



# FallSafe guidance notes

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**i Observe: call bell in sight & reach?**

Dementia units who do not have a call bell system as too few patients who can use call bells can skip this measure.

Collect by walking around to observe your patients.

Measure applies to anywhere patients are sitting or lying at the time you do the check.

Hopefully yes is self-explanatory

*n/a* can be used for any patient too ill or too confused to use a bell, for patients walking around at the time, for patients with a staff member caring for them hands-on at the time, and for patients in the toilet (as too intrusive to check).

If you have patients in beds, chairs or day rooms where no bells can be made to reach, these count as *no* – and think about using some of the improvement money to fix this!

**ii Observe: safe footwear on feet?**

Take this observation at a time when most of your patients who are well enough are likely to be out of bed. Collect by walking around to observe your patients.

*n/a* can be used for any patient in bed and under the covers, any hoist-dependent patient, and any patient who has been offered safe footwear but *refuses* to wear it (not just forgets to wear it).

*No* should be recorded if patient has:

- > bare feet
- > socks only (but treaded non-slips socks – toasties or cositoes, etc – are ok)
- > anti-embolism stockings only
- > bandages or dressings only
- > shoes or slippers that are visibly too big
- > shoes or slippers that are visibly too small
- > lace up shoes without laces, or with trailing laces
- > shoes or slippers worn with squashed backs
- > novelty slippers
- > backless shoes or slippers except for very confidently mobile patients
- > foam disposable slippers except for very confidently mobile patients
- > high heeled shoes except for very confidently mobile patients.

Anything else should be good enough footwear to count as yes. For mobile patients sitting or resting on the bed but too polite to wear their shoes/slippers on the bed, you can count yes as long as they have safe shoes/slippers within easy reach (not shut away in a cupboard).

### iii Notes: asked about history of falls?

Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork (eg falls assessment form, documentation on sections on problems with mobility) but don't feel you have to read their entire case notes. It doesn't matter what area of notes (nursing, medical physio or OT notes) or who asked the questions – nurse, doctor or physio or OT equally fine, as long as it is in case notes accessible to all the team.

If you have a patient where asking the question would feel embarrassingly inappropriate – e.g. a young person who is fully independent, or a patient who is unconscious and dying – you can count as *n/a*, but record why you thought this, and be consistent as you repeat the measurement on future occasions. If the patient is unable to answer – eg unconscious or severe dementia – and there is no carer to ask (neither on admission nor visiting later) you can count as *n/a*.

Otherwise *yes/no* should be self-explanatory (remember it is *yes/no* in terms of were they asked, not whether their answer is yes or no).

- **Note we have simplified this measure – you don't have to collect information on how well any fall was described any more.**

### iv Notes: asked about fear of falling?

Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork (eg falls assessment form, documentation on sections on problems with mobility) but don't feel you have to read their entire case notes. It doesn't matter who asked the questions – nurse, doctor or physio or OT equally fine, as long as it is in case notes accessible to all the team.

If you have a patient where asking the question would feel embarrassingly inappropriate – eg a young person who is fully independent, or a patient who is unconscious and dying – you can count as *n/a*, but record why you thought this, and be consistent as you repeat the measurement on future occasions. If the patient is unable to answer – eg unconscious or severe dementia – and there is no carer to ask (neither on admission nor visiting later) you can count as *n/a*.

- Otherwise *yes/no* should be self-explanatory (**remember it is *yes/no* in terms of were they asked, not whether their answer is yes or no**).

### v Notes: urinalysis performed?

The standard measure is whether urine has been dipped at least once **during each inpatient stay not necessarily on**

**admission.** If you have a long stay unit and that doesn't feel often enough for your unit, this will need further consideration.

Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork – maybe nursing admission proforma or bedside observation charts. If you can't find it with a reasonably good look-through you can count as no – if it was that hidden, it probably wouldn't be acted on anyway!

