Prevention and Management of Falls and Frailty Fractures

Guideline Reference: 1684  Version: 2.1  Status: Adopted

Type: Clinical Guideline

Guideline applies to (Staff Group) All West Suffolk Hospital Employed SCH Staff

As part of transition to the new service contract this Suffolk Community Healthcare (Serco) procedural document has been adopted by West Suffolk NHS Foundation Trust with the following amendments:

- Pg. 3 removal of statement of overarching principles
- Pg. 5, 6 SCH replaced with West Suffolk NHS Foundation Trust (as referring to the organisation)
- Pg. 5, 6.4 roles amended to reflect WSH – Chief Operating Officer, Exec Chief Nurse, and added consortia to prefix Risk Management and Clinical Governance Team
- Pg. 8, 8.4 consider a multifactorial assessment replaced with ‘complete a multifactorial assessment’
- Pg. 9, 11.2 removed reference to Harmoni
- Version change to 2.1 – minor amendment as above

Where the procedural documents refer to Suffolk Community Healthcare (SCH) this is referring to those staff employed by West Suffolk NHS Foundation Trust as part of the Suffolk Community Healthcare Consortia, with The Ipswich Hospital NHS Trust and Norfolk Community Healthcare and Care Trust.

Following a 30 day settling in period, a programme of review for all SCH procedural documents aligned with West Suffolk NHS Foundation Trust will be reviewed in consultation with subject matter experts and Suffolk Community Healthcare staff.

Date Adopted: 30 September 2015

Review Date: No later than 31 March 2016
PREVENTION AND MANAGEMENT OF FALLS AND FRAGILITY FRACTURES

Policy Reference: SCH Serco CP18  Version: 2.0  Status: Approved

Policy Type: Clinical
Policy applies to: Suffolk Community Healthcare (SCH)

Policy applies to (staff groups): All Staff employed within NHS Suffolk including Suffolk Community Healthcare employees.

Required compliance: This policy must be complied with fully at all times by the appropriate staff. Where it is found that this policy cannot be complied with fully, this must be notified immediately to the owner through the waiver process.

Policy owner: Director of Nursing, Therapies and Governance

Policy authors: Falls Prevention Co-ordinator East Suffolk; Falls Prevention Coordinator, West Suffolk; Falls and Fragility Fracture Prevention Specialist Nurses; Osteoporosis Specialist Nurse, East Suffolk.

Other contact: Head of Nursing and Professional Practice

Date this version adopted: September 2014

Last review date: Updated June 2014 to reflect NICE Clinical Guideline CG161

Reviewer: Anita Walkinshaw

Next review date: September 2017

Location of electronic master: Suffolk Community Healthcare Intranet

AGREED POLICY REVIEW / RATIFICATION / ADOPTION PATH:

Level 1:
Agreed by: Falls Working Group
Date: June 2014

Level 2:
Agreed by: Clinical Policy Group
Date: 29/7/14

Level 3:
Agreed by: Clinical Quality and Safety Assurance Group
Date: 23/9/14
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</tbody>
</table>
1 Introduction and Executive Summary

1.1 Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. (Department of Health 2001)

1.2 The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year (National Institute for Health and Care Excellence, 2013). Therefore falling has an impact on quality of life, health and healthcare costs.

1.3 It is estimated that 4.6 million hospital bed days were used in 2006/7 in England for fractures in over 60 year olds and frailty-related falls in over 75 year olds. The number of admissions for falls increased by 36% over the five years between 2003–4 and 2008–9. With an ageing population, this is likely to continue to increase. The combined cost of social and hospital care for patients with fragility fractures has been reported as more than £1.8 billion per year in the UK, though this is likely to be an underestimate. Of total costs, about 45% is for acute care, 50% for social care and long term hospitalisation and 5% for drugs and follow up.

