Falls

Accident and Emergency Policy for Patients Who Present Following a Fall or Who Are Identified as Being at High Risk of Falls

Date: February 2012
Version Number: Three

Author: Falls Strategy Group, Co-ordinated by Jo Robinson

Date of Approval: February 2012
Review Date: February 2014

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# Document Development Coversheet

<table>
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<th>Accident and Emergency Policy for Patients Who Present Following a Fall or Who Are Identified as Being at High Risk of Falls</th>
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<tr>
<td>Registration Reference Number</td>
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<tr>
<td>Author</td>
<td>Falls Strategy Group</td>
</tr>
<tr>
<td>Executive Lead</td>
<td>Kathleen Carolan</td>
</tr>
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## Proposed Groups to Present Document to:

<table>
<thead>
<tr>
<th>Falls Strategy Group (FSG)</th>
<th>CHP Management Team (CHPMT)</th>
</tr>
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<tbody>
<tr>
<td>Clinical Services Management Team (CSMT)</td>
<td>SCN/Team Leaders Group (SCNTLG)</td>
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<td>ALL</td>
<td>Provide technical content</td>
<td>Self assessments agreed</td>
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<tr>
<td>10/11</td>
<td>2.0</td>
<td>ALL</td>
<td>Firm up monitoring arrangements</td>
<td>Training, audit, responsible officer detail added</td>
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<tr>
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<td>Finalise the content</td>
<td>Referral arrangements, assessments checked and verified</td>
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<td>Outcomes Following Meeting</td>
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<tr>
<td>04/11</td>
<td>Initial outline circulated</td>
</tr>
<tr>
<td>10/11</td>
<td>DNMAHPs added in referral information, training, roles and responsibilities, KPIs and communication plan</td>
</tr>
<tr>
<td>11/11</td>
<td>HoD of Physiotherapy added in the assessment tools and guidance for STRATIFY</td>
</tr>
<tr>
<td>11/11</td>
<td>HoD of Dietetics reviewed the documentation to ensure that it corresponds with bone health and nutritional guidelines</td>
</tr>
<tr>
<td>11/11</td>
<td>HoD of Physiotherapy defined the risk assessment levels for referral into the Physiotherapy service using the STRATIFY tool</td>
</tr>
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Falls

Accident and Emergency Policy for Patients Who Present Following a Fall, or Who are Identified as Being at High Risk of Falls

1.0 Introduction

In February 2007, the Health Department of the Scottish Executive issued their Delivery Framework for Adult Rehabilitation and Prevention of Falls in Older People. Health Boards were asked to take the lead in developing with all relevant partners a combined falls prevention and bone health strategy by the end of 2007-8.

NHS Shetland and the Community Health and Care Partnership (CHCP) has developed a local strategy which sets out our key objectives in regard to the promotion of bones health and preventative strategies to reduce the number of falls occurring across hospital, community and social care settings. Operational policies have been put in place to ensure that these preventative initiatives and interventions are taken forward.

This policy is one in a series of four – the policies are:

A& E Falls Management
In-Patient Falls Management
Managing Falls in the Community
Managing Falls in the Care Home Setting

2.0 Definition of a Fall

A fall is commonly defined as “an event which results in the person coming to rest inadvertently on the ground or other level”¹ and may be further defined as “other than as a consequence of the following; sustaining a violent blow, loss of consciousness, sudden onset of paralysis, or an epileptic seizure” ²

3.0 National Information

- 30% of all people aged over 65 living in the community fall each year ⁴
- 42% of all people aged over 75 fall each year ⁵
- Over 50% of hospital admissions are due to accidental injury (National Osteoporosis Society Facts and Figures) (put this as a reference)

In 2001 the combined NHS and Social care costs for a single hip fracture in the UK were estimated to be £20,000. Recent evidence suggests that each hip fracture costs the NHS alone £12,137, over £7,000 more than the figure used in earlier estimates ¹²
4.0 Local Information
In the period 01/01/08 to 30/06/08:

- 90 responses from the Scottish Ambulance Service following a fall
- 77 patients seen in A&E following a fall
- 30 admissions to hospital from A&E following a fall

5.0 Aim of this Policy
The aim of this policy is to:

1. Reduce the total number of falls occurring in the Shetland Community by providing an evidence-based, user-centred approach to reducing the risks of harm and promote patient safety;
2. Heighten awareness and knowledge of staff, patients and carers on the prevention and causes of slips, trips and falls;
3. Provide guidance for the actions to be taken when a user has fallen;

6.0 Scope
This policy applies to all staff working within A&E in NHS Shetland’s Gilbert Bain Hospital.

7.0 Falls and Risk
7.1. Falls management requires an approach that increases patient safety by identifying users at risk and implementing interventions that reduce falls, including consideration and assessment of environmental risk factors. It is, however, recognised that patient safety should be balanced with the promotion of independence.

