed. Use of the ultralow bed position may be a suitable alternative to using bed rails where these are deemed not to be appropriate, but the patient remains at risk of falling out of bed. Staff should consider the following whilst nursing a patient in the ultralow bed position:

- The bed should be left in the lowest position which is safe for the patient (unless the patient is receiving hands-on care from staff when the bed should be raised to ensure staff safety while completing moving and handling tasks, facilitating eating and drinking or other direct care).
- Bed rails are not recommended for use on an ultralow bed, except when the patient is being transported.
- The ultralow position should not be used as a form of restraint (e.g. if a patient is unable to stand from a low height).

The ultralow bed position is not a standalone falls prevention solution, and even with the bed in an ultralow position, some patients may still sustain an injury in the event of falling from bed.

Patients should be individually assessed for whether use of the ultralow bed position is an appropriate intervention to reduce risk of falls injury, and a decision to use the ultralow bed position should be documented in the patient's healthcare record. The patient's wishes should be taken into consideration and the decision discussed with their next of kin or family, where appropriate.

It is important to consider the following before using the ultralow bed position:

- The unusually low position may aggravate distress, confusion and/or agitation in some patients.
- The ultralow position may reduce a patient's ability to transfer in and out of bed independently so may contribute to risk of deconditioning.
- The ultralow position makes it more difficult to position the over-bed table close enough to the patient to allow them to easily access drinks and personal items. If this is the case the bed may need to be raised during mealtimes to facilitate improved access to the table, however the patient should be supervised at all times while the bed is in this position.

Ultralow beds are available to hire from Arjo or DHG Nightingale (Bariatric). The Ward Manager/Matron is responsible for the bed hire, prompt return and payment of hired beds.

6.9 Use of Falls Alarms

Falls alarms serve as an early warning to staff when 'at risk' patients are engaging in activities which may result in a fall. A falls alarm system uses sensor mats on the chair or bed or attached to the patient in the bathroom connected to an alarm box. The falls alarm warns staff that the patient has changed position and is about to leave the bed, chair, wheelchair or the toilet. This aims to ensure staff can provide urgent assistance to the patient, maintaining their safety and reducing risk of falling.

A falls alarm may be particularly useful for patients who are non-compliant, have a communication deficit, are unable to use the call bell due to cognitive impairment or lack insight into their current capabilities, therefore are likely to attempt to get out of bed or mobilise without support from staff, even when support is needed. Falls alarms are not a substitute for other falls risk reduction measures, and should only be used following individualised assessment, considering patient-specific risk factors.

Where falls alarm systems are installed, the Ward Manager is responsible for ensuring they are in full working order and regularly checked. A patient-specific assessment must be completed to determine whether the use of a falls alarm is appropriate as part of that individual's care plan.

If a falls alarm system is found to be faulty or malfunctioning, the Ward Manager (or designated staff member) must immediately take the equipment out of use and report the fault through the appropriate internal reporting system. The equipment supplier should then be contacted promptly to arrange repair or replacement, following local procedures for managing equipment issues to ensure patient safety is maintained at all times.

6.10 Physical activity and exercises

Encourage people to remain active during their hospital stay by:

- reassuring them that they can still get up and do not need to restrict their activity (unless they have been advised not to) **and**
- helping them to be less sedentary and more active, for example, encouraging them to get out of bed, get dressed and regularly stand up and walk around **and**
- for people able to exercise, look for opportunities to encourage physical activity that addresses the person's risk of falls, such as balance, coordination, strength and power.

6.11. Patient Education

Discuss ways that individuals can reduce their risk of falls as well as improving their overall wellbeing and provide information that they can take away. Involve the person's family and carers as appropriate. Topics to discuss include the following:

- A patient's risk of having a fall depends on their individual risk factors (for example, increasing age, taking certain medicines, or having low blood pressure or cataracts), and that some risk factors can be modified (for example, by undertaking appropriate exercise interventions, having a medication review, or having cataract surgery). It is important to highlight that risk factors may change when in hospital.
- That some falls are preventable, with suggestions and ideas to reduce the risk of falling, tailored to their individual risk and circumstances. It is important that they, or hospital visitors (such as family members, carers etc.), can alert staff about potential falls hazards.
- How interventions to prevent falls can help, and how to stay motivated. It is important to highlight how to move around safely and stay as active as possible while in hospital, and

when and how to seek help (for example, if they need to call for assistance to go to the bathroom & using call bells and bed controls correctly).
- What to do if they have a fall, including how to get up, and when and how to seek help.
- Sources of further information (for example, Worcestershire County Council website to find local group exercise programmes and ways to stay active) & what support may be available after they are discharged from hospital to reduce their risk of having a fall.

7.0 Post Fall Management

7.1 Assessment and Examination

- All adult inpatients who sustain a fall must be assessed and examined post fall.
- The 'Falls Register' & associated proforma (Falls Risk Assessment/Evaluation Plan) within the Nursing Risk Assessment must be completed immediately on Sunrise EPR after a fall by a registered healthcare professional. An updated bed rail assessment must be completed (if applicable) also.
- The 'Post Falls Assessment' must be completed after a fall by a doctor or advanced clinical practitioner on Sunrise EPR.
- All patients with a suspected spinal injury must not be moved until a scoop and blocks are available (refer to the in-patient Head and C-spine injury guideline WAHT-MED-013).
- If a fall is unwitnessed or the patient is witnessed to sustain a head injury neurological observations must be carried out as per national guidance: ½ hourly for the first 2 hours (or until GCS reaches 15), hourly for the following 4 hours and 2 hourly thereafter for 24 hours – this is regardless of whether a CT head shows no injury.
- All patients with an altered level of consciousness or a suspected lower limb fracture must be recovered from the floor using flat lifting equipment (Hoverjack/Flojac), or scoop if the former not available. Details of locations of flat lifting equipment can be found on "The Source" Falls page.
- All other patients must be recovered with the correct manual handling e.g. independently, two chair technique, hoist.
- In the case of IT failure, Post fall paperwork is available as a pack (Xerox-WR5241).
- The 'Post Falls Medication Review' must be completed on Sunrise EPR after a fall by a doctor, advanced clinical practitioner or advanced pharmacist practitioner. This document can also be used for patients admitted to the Trust following a fall as their presenting complaint.

7.2 Incident Reporting

All witnessed falls, and unwitnessed falls in any inpatient setting, must be reported using Datix.