1.4 The most common serious consequence of falling is hip fracture. This occurs in approximately 76,000 people per year in the UK. Half of people suffering a hip fracture never return to their previous level of independence. About 10% die within a month and approximately 20% enter a care home. (Royal College of Physicians (RCP), 2011)

1.5 Most fractures in older people occur in the context of increased bone fragility, osteopenia or osteoporosis. There is considerable evidence for interventions that reduce the risk of falling and for medications that reduce the risk of fracturing. It is estimated that, if all clinicians and services implemented this evidence in a fully integrated falls and bone health service, it would lead to an estimated reduction of 4,500 hip fractures in the UK per year, with a net saving of £34 million (RCP 2011).

1.6 Falls in hospital are a common occurrence especially among older adults and are the most common safety incident reported to the National Patient Safety Alert System (NPSAS) from hospitals.

1.7 Falls are often the marker of a patient’s underlying medical illness and frailty and their occurrence does not necessarily mean that there has been a failure in the duty of care or that anyone or any system is to blame. However, inpatient falls have a dramatic impact on morbidity, extended lengths of hospital stay and increased discharge costs to long term care settings (Chang et al 2004). Falls may also lead to complaints, coroners’ inquests and litigation and very often service users, their relatives and carer’s feel anxiety and anger.

1.8 It is accepted that for some patients, despite all reasonable measures being taken, the risk of falling remains high even when providing rehabilitation. However, in such cases, minimising falls related injury becomes a priority and measures can be put in place to minimise a person’s risk of falling and injuring themselves.

1.9 Everyone within the multi-disciplinary team (MDT) has a responsibility in the prevention of falls and falls related injuries and the prevention of osteoporosis. Successful assessment and management involves an holistic approach and will frequently involve MDT interventions. It is therefore the responsibility of the nurse, physiotherapist, occupational therapist, assistant practitioner, generic worker, health care assistant, or any other health professionals; whoever is the first person to come into contact with the patient to complete falls and bone health risk assessment and make referrals as necessary.

1.10 Guidance from the National Institute for Health and Care Excellence (NICE) CG21 (2004) and NICE CG161 (2013) recommend that all people aged 65 or older coming into contact with healthcare professionals
must be routinely asked about any falls in the last 12 months including frequency, context, and characteristics. Older people who present with a history of recurrent falls or demonstrate abnormalities of gait and/or balance should be offered a comprehensive holistic and multifactorial risk assessment and concomitant interventions. This is because people in this age group have the highest risk of falling and sustaining an injury.

1.11. The latest clinical guidance from the NICE (CG161; 2013) which sits alongside CG21 includes inpatient units and recommends that all patients admitted to an inpatient unit aged 50 – 64 years old who are judged to be at risk of falls due to their underlying conditions should be assessed for falls and osteoporosis prevention during their hospital stay.

1.12. This guideline provides recommendations for the assessment and prevention of falls in older people.

2 Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Fall</td>
<td>For the purposes of this policy, a fall is defined as “an event whereby an individual unexpectedly comes to rest on the ground or another lower level with or without known loss of consciousness. (American Geriatric Society/British Geriatric Society 2001, NICE 2004).</td>
</tr>
<tr>
<td>Multifactorial Fall Risk Assessment:</td>
<td>Assessment of known predisposing factors within the person and in the environment that increase the risk of falling.</td>
</tr>
<tr>
<td>Multifactorial Intervention:</td>
<td>An intervention made up of a subset of interventions provided by different professional groups that are selected and offered to an individual to address the specific risk factors identified through a multifactorial fall risk assessment.</td>
</tr>
<tr>
<td>Falls Care Pathway:</td>
<td>An algorithm or flow chart that guides the patient journey from admission into a service to discharge.</td>
</tr>
<tr>
<td>Falls Assessment Tool:</td>
<td>A tool which forms part of the detailed falls assessment.</td>
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<tr>
<td>DEXA Scan:</td>
<td>Dual energy X-ray absorptiometry - a test to measure the density of bones.</td>
</tr>
<tr>
<td>Root Cause Analysis:</td>
<td>A framework for reviewing and analysing patient safety incidents to identify and recommend areas for change in the care of the patient.</td>
</tr>
<tr>
<td>Older Person:</td>
<td>Someone defined as being 65 years old and over.</td>
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</table>

3 Purpose and Scope of this Clinical Policy

3.1. The purpose of the policy is to reduce, as far as is reasonably practicable, the number of falls and subsequent injuries and to ensure effective treatment and rehabilitation for those who have fallen. This includes signposting to other services as required by the patient.