7.2. Management of patients at risk of falls should be tailored to individual risks and needs.

8.0 People who are Known to be at Increased Risk of Falls:
- Over 65 years of age
- History of falls
- Mobility impairment
- Person in need of frequent toileting especially at night
- Person agitated or confused
- Sensory deficits e.g. vision, hearing, sensation
- Neurological changes
- Medication known to affect balance/cognition or poly-pharmacy

9.0 Medications that Increase Risk of Falls

Older people are more sensitive to the effects of medication and evidence suggests that there is a significantly increased risk of falling in those people that receive the following medications:

- Psychotropic medication (neuroleptics, benzodiazepines and antidepressants)
- Anti-arrhythmic medications
- Digoxin
- Diuretics
- Opioids

Patients who have fallen should have their medications reviewed and, if appropriate, altered or stopped (in light of their risk of future falls).

Particular attention should be given to:

- Poly-pharmacy
- Psychotropic medications

10.0 Prevention of falls within A&E – Environmental Factors

There are a number of NHS Shetland initiatives, which ensure that the patient environment is safe. These include a programme of Health and Safety Inspection visits which are undertaken on an annual basis and more frequently in high-risk areas. The Patient Safety Leadership walkarounds are also an opportunity to identify key clinical and/or environmental factors where corrective action can be taken to reduce harm to patients such as avoidable falls.

Heads of Department (HoDs) are responsible for ensuring that appropriate actions are taken following H&S Inspection visits where environmental hazards are identified and ensure that the relevant support services are contacted to complete any remedial works or repairs that need to be carried out and timescales for completion as well as the need for any additional resources.

Any serious risks must be reported to the Estates department as an urgent repair. Bearing in mind that repairs may involve the hire of external contractors, materials to be ordered and have Healthcare Acquired Infection implications, the risk should be managed appropriately until a repair can be arranged.
The H&S policy set can be found at the following link: http://www.shb.scot.nhs.uk/documents/pphandbook/documents/HealthAndSafety.pdf

In regard to the safety of individual patients, then the following guidelines should be followed:

- Ensure bed/ trolley brakes are locked and the bed/ trolley is in a low position (except when giving care) and access to a low level stool is made available so patients can safely transfer from the trolleys.

- Ensure that the chair is at appropriate height for patient

- If patient is considered to be at risk of falling from the bed implement an ‘at risk’ of falling from bed care plan.

- Ensure the call system is working, within sight and easy reach and patient is able to use it.

- Ensure correct spectacles are within easy reach and are clean – if the patient brings them into hospital with them.

- Ensure correct use of hearing aid.

- Ensure personal items are within easy reach.

- Ensure tripping/slipping hazards are eliminated (refer to environmental assessment).

- Ensure any footwear is in good condition, non-slip, low heeled and well fitting.

- Ensure correct mobility aid is used – is labelled with patient’s name, and is in good condition (including ferrules) and where appropriate, within easy reach

10.1 People Who Present as a Result of a Fall or Fracture

A STRATIFY falls risk assessment and FRAX assessment should be carried out on all patients known to have fallen. These tools allow the future risk of falls and fractures to be identified, and will allow appropriate action to be taken. The STRATIFY tool is shown in Appendix 2 and the FRAX calculator can be accessed via the following link: http://www.shef.ac.uk/FRAX/tool.jsp?country=1

It should be clearly recorded on EDIS that the patient has had a fall along with the details of the assessment, so that the information can be included in correspondence to other clinicians (e.g. Consultant if the patient is admitted and/or GP if the patient is discharged directly from the A&E department).

NEXT STEPS – ACTION TO BE TAKEN BY THE A&E NURSE
If a patient is assessed as ‘high risk’ of fractures and/or falls then an onward referral needs to be made so that a multifactor falls assessment can be carried out.

ALWAYS – send a copy of the FRAX and STRATIFY results to the GP advising that a full falls assessment is carried out.
ALWAYS – refer the patient to the Occupational Therapy team for follow up and home assessment (regardless of the FRAX and STRATIFY scores).
REFER to the Physiotherapy team for follow up if the STRATIFY score is 3 or 4.