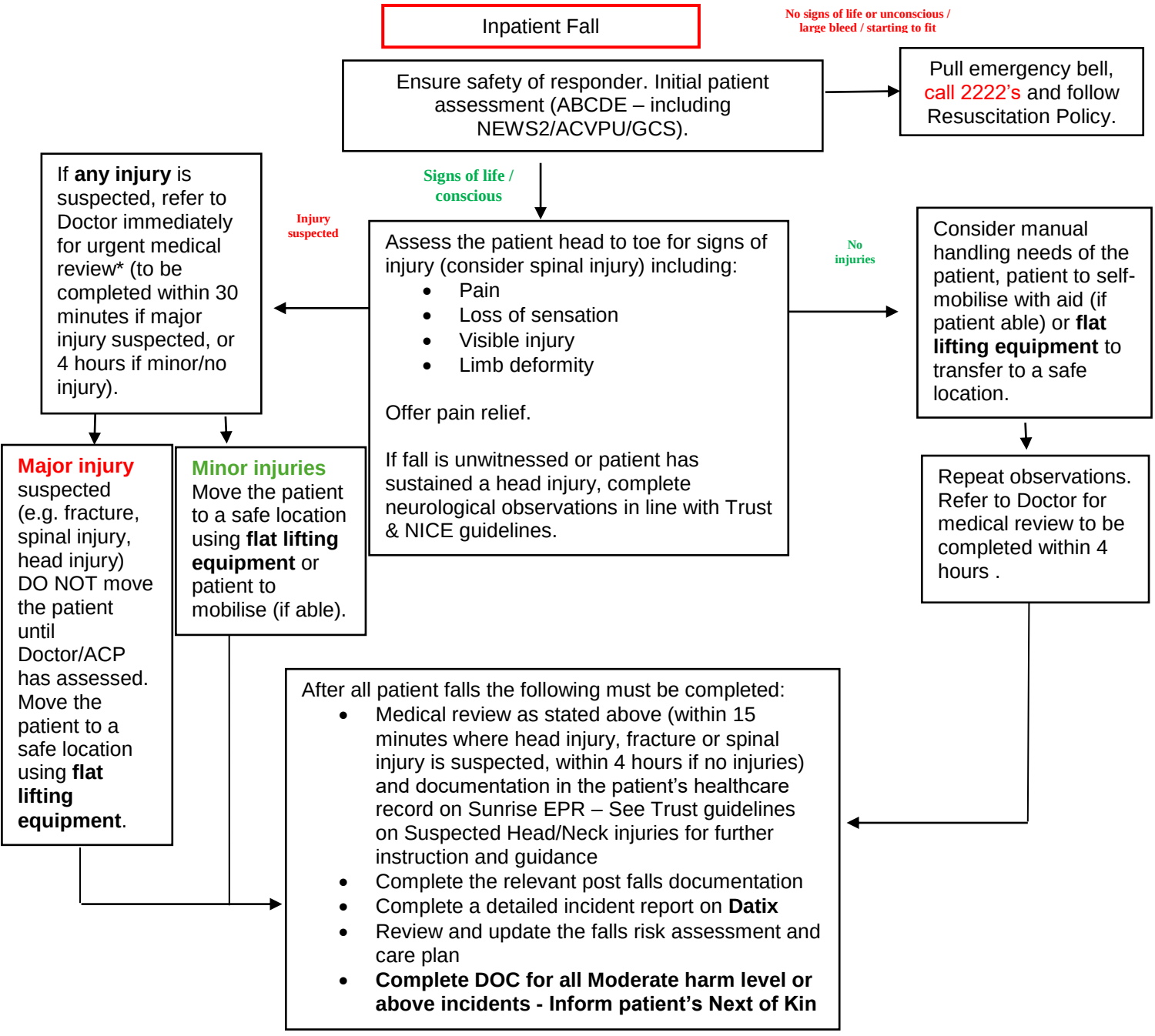
- Exact location, category and subcategory must be reported.
- The description of the incident and actions must be comprehensive.
- The harm severity must be completed (this may be amended after review).

7.3 Falls with injury

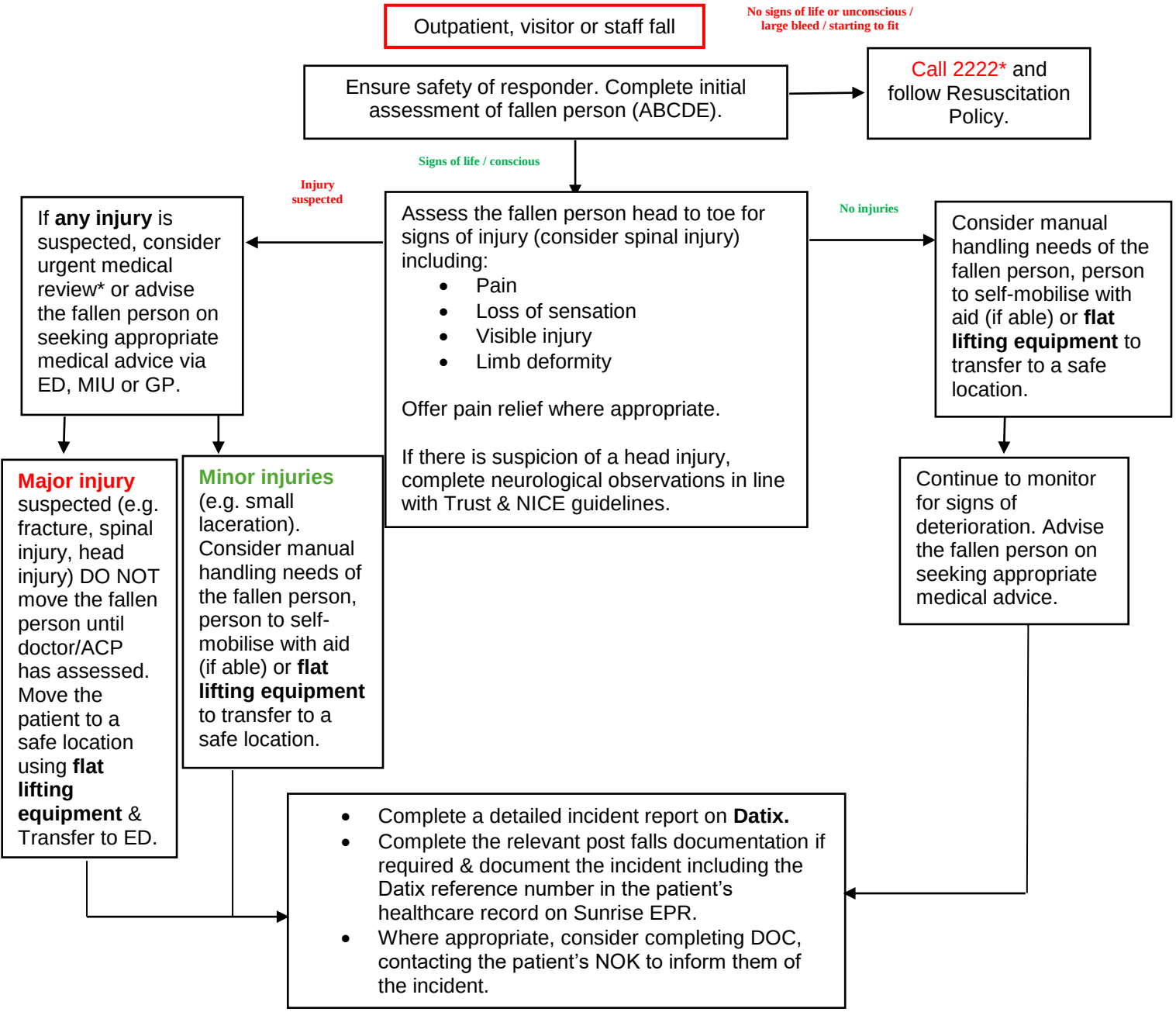
- All falls with which result in moderate, severe or (catastrophic) fatal injury will alert divisional governance and the patient safety team.
- A “check and challenge” rapid review with the Trust Falls Lead/Safer Care Practitioner will take place within 1 week and alerted to the Healthcare Standards Team and CNO Production Board.
- Relevant fields in DATIX investigation to be completed by handler (usually ward manager), supported by divisional governance team – DOC (Duty of Candour) to be completed for all falls with moderate harm / impact to the patient or above.
- Ward manager to share learning from incident with ward staff as applicable
- The incident can then be managed in three ways;
    - Incident to be closed by divisional governance team once investigation completed on DATIX and if no new learning found (DOC may still be required).
    - Any new learning found requires the incident to be discussed at divisional governance and if learning trust wide then to be presented at the next PSIRG (Patient Safety Incident Review Group) meeting & additional levels of investigation agreed upon before incident can be closed.
    - Incidents that require a deeper level of investigation or review (such as those possibly linked to a patients death) then need to complete the ‘Falls with harm’ review proforma (See Appendix d). This will be completed by ward manager & divisional governance team, then presented at the next available PSIRG meeting for sign off before incident can be closed and prior to sharing report outside of organisation.
- All incidents with a fracture/head injury (see NAIF criteria) will be reported externally by Falls clinical lead/safer care practitioner, but don’t automatically require the deeper review – follow above process, however DOC would still apply.
- If no omissions in care are identified on completion of the investigation a request for downgrade will be supported.