3.2. This policy sets out the guidelines for the identification, assessment, prevention and management of falls and fracture risks in patients aged 65 and older. People aged 65 and older have the highest risk of falling, and also people aged 50 to 64 who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition.

3.3. Patients aged 18 and over in special circumstances who are judged to be at higher risk of falls, osteoporosis or fragility fractures due to medical, physical, or other conditions and may be included.

3.4. This policy also serves to identify patients at risk of osteoporosis and fragility fractures so that appropriate assessment and treatment can be offered. This includes concordance with bone sparing medication and health promotion and signposting to other services as required by the patient.

3.5. This policy and associated documents applies to SCH staff to ensure that patients under our care receive an appropriate falls and bone health risk assessment, intervention, health promotion information, training education for older people and/or anyone at risk of falls and fractures and to empower patients to take responsibility for their own health and wellbeing.
4 Policy Agreement Path

Refer to front sheet for Policy Agreement Path

5 Principle Legislation and Guidance

5.1. SCH has a duty of care under:

a) Health and Safety at Work Regulation 1999, in line with Health and Safety at Work Act 1974, to assess risk (including slips, trips and falls), monitor, and review any measures to safeguard health and safety identified by risk assessment.

b) This policy and accompanying documents applies to staff who work in SCH Adult Services to ensure that patients under our care have a falls and bone health risk assessment undertaken and an appropriate management plan actioned according to NICE guidelines CG21 (2004), CG161 (2013) and NICE falls pathway in older people January 2014.

c) This policy also applies to the general public whilst on SCH business on SCH premises.

d) National Patient Safety Agency (2011) Slips Trips and Falls in Hospitals stresses the importance of understanding the scale and consequences of patients falling in hospitals, and suggests interventions that, when used together, can reduce falls and injuries.

e) British Geriatric Society (2009) Prevention of Falls in Older People 2010 American Geriatric Society/British Geriatric Society Clinical Practice Guideline: Prevention of Falls in Older Persons Summary of Recommendations provides guidelines for the widespread use of effective, evidence-based fall prevention services for older people which includes appropriate screening of individuals at risk of falls and providing multifactorial assessment and tailored interventions, with the understanding that these interventions need to be integrated and balanced with other health care priorities.

6 Roles and Responsibilities:

N.B. the information contained herein applies to all West Suffolk NHS Foundation Trust employed SCH staff as appropriate and relevant to their specific role and responsibilities. If any member of SCH staff is unsure as to their role/responsibilities with regard to this clinical policy, they should contact their line manager for guidance and support.

6.1. It is the duty and responsibility of West Suffolk NHS Foundation Trust employees to work within the organisation’s policies and procedures.

6.2. WSH employees have a responsibility to provide a safe and therapeutic environment for patients whilst maintaining privacy and dignity and promoting rehabilitation and independence.

6.3. WSH employees have a responsibility to remove and report any identified hazards which may cause harm.

6.4. The following key employees will have responsibility for implementing and monitoring of this policy and associated processes, and procedures as appropriate to their role.

- CEO
- Chief Operating Officer
- Executive Chief Nurse
- Community Hospital Manager
- Doctors
- SCH Consortia Risk Management and Clinical Governance Team
- Local Area Managers (or equivalent)
- Clinical Team Leaders (or equivalent)
6.5. **Case/ Risk Identification**

a) Older people who come in contact with SCH clinicians in the community, and people aged 50-64 who are admitted into community hospitals, should be asked routinely whether they have fallen in the last 6 - 12 months and asked about the frequency, context and characteristics of the fall/s, injuries and other consequences. [NICE CG 21, 2004, & NICE CG161, 2013]

b) If the patient reports a slip, trip or fall in the past 6 months, reports a fear of falling or has significant difficulty when walking which may increase their risk of falling they should be offered a multi-factorial assessment and interventions. Interdisciplinary Referrals to other services, within SCH or external organisations will require communication between those services and care plans may need to be adjusted as a result of any extended assessment by other professionals.

c) Older people in contact with SCH clinicians should be asked routinely whether they have sustained a fragility fracture after the age of 50 years.

d) Older people in contact with SCH clinicians should be provided information on falls prevention, how to keep bones healthy, osteoporosis, health and well-being advice and appropriate support services available in the community.