Note: If the person is admitted to the ward, the inpatient policy applies.

10.2 People Who Present and May be at Future Risk of Falls
A STRATIFY falls risk assessment and FRAX assessment should be carried out on all patients over the age of 65 years and has at least one other risk factor. These tools allow the future risk of falls and fractures to be identified, and will allow appropriate action to be taken.

1 Risk factors include:
Over 65 years of age;
History of falls;
Mobility impairment;
Person in need of frequent toileting especially at night;
Person agitated or confused;
Sensory deficits e.g. vision, hearing, sensation;
Neurological changes;
Medication known to affect balance/cognition or poly-pharmacy;

The details of the risk assessments should be clearly recorded on EDIS, so that the information can be included in correspondence to other clinicians (e.g. Consultant if the patient is admitted and/or GP if the patient is discharged directly from the A&E department).

NEXT STEPS – ACTION TO BE TAKEN BY THE A&E NURSE
If a patient is assessed as ‘high risk’ of fractures and/or falls then an onward referral needs to be made so that a multifactor falls assessment can be carried out.

ALWAYS – send a copy of the FRAX and STRATIFY results to the GP advising that a full falls assessment is carried out.
ALWAYS – refer the patient to the Occupational Therapy team for follow up and home assessment (regardless of the FRAX and STRATIFY scores).
REFER to the Physiotherapy team for follow up if the STRATIFY score is 3 or 4.

If the patient is admitted to a ward, the Inpatient Falls Policy applies.

2 Some patients may refuse the offer of home OT assessment. If this is the case, clearly record this on EDIS and notify the patients GP.
11.0 Incident Reports

All inpatient falls must be reported in accordance with the NHS Shetland Incident Reporting, Investigation and Management Policy 2010 via the DATIX system. Staff should discuss the actions and learning points that have arisen from any incidents at team meetings and/or governance meetings.

Data describing the number of falls and associated information about lessons learnt will be discussed in the following clinical governance for a:

- The Clinical Governance Co-ordinating Group (CGCG)
- The Falls Strategy Group (FSG)
- The Quality and Safety Group (QSG)

This is to ensure that there is an opportunity to share improvement ideas and spread good practice as well as evaluate the current performance against falls CQIs.

12.0 Patient Information and Education

It is important to ensure that patient information is provided to maintain and promote patient safety in relation to falls prevention. A&E nurses must ensure that appropriate written advice is given to patients with a risk of falls and that this is documented on EDIS or in the hardcopy health record (if appropriate).

The following leaflets are available from the Health Improvement Resource Officer in Brevik House:

- Reducing Patient Falls
- Postural Hypotension (feeling dizzy and faint when you stand up) – leaflet no.
- Safe use of bedrails in hospital (refer to NHS Shetland Adult Restraint Policy including use of bedrails)
- Staying Steady; Improving Your Strength and Balance
- Your Safety – Preventing Accidents in Your Home
- Healthy Bones

13.0 Documentation

The record keeping standards guidelines (as set out in the NHS Shetland record keeping audit) must be adhered to. Only assessments, which have been approved by the Falls Strategy Group and Area Nursing & Midwifery Council (ANMAC) and Area Advisory Committee for Allied Health Professionals (AACAHP) will be used to ensure that there is consensus for adoption and that the assessments are derived from an appropriate evidence base.
14.0 Training for Staff
The Board will ensure that all staff who are required to complete a falls risk assessment receive appropriate training to:

- Undertake a risk assessment
- Design an appropriate care plan
- Signpost patients to information about falls prevention
- Make referrals to other services and/or teams for further assessment

15.0 Audit/Monitoring
There are a number of ways in which the policy implementation will be reviewed:

- An annual audit of the KPIs associated with the A&E Falls Policy
- Monthly review of incident cases of falls at ward level, using data from DATIX;
- Monthly review of adverse events using the Global Trigger Tool (GTT) or revised local tool, to identify cases where the patient had a fall whilst in hospital (in any setting);
- Monthly review of CQIs for falls management (where applicable including patients identified via A&E);
- Quarterly review of all incident cases of falls at the CGCG, QSG or FSG.

16.0 Roles and Responsibilities

**Director of Nursing, Midwifery & AHPs** – is the executive lead for this policy area and is responsible for ensuring that appropriate governance systems are in place to support falls prevention across the Board.