7.4 Post Falls Protocol Flowcharts

Hospital Inpatients:



Outpatients, Visitors and Staff:



*for falls outside of hospital building e.g., in car park consider calling 999 if an ambulance is likely to be required to transfer patient to ED

Post Fall Medical Examination Guidance

A structured and systematic approach is essential to identify potential injuries, particularly fractures, and to guide safe handling and appropriate medical intervention. The following provides a step-by-step approach for the examination and management of patients following a fall, ensuring optimal patient outcomes and minimising further harm.

Key Common Presenting Symptoms of a Suspected Hip Fracture:

- Pain
- Not being able to lift, move, or rotate (turn) the leg.
- Not being able to stand or put weight on the leg.
- Bruising and swelling around the hip
- Injured leg appearing shorter than the other leg.
- Injured leg turning outwards (external rotation).

NOTE: Approximately 15% of fractures are undisplaced and therefore may produce no shortening or external rotation of the limb. Hip movements, although painful, may be possible and the patient may even be able to walk.

<u>Post-Fall Medical Examination</u>

Step 1: Primary Survey (**ABCDE** Approach)
A. Airway Ensure the airway is clear and the patient is breathing adequately.
B. Breathing Check respiratory rate, oxygen saturation, and signs of distress.
C. Circulation Assess pulse, blood pressure, and capillary refill time. Look for signs of shock.
D. Disability Assess neurological status (Glasgow Coma Scale, pupil response).
E. Exposure Check for visible injuries, bleeding, or other trauma.

Step 2: Focused Physical Examination – Upper/Lower Limb
- Mobility & Function:
  - Attempt passive and active movement (if tolerated).
  - Check if the patient can lift, rotate, or move the leg.
  - Assess weight-bearing ability.
- Limb Inspection:
  - Look for bruising, swelling, or deformity around the hip.
  - Compare leg lengths (shortened injured leg suggests a hip fracture).
  - Check for external rotation of the affected leg.
- Palpation:
  - Gently feel for tenderness along the hip, groin, and thigh.
  - Palpate for crepitus (grating sensation).

Step 3: Neurovascular Assessment:

- Check pulses, capillary refill, and sensation in the foot and lower leg.

N.B. For suspected Hip Fracture (One or more key symptoms present):

1) Immediate Immobilisation:
   Lift the patient from the floor to a bed using flat lifting equipment (Hoverjack/Flojack). Avoid unnecessary movement.
2) Pain Management:
   Administer appropriate analgesia (IV paracetamol, opioids if needed/appropriate).
3) Imaging:
   Request X-ray of the hip & pelvis (if unclear, consider CT scan).
4) Surgical Referral:
   Notify the Orthopaedic Team.

If no Hip Fracture Suspected - Consider soft tissue injury, sprain. Assess for alternative injuries (e.g., spinal fracture, head injury) and monitor for delayed swelling or increasing pain.

7.5 Flat Lifting equipment

The **'FloJac'** was implemented at Worcestershire Royal Hospital, to replace the **'Hoverjack'** devices. The Alexandra Hospital and Kidderminster Treatment Centre will continue to use existing Hoverjacks as previous.

Both kits are similar but there are subtle differences in how the kits are operated so training for each type of kit is required before use. Please see ward manual handling trainers for training on new or existing flat lifting equipment or book onto training sessions with the Manual Handling Team through ESR.

Do not use this equipment unless you have been trained.

Flojac

Hoverjack

For WRH:

When a FloJac is required, please contact ISS Switchboard (33333 option 3) and request an urgent job for Porters to collect the Flojac and deliver to your area as they will carry out the correct signing in/out procedure. Please replace the slide sheets from your areas stock & clean the equipment after each use, using Green 'Clinell' wipes and call switchboard again for the Porters to collect and return to its storage location.

If you find any faults with the FloJac equipment, please do not return to storage area, report to Siemens immediately – Phone Ext. 33333, Select Option 2 for the Siemens Helpdesk.
· Please note to log the fault you will require the siemens asset number which will be found on the FloJac and provide a description of the fault.
· Please decontaminate the device and attach a decontamination label for collection by Siemens.

8.0 Education and Training

- All staff must complete mandatory Health and Safety training (on a 3 yearly cycle) where the subject of non-clinical slips, trips and falls is covered. This is also provided at mandatory corporate induction. Training should be included in local induction.
- All registered healthcare professionals must complete the essential-to-role Falls e-learning available ESR every 3 years. All new HCSW's receive in person Falls training during induction. It is recommended that local training records are kept in case of ESR failure.
- Moving and Handling training (completed 3 yearly for all clinical staff) includes post falls management and patient falls prevention awareness for relevant staff groups. Moving and Handling training is delivered by the Learning and Development team or department manual handling trainers, and as part of mandatory corporate induction.
- Additional in person Falls training available on Tier 2 Dementia and Preceptorship courses.
- Bespoke training can be provided by the falls team on request.

8.1 Raising Awareness

Awareness of patient falls prevention will be promoted through a combination of initiatives and training, including those outlined above. Specific actions to raise awareness include:

- Daily Safety Huddles: Led by the Ward Manager or deputy, with falls prevention discussed as a routine safety focus.
- Trust Intranet Resources: Accessible information on the Falls Prevention and Health and Safety intranet pages.
- Managerial oversight: Regular ward and departmental rounding, inspections, and audits conducted by managers to reinforce best practice and identify areas for improvement.

9.0 Quality Improvement

The Trust acts on recommendations published by NICE and the RCP National Audit of Inpatient Falls (NAIF).

10.0 Monitoring Compliance and Audit

Falls and falls with injury incident rates, themes and trends are monitored via DATIX, SQuID and WREN dashboards. Various aspects of documentation and falls prevention measures are audited via the Trusts quality audits.

11.0 Duties and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for patient safety and ensuring that there are effective risk management processes in place within the Trust.

Chief Nursing Officer and Chief Medical Officer

The Chief Nursing Officer and Chief Medical Officer are responsible for overseeing the implementation and adherence to this policy reporting to the Chief Executive with any related issues. They will also monitor compliance against the national benchmark for falls which is measured per 1000 bed days (6.63).