7 **Multifactorial Falls, Osteoporosis, and Fragility Fracture Risk Assessment**

7.1. Older people who present for medical, nursing or therapy attention because of a fall, or report recurrent falls in the last 6 - 12 months, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience. This assessment should be part of an individualised, multifactorial intervention. [NICE, CG21, 2004]. This includes inpatients within community hospitals aged 50 – 64yrs who are identified at risk of falling.

7.2. Multifactorial Assessment may include the following:

a) Identification of falls history including causes and consequences such as injury, fear of falling. (appendix 1 or link to intranet)

b) Assessment of gait, balance and mobility, and muscle weakness

c) Assessment of osteoporosis and fragility fracture risk (Appendix 2 FRAX or link to intranet) and adherence for those on bone protection medication.

d) Assessment of the older person’s perceived functional ability and fear of falling

e) Assessment of visual and hearing impairment

f) Assessment of cognitive impairment (Appendix 3 GP COG or link) and neurological examination

g) Assessment of urinary incontinence
h) Assessment of home hazards
i) Medication review including modification/withdrawal – see medication list - LINK
j) Assessment for postural hypotension and cardiovascular examination
k) Assessment of feet and footwear
l) Assessment of excess alcohol
m) Assessment for depression
n) Health problems that may increase their risk of falling
o) Syncope symptoms

7.3. Multi-factorial Interventions

a) All older people and inpatients aged 50 – 64yrs, assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention based on the risk identified [NICE CG 21, 2004]. Success multifactorial interventions include the following:
   i) Medication review with modification/withdrawal
   ii) Strength and balance training
   iii) Home hazard assessment and intervention
   iv) Onward referral for vision assessment.

b) Following treatment for an injurious fall, older people and inpatients aged 50 – 64yrs should be offered a multidisciplinary assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function. [NICE CG 21, 2004].

7.4. Strength and Balance Training

a) Strength and balance training is recommended. Those most likely to benefit are older people living in the community with a history of recurrent falls and/or balance and gait deficit. A muscle-strengthening and balance programme should be offered. This should be individually prescribed and monitored by an appropriately trained professional. [NICE CG 21, 2004].

7.5. Home Hazard and Safety Intervention

a) Older people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional. Normally this should be part of discharge planning and be carried out within a timescale agreed by the patient or carer, and appropriate members of the health care team. [NICE CG 21, 2004].

b) Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation. [NICE CG 21, 2004].

7.6. Psychotropic Medications

a) Older people on psychotropic medications should have their medication reviewed, with specialist input is appropriate, and discontinued if possible to reduce their risk of falling. [NICE CG 21, 2004]

7.7. Education and Information Giving

a) All SCH clinicians working with patients known to be at risk of falling should develop and maintain basic professional competence in falls and fracture assessment and prevention. [NICE CG 21, 2004].

b) Individuals at risk of falling, and their family carers, should be offered information orally and in writing about:
i) what measures they can take to prevent further falls

ii) how to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components

iii) the preventable nature of some falls

iv) the physical and psychological benefits of modifying falls risk where they can seek further advice and assistance

v) how to cope if they have a fall, including how to summon help and how to avoid a long lie. [NICE CG 21, 2004].

7.8. Interventions not recommended as insufficient evidence base (NICE Guidelines 161 June 2013 (1.1.12)

a) Low intensity exercise combined with incontinence programmes

b) Group exercise (untargeted)

c) Cognitive/behavioural interventions

d) Referral for correction of visual impairment

e) Vitamin D

f) Hip protectors

8. Risks of Falls in Older People In Inpatient Units

8.1. The following groups should be regarded to be at risk of falling (falls risk prediction tools must not be used to predict inpatients' risk of falling in hospital; NICE CG 161, 2013):

a) all patients aged 65 years or older

b) patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition. (NICE CG 161, 2013).

