Royal College of Physicians

The FallSafe care bundle

Bundle for all patients

1 A history of previous falls and of fear of falling is taken at the time of admission.*
   > Admission processes and paperwork need to be changed to include these items.

2 Urinalysis is conducted on admission

3 New prescriptions of night sedation are avoided.

4 A call bell is in reach.
   > The existing call bell system must be able to reach all patient beds and chairs.
   > Systems are needed for rapid repair of faulty call bells.

5 Appropriate footwear is available and in use.
   > Supplies need to be made available for patients without relatives or friends.

6 There is immediate assessment for and provision of walking aids.
   > Physiotherapists must train nursing staff to provide appropriate walking aids at the time of admission to the ward, or as soon as they might be required.
   > Walking aids need to be made available for each ward area, and need a suitable storage area.

Bundle for older and more vulnerable patients

7 A cognitive assessment (mini-mental state examination (MMSE) or abbreviated mental test score (AMTS)) is conducted in all admissions aged >70yrs .

8 Those at risk are tested for delirium (confusion assessment method).
   > Trusts must implement delirium screening as per NICE guidelines.

9 An assessment of risk versus benefit for use of a bedrail is conducted.

10 Visual assessment is conducted.
   > The ability to recognise objects from end of the bed can be used as a screen for severe eyesight problems, and fuller assessment should be carried out if required.

11 Lying and standing blood pressure are taken with a manual sphygmomanometer.

12 Medication is reviewed with respect to cardiovascular and central nervous system acting medications (see enclosure).
   > Nurses should request a review of medication to try and reduce the burden of drugs, particularly those associated with falls, and in patients who are unsteady, hypotensive, or have orthostatic hypotension.

13 Based on observation, toileting arrangements are assessed and planned (tailored to needs rather than the standard two-hourly arrangement).

Bundle for after a fall

14 After a fall, appropriate assessments and procedures are followed (see enclosure), including neurological observations in those who have hit their head or had an unwitnessed fall.
   > Trusts have been mandated to include these procedures within their policies by July 2011.

15 A post-fall review (how can further falls be prevented for this patient) is conducted.

16 A complete incident report (all falls) is created.

17 A root cause analysis (lessons to prevent falls for future patients) is carried out for severe harm falls.

* Long stay units may wish to amend to 'at least monthly' rather than 'on admission'

† For rehabilitation units, community hospitals, stroke units, orthogeriatrics units, care of the elderly units, and dementia units this should equate to all patients. In wards and units with a more mixed population, patients with a high vulnerability to falls is likely to be determined by local policy e.g. positive response to any of the NPSA 'four questions', total of Morse score or STRATIFY score, or all patients not fully independent and mobile.

Supported by:

The Health Foundation Inspiring Improvement
Royal College of Nursing
avma action against medical accidents
British Geriatrics Society
NHS National Patient Safety Agency
NHS South Central