Falls Clinical Lead

The Falls Clinical Lead is responsible for operational leadership in implementing this strategy and policy, providing clinical guidance on falls risk reduction and management, and leading the RCP National Audit of Inpatient Falls. They will monitor falls incidents, review inpatient fall data, recommend actions to divisions, and oversee the local implementation of falls risk reduction and management policies. Additionally, they will monitor performance indicators (e.g., falls per 1,000 bed days), devise improvement programmes, and contribute to the quality account on falls prevention. The Clinical Lead will report to the Trust Leadership Team and escalate issues to appropriate staff and forums.

Directors of Nursing, Clinical Directors, Directorate Managers, Matrons and Departmental and Ward Managers

a) Providing leadership in the risk reduction and management of inpatient falls.
b) Ensuring compliance with Trust policies and national guidance related to falls prevention.
c) Monitoring and reviewing falls data within their areas of responsibility to identify trends and inform improvement actions.
d) Ensuring that all falls are accurately identified, reported, and investigated in accordance with Trust procedures.
e) Ensuring that falls data, learning, and actions are included as a standing agenda item in divisional governance meetings, to support continuous improvement and shared learning across services.

Falls Link/Champion

The role of the Falls Link Nurse or Falls Champion is key in supporting ward-level implementation of falls risk reduction strategies. They will:

a) Act as a Ward-Based Lead for falls prevention, promoting best practice and supporting the implementation of Trust falls prevention policies and procedures.
b) Raise Awareness among colleagues about falls risk factors, prevention strategies, and the importance of accurate assessment and documentation.
c) Share key messages from Trust-wide falls initiatives, campaigns, and audits.
d) Promote a Culture of Safety by encouraging incident reporting and supporting reflective learning from falls at ward level.
e) Ensure good communication (e.g information board, leaflets) regarding falls is available for patients, relatives and carers.

Clinical Staff (Nursing and Allied Health Professionals)

a) Undertake falls risk assessments as part of routine clinical care, ensuring assessments are completed accurately, at the appropriate time.
b) Implement individualised falls Prevention interventions based on assessment outcomes, tailored to the patient's needs, capabilities, and preferences.

c) Promote and Support Safe Mobility, ensuring that patients have access to mobility aids, appropriate footwear, and environmental modifications to reduce risk.
d) Encourage activity and independence, balancing risk reduction with the need to avoid deconditioning.
e) Communicate clearly and effectively with patients, carers, and the wider multidisciplinary team regarding falls risk, prevention plans, and any changes in condition.
f) Report and respond to falls incidents by following Trust procedures, completing accurate documentation, and participating in post-fall reviews or huddles.
g) Contribute to a culture of continuous learning by engaging in reflective practice, raising concerns, and supporting shared learning from incidents and audits.
h) Engage in training and education relevant to falls prevention and promote evidence-based practice within their professional role.

Doctors/Advanced Clinical Practitioners

Doctors and Advanced Clinical Practitioners will:

a) Conduct post-fall medical reviews promptly, in line with this policy.
b) Assessing for injuries such as head trauma, fractures, or internal injuries post fall.
c) Document a clear clinical examination and any investigations required.
d) Ensure timely request and review of diagnostic imaging where appropriate.
e) Identify and address any medical factors contributing to the fall (e.g. infection, hypotension, medication side effects, delirium).
f) Contribute to falls risk assessment by identifying and informing nursing colleagues of clinical risk factors such as acute illness, frailty, cognitive impairment, or medication-related risks.
g) Review and optimise medications that may increase the risk of falling, including sedatives, antihypertensives, anticholinergics, and polypharmacy. Engage with pharmacy colleagues as needed.
h) Support multidisciplinary decision-taking around falls risk reduction strategies, particularly in complex cases where clinical risk, capacity, and patient preferences must be balanced.
i) Ensure timely escalation and referral to specialist teams (e.g. geriatrics, physiotherapy, trauma and orthopaedics) when appropriate, especially for patients with recurrent or unexplained falls.
j) Document Clearly in the medical record, including, post-fall assessment findings, clinical plan of care following a fall, discussions with patients or families/carers
k) Promote a culture of safety and learning by engaging in incident reviews, contributing to post-fall huddles or governance discussions, and supporting junior staff in understanding their role in falls prevention and management.

Pharmacy staff

Support medical and clinical staff in carrying out pharmacological reviews of at-risk patients.

12.0 Associated Documents

- WAHT-CG-086 Patient Safety Incident Response Policy
- WAHT-NUR-085 In-patient Enhanced Observation Guideline - Adults
- WAHT-NUR-097 Postural (Orthostatic) Hypotension Policy and Guideline
- WAHT-MED-013 The Assessment of Ward Patients (Adults) who have Fallen and Sustained a C-Spine / Head Injury

13.0 References

This policy is driven and informed by national and local policy and priorities including:

OHID 2022

NHS England (2022) Patient Safety Incident Response Framework. Available at: NHS England » Patient Safety Incident Response Framework

Royal College of Physicians (2022) Fallsafe: care bundles and resources to reduce inpatient falls. Available at: FallSafe resources - original | RCP London

National Institute for Clinical Excellence (2025) NG249 Falls: assessment and prevention in older people and in people 50 and over at higher risk, available from https://www.nice.org.uk/guidance/ng249/chapter/Recommendations#interventions-to-reduce-the-risk-of-falls.

National Institute for Clinical Excellence (2025), Quality Standard QS86 Falls in older people, available from: Quality statement 5: Safe manual handling after an inpatient fall | Falls in older people | Quality standards | NICE.

National Patient Safety Agency (2010) 'Slips trips and falls data update: from acute and community hospitals and mental health units in England and Wales' Available from: www.nrls.npsa.nhs.uk/resources/patient-safety-topics/patient-accidents-falls/?entryid45=74567