8.2. Falls and Fracture Risk Assessment will be commenced on admission and completed within 24 hours unless otherwise clinically inappropriate. In such cases, it should be documented as to the reason for not completing a falls and fracture risk assessment. This duty must be undertaken by the lead nurse on every shift or the clinician attending to the patient and all hazards removed/reduced/and reported.

8.3. Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed. (NICE CG 161, 2013).

8.4. For patients at risk of falling in hospital, complete a multifactorial assessment and a multifactorial intervention ensure that any multifactorial intervention promptly addresses the patient's identified individual risk factors for falling in hospital and takes into account whether the risk factors can be treated, improved or managed during their hospital stay.

8.5. Inter-organisational referrals between SCH and other providers must include two-way communication around risk of falls and fragility fractures

8.6. Information and support should include:

a) explaining about the patient's individual risk factors for falling in hospital

b) showing the patient how to use the nurse call system and encouraging them to use it when they need help

c) informing family members and carers about when and how to raise and lower bed rails

d) providing consistent messages about when a patient should ask for help before getting up or moving about
helping the patient to engage in any multifactorial intervention aimed at addressing their individual risk factors. (NICE CG 161, 2013).

9 Falls and Fracture Competency Training

9.1. It is the responsibility of individual members of staff to complete relevant training for falls prevention and bone health.

9.2. SCH Consortia will ensure that appropriate training is available to all relevant staff groups. It is the responsibility of each staff member to ensure that they attend the relevant training for their profession, and it is the responsibility of their Team Lead to identify that the competencies are met.

10 Links to Other Policies & Guidelines

This policy should be read, understood and implemented alongside other SCH policies e.g.
- Admission & Discharge Policy
- Assistive Technology Policy
- Bedrail Policy
- Clinical Audit Policy
- Health & Safety Policy
- Moving & Handling Policy
- Guidance for Undertaking Risk Assessment

11 Communication of this Policy

11.1. This policy document needs to be shared with/available to all staff working within SCH.

11.2. This policy also needs to be communicated to and shared with other agencies working with or providing services for older people, e.g.
- General Practitioners
- Acute Trusts
- Adult and Community Social Services
- County and District Councils
- East of England Ambulance Services
- Private and voluntary care agencies (e.g. Age UK/Suffolk Family Carers/Suffolk Careline/ British Red Cross)
- Out of Hours Services

12 References/Resources

- World Health Organisation, WHO Fracture risk assessment tool
- National Osteoporosis Society, 2011, What is osteoporosis
13 Falls & Fracture Paperwork and Guidance:

13.1 If you have any queries regarding this information, please contact your local Falls Prevention Coordinator or Fracture Liaison Nurses or Osteoporosis Nurse Specialist for advice.

Title of Policy/Guideline: Falls, Fracture and Fragility Policy

Description:
This policy sets out the guidelines for the identification, assessment, prevention and management of patients who are at risk of falling prior to or subsequent to admission into Suffolk Community Healthcare (SCH) community hospitals, or whilst on SCH property for other reasons such as rehabilitation, or outpatients attendances.

Part 1: Assessment of Impact

a) How will the policy meet the needs of different communities and groups?

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Age</td>
<td>This policy applies to all patients, staff and visitors to SCH. Within this group, it is not considered that the age will have any impact on the application of this policy</td>
</tr>
<tr>
<td>Disability</td>
<td>It is anticipated that this policy will impact on all adult patients in equal measure</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>This organisation is aware of different practices and different ethnic groups but this policy is considered to meet the needs all such groups</td>
</tr>
<tr>
<td>Gender (including transgender)</td>
<td>This policy is intended to meet the needs of all such groups regardless of gender.</td>
</tr>
<tr>
<td>Other</td>
<td>This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers. It also recognises that some patients may be more vulnerable in relation to procedures outlined within this document. However, this policy should be applied equally to all SCH service-users.</td>
</tr>
</tbody>
</table>