To count as *yes* the urinalysis result would **need to be recorded as at least pH number plus *NAD* or *nil found*, or if any abnormalities are detected that these are noted.**

If the records note they tried **more than once** to get a sample but failed you can count as *not applicable*. However, remember even in an incontinent patient a contact dip (eg pressing the urine stick against a wet sheet) is better than nothing – you need to treat results with a bit of scepticism in case there was a contaminant, but they could still point you towards an underlying problem.

### vi Drug card: given night sedation last night?

What we are aiming for is no new night sedation prescribed (unless there were very good clinical reasons to do so) *but* to make data collection more straightforward, we are only asking you to count night sedation doses given. This means **you don't have to look back to find out what night sedation the patient was taking at home.** If you are making a difference and discouraging colleagues from prescribing new night sedation (or from administering PRN night sedation) we'd expect this to show up in a reduced number of doses given. If your team was already very good at avoiding this, we'd expect your numbers to at least stay steady and not increase. But there is no 'right number' of doses given.

Check their drug card and look for doses of night sedation given on the night time drug round the night before (usually 22:00 doses in most hospitals). Remember to look for stat or p.r.n. doses as well as those regularly prescribed. Remember which drugs are considered sedatives:

- Temazepam etc (all other -azepam except clonazepam)
- Chlordiazepoxide (*don't* count if it is being used for alcohol withdrawal)
- Zopiclone, Zolpidem
- Trazodone (*don't* count if the patient has a diagnosis of depression and trazodone is being used to treat depression)
- Amitriptyline (*don't* count if being used to treat depression or a small dose to reduce urinary frequency overnight or if being used as part of pain relief).

Count as *n/a* any patients who have *not* been on the ward for at least one night or who are *not* able/allowed to take oral medication.

### **vii Notes: cognitive screen completed?**

You only have to collect this for patients in your sample of 20 patients who are aged over 70 years.

Any format of cognitive screen is ok (e.g. AMTS, MMSE, etc.) – either ones that are already in standard use in your trust or as part of your improvement work you will be introducing the AMTS template you were given last FallSafe day.

Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork but don't feel you have to read their entire case notes. It doesn't matter what area of notes (nursing, medical physio or OT notes) or who asked the questions – nurse, doctor or physio or OT equally fine, as long as it is in case notes accessible to all the team. A good place to look is doctor's admission notes – they may record just the score rather than detail questions eg 'AMTS 7/10' but that is still ok.

You can count as N/A if the patient is unable to answer – eg unconscious or aphasic or non-verbal. Also if they don't have good spoken English and no translator is available. Just being very confused wouldn't be a reason to put *n/a* – you can still try, and record as *0/10* if that is all they can do.

Otherwise *yes/no* should be self-explanatory

### **viii Charts: Lying and standing Blood Pressure recorded?**

You only have to collect this for patients in your sample of 20 patients who are considered to be at *higher risk* of falls. In some FallSafe wards all patients are counted as high risk, for other FallSafe wards only some (eg those with risk scores over a certain number) – follow your local policy.

We'd expect this to be recorded on observation charts.

You can count as *n/a* if the patient is unable to stand/too ill to stand/unable to cooperate with staff.

Otherwise *yes/no* should be self-explanatory.

### **ix Notes: full medication review requested?**

You only have to collect this for patients in your sample of 20 patients who are at 'higher risk' of falls. In some FallSafe wards all patients are counted as high risk, for other FallSafe wards only some (eg those with risk scores over a certain number) – follow your local policy.

You are measuring that the *request* has been made, not the response. Check their notes in all the places where you might reasonably expect this to be recorded given your local paperwork but don't feel you have to read their entire case notes. The logical place to put the request would be for nurses to write the request or to stick a request label in the current section of the medical notes where it should be seen next doctors' round or MDT meeting.

You can count as *n/a* if the patient is on no medication at all.

Otherwise *yes/no* should be self-explanatory. ■