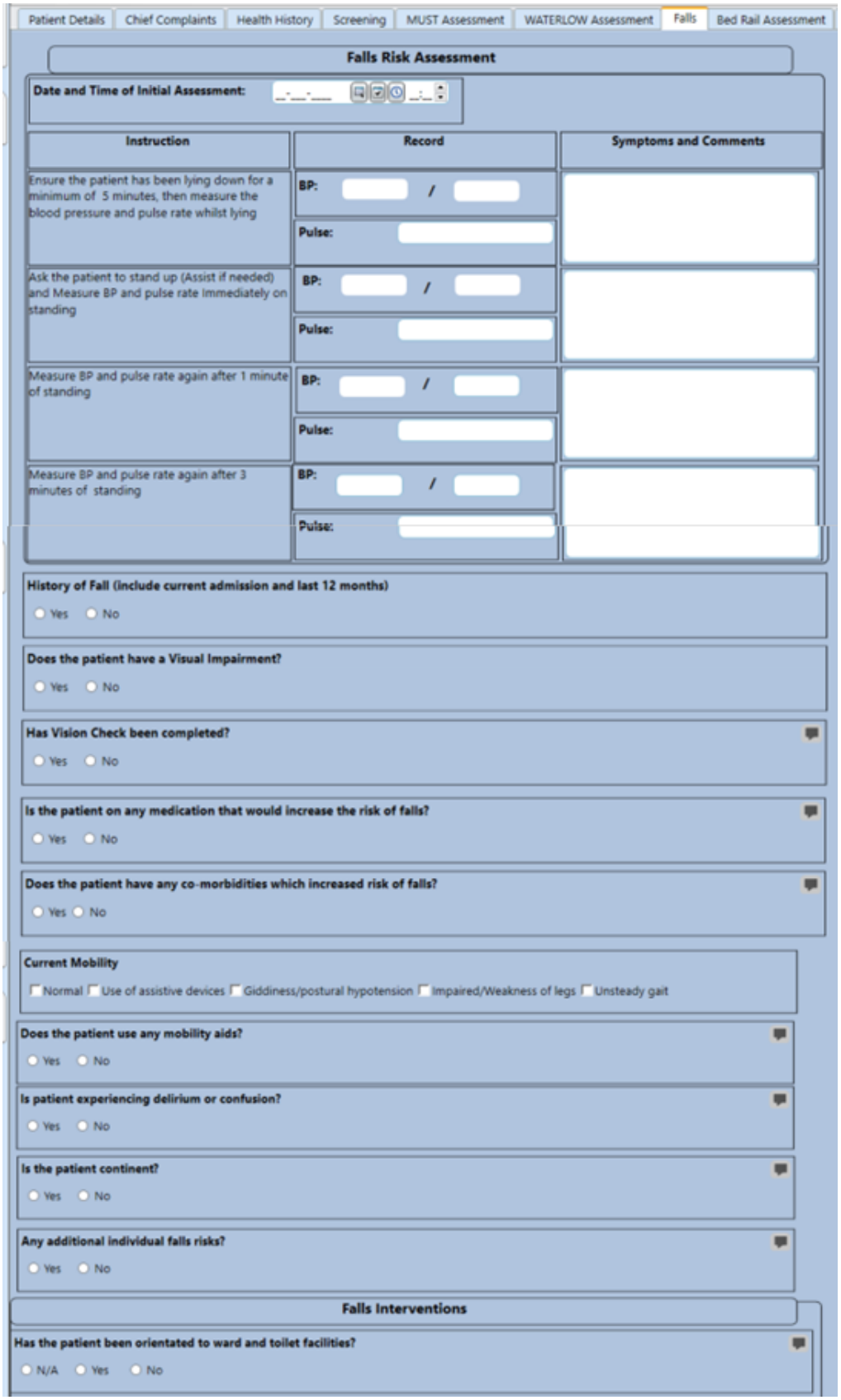
Department of Health (Aus.), 'Falls Prevention in Maternity Inpatients'. Available from: Falls prevention in maternity inpatients (health.wa.gov.au)

Hrvatin, I and Rugelj D (2022) 'Risk factors for accidental falls during pregnancy – a systematic literature review', *The Journal of Maternal-Fetal & Neonatal Medicine*, 35:25, 7015-7024, DOI: 10.1080/14767058.2021.1935849

14.0 Appendices

a. Falls Risk Assessment Tools available on Sunrise EPR

Initial Falls Risk Assessment:



Patient Details | Chief Complaints | Health History | Screening | MUST Assessment | WATERLOW Assessment | Falls | Bed Rail Assessment

Falls Risk Assessment

Date and Time of Initial Assessment: __/__/____ __:__

Instruction	Record	Symptoms and Comments
Ensure the patient has been lying down for a minimum of 5 minutes, then measure the blood pressure and pulse rate whilst lying	BP: / Pulse:	
Ask the patient to stand up (Assist if needed) and Measure BP and pulse rate immediately on standing	BP: / Pulse:	
Measure BP and pulse rate again after 1 minute of standing	BP: / Pulse:	
Measure BP and pulse rate again after 3 minutes of standing	BP: / Pulse:	

History of Fall (include current admission and last 12 months)
Yes No

Does the patient have a Visual Impairment?
Yes No

Has Vision Check been completed?
Yes No

Is the patient on any medication that would increase the risk of falls?
Yes No

Does the patient have any co-morbidities which increased risk of falls?
Yes No

Current Mobility
Normal | Use of assistive devices | Giddiness/postural hypotension | Impaired/Weakness of legs | Unsteady gait

Does the patient use any mobility aids?
Yes No

Is patient experiencing delirium or confusion?
Yes No

Is the patient continent?
Yes No

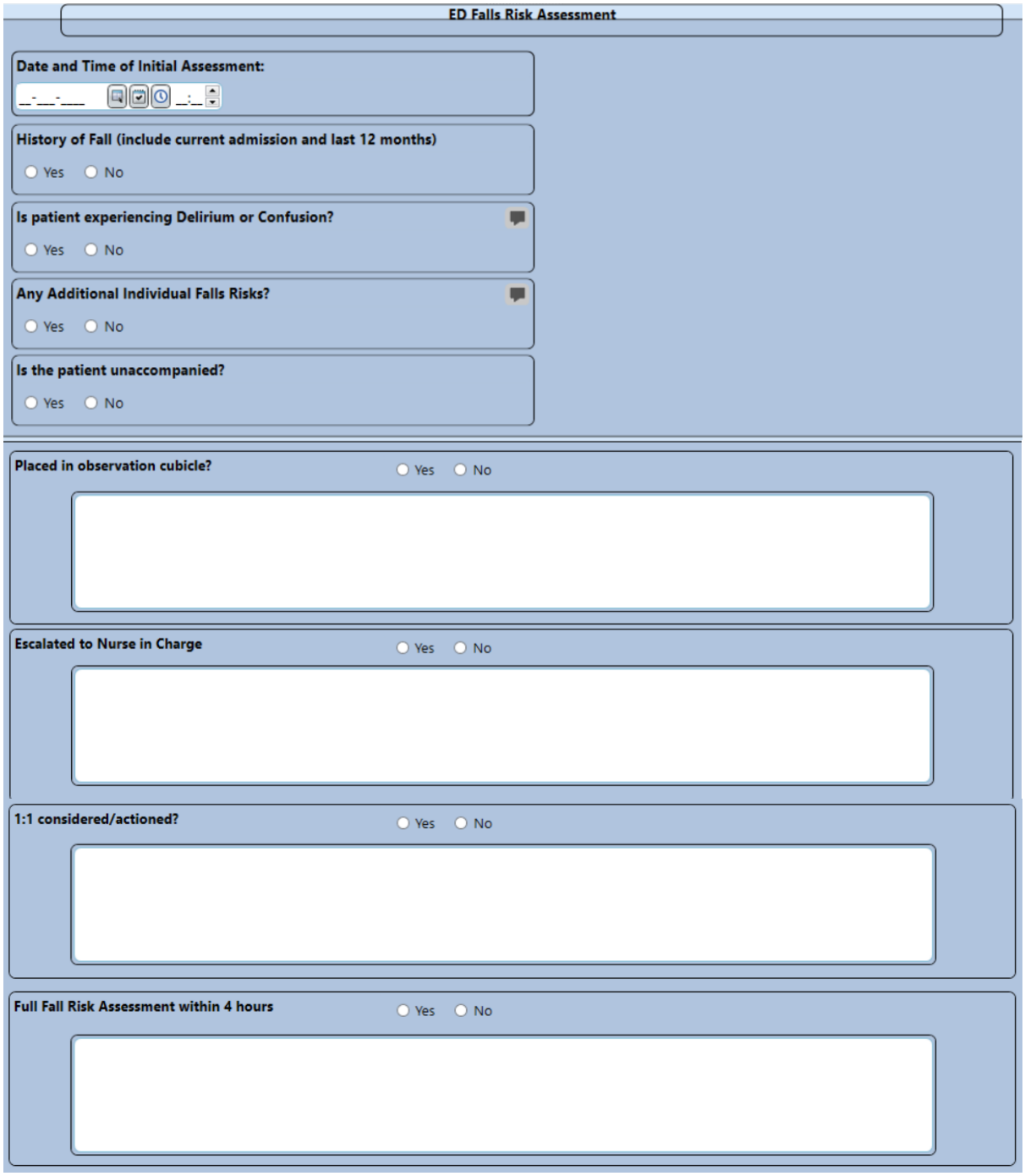
Any additional individual falls risks?
Yes No