b) Positive Impact: Reducing Inequalities: How is the Policy likely to have a significant positive impact on equality by reducing inequalities that already exist? Explain how it will meet our duty to:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Promote equal opportunities</td>
<td>This policy will ensure that all staff are equally aware of the correct procedure so that adherence to the guideline is standardised through all patient groups.</td>
</tr>
<tr>
<td>Promote good community relations</td>
<td>As with other policies and guidelines within the organisation, this one aims to ensure that SCH provides quality services to the community of Suffolk ensuring that the whole community has access to a safe healthcare environment. Fostering good relations with partner organisations will be enhance by the application of this policy.</td>
</tr>
<tr>
<td>Get rid of discrimination</td>
<td>Staff working within this guideline and within professional guidelines should avoid discrimination at any level.</td>
</tr>
<tr>
<td>Promote positive attitudes</td>
<td>This guideline applies to all patients equally irrespective of any disability and staff will make all reasonable adjustments to accommodate any disability.</td>
</tr>
<tr>
<td>Promote and protect human rights</td>
<td>SCH recognises that patients to whom this policy applies are potentially vulnerable but this guideline is designed to ensure their human rights are not affected in any way</td>
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- **Age** – Within the defined age group it is anticipated that age will not have a negative impact on this policy.
- **Religion or Belief** – Staff are expected to be aware of the possibility of differing views by religious groups but this should not impact on the application of the policy.

- **Disability** – This policy should be applied equally regardless of any disability
- **Sexual Orientation** – This policy will apply equally regardless of sexual orientation.

- **Ethnicity** – It is not considered that ethnicity will have a negative impact on this policy although the attitudes towards it may vary according to ethnic group.
- **Socio-economic groups** – It is not anticipated that this policy will have a negative impact in relation to this.

- **Gender (including transgender)** – This policy will be applied equally regardless of gender.
- **People living in rural areas** – It is not anticipated that this will have a negative impact.

**Other:** This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers and/ or more vulnerable. However, this policy relates to all individuals who are service-users, staff or visitors and as such will be applied equally and should not have a negative impact.

### Part 2: Evidence

**What is the evidence for your answers above?**

<table>
<thead>
<tr>
<th><strong>Age</strong></th>
<th><strong>Religion or Belief</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the intention and aims of this policy that in consultation with statutory and non-statutory bodies that the policy reflects current best evidence and practice and will be applied equally regardless of the age of the recipient within the defined age-group.</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on religion or belief.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Disability</strong></th>
<th><strong>Sexual Orientation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the intention and aim of this policy that it will reflect best evidence based practice and not discriminate based on a physical or mental disability.</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on sexual orientation.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Ethnicity</strong></th>
<th><strong>Socio-economic groups</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on ethnicity.</td>
<td>It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on socio-economic status.</td>
</tr>
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<table>
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<tr>
<th><strong>Gender (including transgender)</strong></th>
<th><strong>People living in rural areas</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the intention and aim of this guideline that it shall be applied equally according to best practice and not discriminate unfairly based on gender.</td>
<td>It is the intention and aim of this guideline that it shall be applied equally according to best practice and not discriminate unfairly based on ethnicity.</td>
</tr>
</tbody>
</table>

**Other:** This organisation recognises that some members of society generally have difficulty accessing health services such as people who are homeless, prisoners or street workers. The organisation also acknowledges the increased vulnerability of certain individuals & groups within society in relation to this policy. However, this policy applies to all individuals who are service-users, staff or visitors and therefore will be applied equally and reviewed regularly to ensure it adheres to current best evidence based practice. Training around equality & diversity issues are also mandatory annually within SCH.

### Part 3: Conclusion

A negative impact in unlikely. The policy has the clear potential to have a positive impact by reducing and removing barriers and inequalities that currently exist.

### Part 4: Next Steps

**Action Plan:** Review operation of the policy as per SCH protocol to ensure there are no changes in its impact.

### Part 5: For the Record

<table>
<thead>
<tr>
<th>Name and Title of people who carried out the EIA: Falls Working Group</th>
<th>Name of Director who signed EIA: Pamela Chappell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date EIA completed: August 2014</td>
<td>Signature of Director: Pamela Chappell</td>
</tr>
</tbody>
</table>

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