Falls Interventions

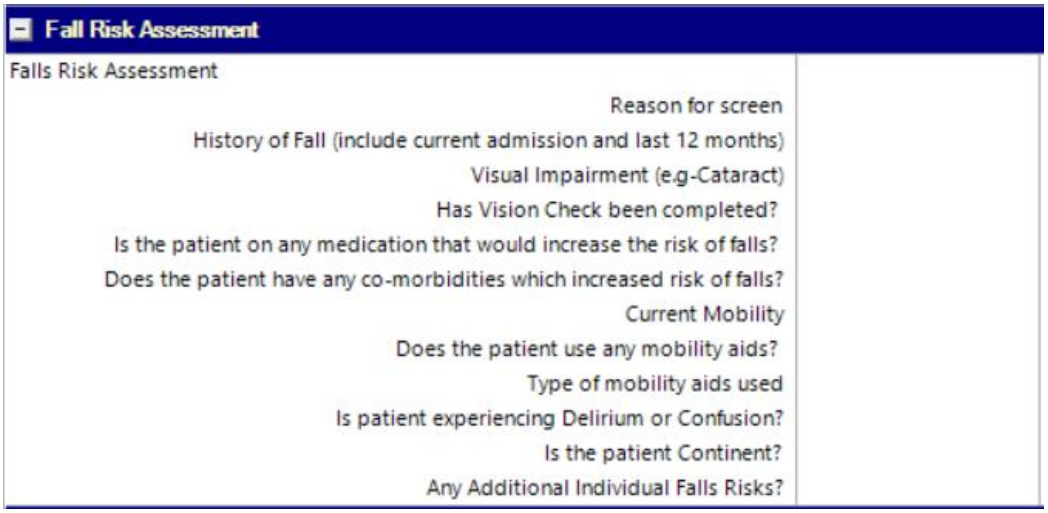
Has the patient been orientated to ward and toilet facilities?
N/A Yes No


Has the call bell system been explained and is within reach?
N/A Yes No
Have you ensured that there are no visible slip or trip hazards?
N/A Yes No
Is the patient's appropriate mobility aid within reach?
N/A Yes No
Has the Patient got personal items and a drink (if Appropriate) within reach?
N/A Yes No
Are the patients glasses clean and within reach?
N/A Yes No
Has the patient got secure, non-slip footwear available and in use?
N/A Yes No
Bed has been set at the lowest height (unless this would impede safe transfers)
N/A Yes No
Has the need for an ultra-low/floor level bed been considered?
N/A Yes No
Has the Daily Care Rounds flowsheet been started for the patient?
N/A Yes No
Has patient and the patient's family been provided with the Fall's Prevention Information Leaflet?
N/A Yes No
Please complete Bed Rails Assessment tab

ED Falls Risk Assessment:

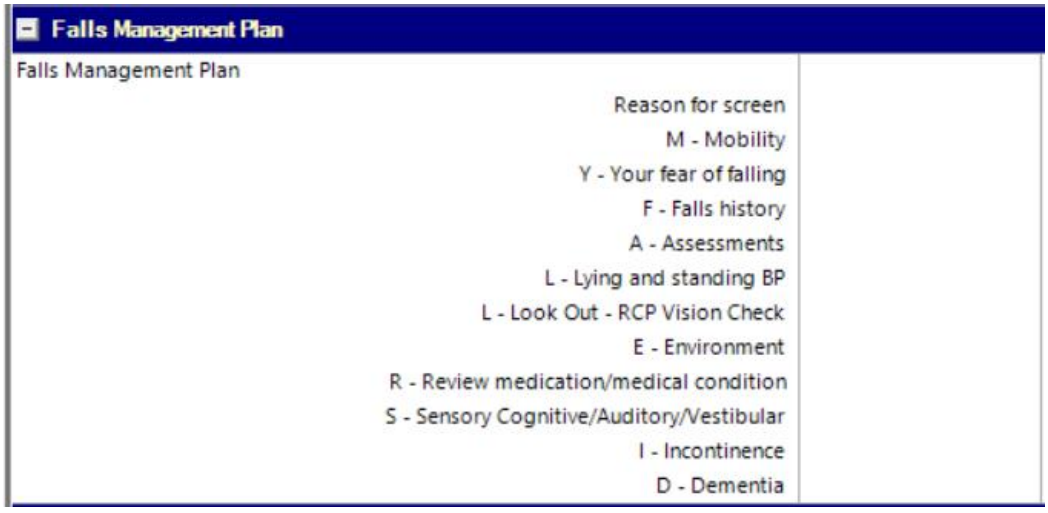


Repeated Falls Risk Assessment:



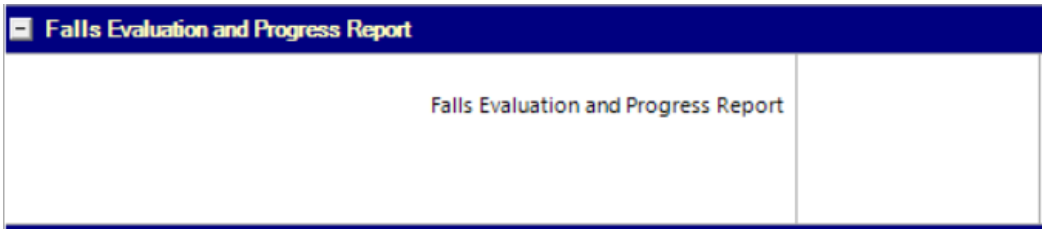
Fall Risk Assessment	
Falls Risk Assessment	
Reason for screen	
History of Fall (include current admission and last 12 months)	
Visual Impairment (e.g-Cataract)	
Has Vision Check been completed?	
Is the patient on any medication that would increase the risk of falls?	
Does the patient have any co-morbidities which increased risk of falls?	
Current Mobility	
Does the patient use any mobility aids?	
Type of mobility aids used	
Is patient experiencing Delirium or Confusion?	
Is the patient Continent?	
Any Additional Individual Falls Risks?	

Falls Management Plan:



Falls Management Plan	
Falls Management Plan	
Reason for screen	
M - Mobility	
Y - Your fear of falling	
F - Falls history	
A - Assessments	
L - Lying and standing BP	
L - Look Out - RCP Vision Check	
E - Environment	
R - Review medication/medical condition	
S - Sensory Cognitive/Auditory/Vestibular	
I - Incontinence	
D - Dementia	

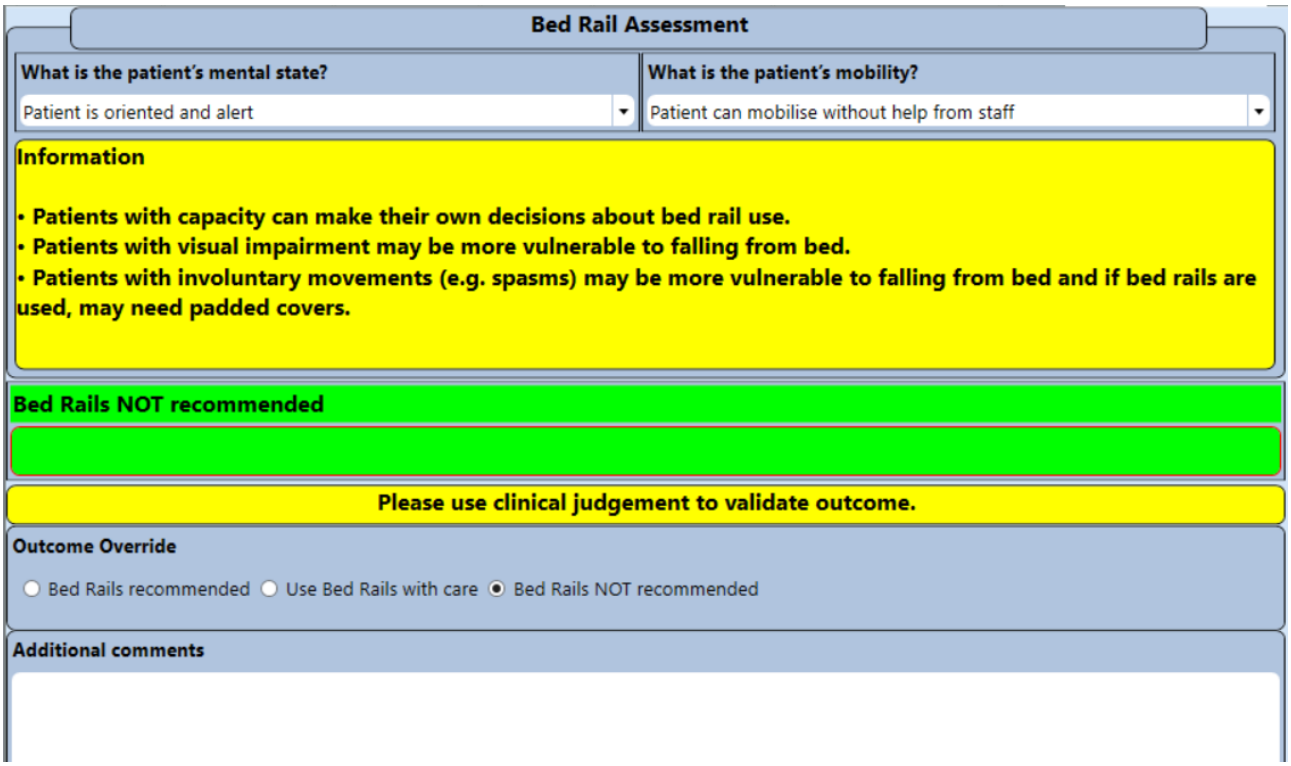
Falls Evaluation and Progress Report:



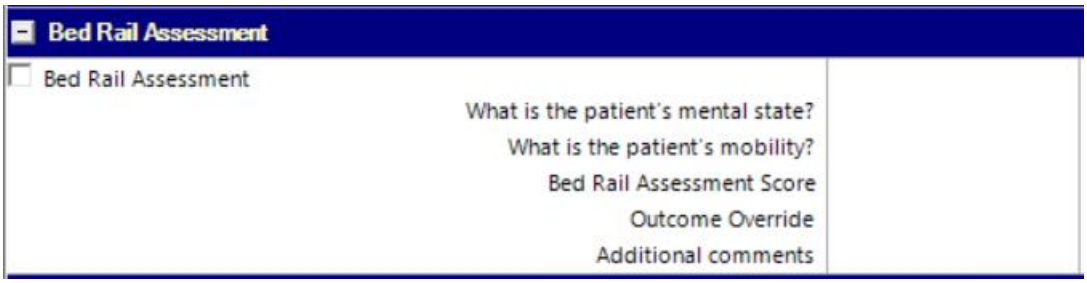
Falls Evaluation and Progress Report	
Falls Evaluation and Progress Report	

b. Bedrails Assessment tool

Initial Bed Rails Assessment:



Repeated Bed Rail Assessment:



c. Falls Prevention in Hospital Leaflet (WAHT-PI-0122)

WAHT-PI-0122 falls prevention in hospital

d. Falls with harm review:

INCIDENT REF: WEBXXXXXX			
Author		**Job Title**	
Date		**Division**	
Brief incident narrative			
Reason for attendance / admission			
Past medical history *(including history of previous falls/harm, osteoporosis, fragility fractures etc.)*			
Was the patient prescribed any bone health medications? *(e.g., bisphosphonates, calcium, vitamin D, etc.)*			
Was the patient on any medications that may affect clotting or increase bleeding risk? *(e.g. anticoagulants or antiplatelet drugs)*			
Does the patient have any bleeding risks associated with their medical treatments or conditions? *(E.g. cancer or blood disorders)*			
List all areas for care episodes	**Date & Time**	**Department/Ward**	
If the patient was known to be at risk of falls, was this handed over on the last transfer?	**YES ☐ NO ☐ N/A ☐**		
Was the patient medically fit for discharge?	**YES ☐** Click or tap to enter a date. **NO ☐ N/A ☐**		
If YES, why had the patient not been discharged? *(Note the reason for any delays e.g. awaiting pathway, funding, out of area etc.)*			

A. FALL & IMPACT			
Date of fall	Click or tap to enter a date.	**Time of fall**	
Location of fall *(ward/department)*		**Location within ward/dept** *(Bay/bathroom)*	
Injury(ies) sustained			
Injur(ies) confirmed via	**X-ray ☐ | CT scan ☐ | MRI ☐ | Other:**		

How long did it take to confirm the injury after the fall?			
Date of surgery *(if needed)*	Click or tap to enter a date.	**Surgery type**	
Surgery within 36hrs of diagnosis?	**Yes ☐ N/A ☐ No ☐ If no, reason:**		
What is the patient's current condition, plan of care and location?			
Date of patient death (if applicable)	Click or tap to enter a date.		
Cause of death (if applicable)			

B. PRE-FALL PHASE				
		Yes	**No**	**N/A**
1	**Did the patient meet the criteria for falls risk assessment?** *(All patients >65 years or <65years with risk factors e.g. falls history, frailty, neurological disorders, post-surgical recovery or cognitive impairment)*			
2	**IF YES: Was a Falls Risk Assessment completed within 4 hours of admission to an inpatient area?**			
3	**If the patient had not been admitted, had they been in A&E for >4 hours?**			
4	**IF YES: What falls risk reduction strategies were in place?** *(e.g. visible to staff, supervision by relative/carer)*	•		
5	**Was the falls risk assessment updated if appropriate?** *(e.g. on transfer, post fall, or following a change in patients' condition or weekly)*			
6	**Did the patient have a risk alert in their bed space and on Sunrise EPR?**			
7	**Were any further risk reduction interventions needed?** *(e.g. Stay in the Bay, assistive technology, Enhanced Observations, 1:1 supervision)*			
8	**If YES, which intervention(s) were needed and were they in place?**			
9	**When was the last lying and standing blood pressure completed before the fall?**	Click or tap to enter a date.		
10	**What was the last recorded lying & standing blood pressure?**			
11	**Did the patient have a 4AT (delirium) assessment completed?**			
12	**IF YES: Did the 4AT identify that delirium / cognitive impairment was present?**			
13	**Did the patient have a known cognitive impairment/dementia/LD?**			
14	**If YES, was an Enhanced Observations assessment carried out in line with the Enhanced Observations Guidelines?**			
15	**If delirium or cognitive impairment was present, were personalised interventions in place?**			
16	**IF YES: Please list all** *(E.g. glasses, walking aids, call-bell etc.)*	•		

17	**If the patient fell from the bed, had a Bedrails Assessment been completed?**				
18	**IF YES: What date was the last bed rails assessment completed before the fall?**	Click or tap to enter a date.			
19	**If the patient fell from the bed, were the bed rails up or down at the time of the fall?**	**UP ☐**	**DOWN ☐**	**N/A ☐**	
20	**Was a Hi-Lo bed considered/used?**				

C. FALL PHASE				
		Yes	**No**	**N/A**
21	**Was the fall witnessed by a member of staff?**			
22	**Were there any obvious environmental or non-medical factors/cause(s)?** *(e.g. socks/footwear, catheter, equipment, obstacles, bed position etc.)*			
23	**IF YES: Please provide details:**			
24	**Were there any obvious medical / health-related factors/cause(s)?** *(e.g. seizure, vasovagal, sedative or antihypertensive medications etc.)*			
25	**IF YES: Please provide details:**			
26	**Were staffing levels and skill-mix adequate at the time of the fall?**			
27	**Staffing level and skill-mix details:**			

D. POST-FALL PHASE				
		Yes	**No**	**N/A**
28	**Was a medical post-fall review completed within two hours?**			
29	**How was the patient moved/recovered post fall?**			
30	**Was the Falls Risk Assessment & Evaluation Plan updated following the fall?**			
31	**Was an updated Bed Rails assessment completed? (if applicable)**			
32	**Were any further risk reduction strategies needed?**			
33	**IF YES: Please provide details:**			
34	**If the fall was unwitnessed, were neurological observations carried out?** *(Half-hourly for 2 hours, hourly for the next 4 hours and 2 hourly thereafter for 24 hours)*			
35	**Was a post-fall medication review / medicines reconciliation completed?**			
36	**IF YES: What changes, were made?**			

E. EDUCATION AND TRAINING OF STAFF		
37	**What is the ward/dept's compliance with falls e-learning?** *(Registered staff only; 'ESR; 000 Preventing Falls in Hospital')*	

38	**IF <90%, please provide details and assurances:**				
39	**Is the ward/department compliant with the Quality Audits?**				

F. DUTY OF CANDOUR				
40	**Has verbal duty of candour been completed?** *(Apology given to patient/family and documented)*	**No** ☐	**Yes** ☐	**Completed:** Click or tap to enter a date.
41	**Duty of candour comments:**			
Please note that any verbal duty of candour should be followed up in writing within 10 working days. A written summary of the findings from this falls review must be offered to the patient/family.				

G. SUMMARY		
42	**Summary of documentation compliance** *(quality and timeliness of assessments, including any omitted/incomplete documentation)*	
43	**Summary of falls prevention measures** *(what was or wasn't in place to reasonably prevent the patient from falling)*	
Complete the Action Plan at the end of this document in relation to any identified omissions or areas for improvement noted.		

H. INFORMATION FOR INQUEST				
44	**Inquest reference number**		**Date of inquest**	Click or tap to enter a date.
45	**Senior Clinician comments on cause of death (section A)**	**[State Clinician Name & Job Title]** [Enter comments here]		

DIVISIONAL APPROVAL			
Divisional Summary			
Divisional Governance Meeting date	Click or tap to enter a date.		
Approved by (name)		**Title**	

TRUST APPROVAL			
PSIRG conclusion on preventability and cause of death *(PSIRG = Patient Safety Incident Review Group)*			
PSIRG Meeting date	Click or tap to enter a date.		
Chaired by (name)		**Title**	

15.0 Equality Impact Assessment

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Donna Kruckow**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Victoria Sturdy	Safer Care Practitioner	victoria.sturdy@nhs.net
Date assessment completed	**21/10/2025**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: In-patient Falls Risk-reduction and Management Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	To provide information and guidance on the risk-reduction and management of inpatient falls within Worcestershire Acute Hospitals NHS Trust.			
Who will be affected by the development & implementation of this activity?	■ ■ ■ ■	Service User Patient Carers Visitors	■ ❑ ❑ ❑	Staff Communities Other _____
Is this:	■ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients /	The policy follows NICE clinical guideline NG249, quality standard QS086 and RCP NAIF recommendations.			

services / staff groups affected, complaints etc.	
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Multidisciplinary members engaged in Falls risk reduction: Consultant Geriatrician: Dr Susan Powell Clinical Lead Physiotherapist: Frailty: Sarah Craister Pharmacy Frailty Practitioner: Sarah Pittaway Karen Apps – Patient Safety Lead
Summary of relevant findings	Policy update agreed.

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age			√	Potentially we do not do a MFFA on a patient between the age of 18 years to 49 years and 11 months old, even if they have falls risk factors. There is no National guidance for this age range also however.
Disability	√			Policy covers this equality group.
Gender Reassignment		√		
Marriage & Civil Partnerships		√		
Pregnancy & Maternity	√			Policy covers this equality group.
Race including Traveling Communities		√		
Religion & Belief		√		
Sex		√		
Sexual Orientation		√		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		√		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		√		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	N/A	.N/A	N/A	N/A
How will you monitor these actions?	N/A			
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	When policy is reviewed			

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	D. Kruckow
Date signed	15th August 2025
Comments:	
Signature of person the Leader Person for this activity	Donna Kruckow
Date signed	15th August 2025
Comments:	

16.0 Financial Risk Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

17.0 Dissemination of Key Documents

To be completed by the key document author and attached to any document, which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	In-Patient Falls Risk-reduction and Management Policy		
Date finalised:	21/10/2025	**Dissemination lead: Print name and contact details**	Donna Kruckow donna.kruckow@nhs.net
Previous document already being used?	Yes		
If yes, in what format and where?	WAHT-CG-017 available on Trust Key Documents site (In-Patient Falls Risk-Reduction and Management Policy)		
Proposed action to retrieve out-of-date copies of the document:	Clinical Governance/Key Documents to replace on intranet. Matrons and Ward/Department Managers will be contacted and asked to remove any old paper versions on ratification of policy.		
To be disseminated to:	**How will it be disseminated, who will do it and when?**		**Comments**
Trust wide	Through Trust wide comms to all staff		

18.0 Policy Review

This policy will be reviewed every two years or sooner should new national best practice or guidance become available.

The following individuals/groups/committees have been involved in the review of this version of the policy:

Name	Designation
Fundamentals of Care Committee	All members
Karen Apps	Patient Safety Team
Julie Noble	Health and Safety Lead
All Divisions	DDN/Governance Lead
Melissa Harris	Moving & Handling