**Medical Director** – is responsible for ensuring that medical staff in primary and secondary care adhere to this policy and promote best practice in relation to bone health

**Senior Managers** – (in general) are responsible for ensuring that all professions adhere to the policy and that there are appropriate resources in place to implement the key aims of the policy.

**Senior Nurses** – (e.g. Assistant Directors) are responsible for ensuring that the policy is monitored and that any associated governance issues are highlighted through an appropriate route (e.g. Clinical Services Management Team) and corrective actions taken (e.g. Senior Charge Nurses, Team Leaders & Heads of Service (HoDs) – are responsible for ensuring that the clinical environments are safe (and regular risk
assessments are undertaken) and staff are adequately supported to work within the policy by ensuring that:

- All of their staff are trained in falls risk assessments and management to an appropriate level for the services that they provide (e.g. nurses will undertake initial assessments and AHPs more specialised assessment and management);
- That staff put in place appropriate care plans for patients with falls risk;
- That falls incidents are reviewed on a regular basis at team meetings and governance meetings.

17.0 **Communication Plan**

This policy will be cascaded to staff via HoDs and made available in electronic format on the Internet and Intranet.

The Clinical Governance Committee is responsible for ensuring that the policy has been developed in accordance with the Framework on Document Development and is reviewed according to the schedule set.

### Key Performance Indicators

<table>
<thead>
<tr>
<th>Item</th>
<th>Target</th>
<th>Comment</th>
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<tr>
<td>All A&amp;E staff will be trained to undertake falls risk assessments</td>
<td>50% of staff trained by September 2012</td>
<td></td>
</tr>
<tr>
<td>All A&amp;E staff will be trained to complete falls care plans</td>
<td>50% of staff trained by September 2012</td>
<td></td>
</tr>
<tr>
<td>All falls risk actions will be completed following the H&amp;S review</td>
<td>75% by September 2012</td>
<td></td>
</tr>
<tr>
<td>All patients who have high risk factors will have a risk assessment</td>
<td>75% by September 2012</td>
<td></td>
</tr>
<tr>
<td>All patients with high risk factors will be referred to the OT</td>
<td>75% by September 2012</td>
<td></td>
</tr>
<tr>
<td>department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put in place systems to accurately record a baseline for Falls</td>
<td>100% by September 2012</td>
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<tr>
<td>presentations to/via A&amp;E</td>
<td></td>
<td></td>
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<tr>
<td>Falls incidents will be discussed at all A&amp;E team meetings</td>
<td>100% by September 2012</td>
<td></td>
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<tr>
<td>There will be a reduction in the baseline of patients presenting</td>
<td>Reduction from the baseline of 10%</td>
<td></td>
</tr>
<tr>
<td>with falls risk who do not already have a risk assessment in place</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References/Bibliography

College of Occupational Therapists Falls Management, Lamb SE, Jorstad-Stein EC, Hauer K and Becker C (2005)


Torgeson D. Inglesias C and reid DM. The effective management of osteoporosis. In The economics of fracture prevention, edited by Vralow DH, Francis RM and Miles A 2001, p111-121


<table>
<thead>
<tr>
<th>Lighting</th>
<th>Ensure night lights are on during hours of darkness (not applicable in A&amp;E)</th>
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</thead>
<tbody>
<tr>
<td>Bed Position</td>
<td>Ensure bed brakes are locked and the bed in low position except when giving care and other equipment such as low stools are available to help safe transfer from trolleys etc.</td>
</tr>
</tbody>
</table>
| Bed Rails | Ensure bed rails are used when patient is nursed on a trolley or during transportation on a bed or trolley.  
Ensure bed rails are used when patient anaesthetised / sedated / during post op recovery  
If bed rails used implement ‘at risk of falling from the bed’ care plan |
| Chair | Ensure that chair is at appropriate height for patient |
| Call System | Ensure nurse call system is working, within easy reach and that the patient is able to use |
| Vision | Ensure correct spectacles are within easy reach and are clean |
| Hearing | Ensure correct use of hearing aid |
| Personal Items | Ensure these are within easy reach |
| Hazards | Ensure tripping/slipping hazards are eliminated |
## STRATIFY Falls Risk Assessment Tool

### Questions 2-4
Do you think the patient is

1. Agitated?
2. Visually impaired to the extent that everyday function is limited?
3. In need of especially frequent toileting?
4. Does the patient have a combined transfer and mobility score of 3 or 4?*

### Patients Name:

<table>
<thead>
<tr>
<th>Date</th>
<th>Yes (=1)</th>
<th>No (=0)</th>
<th>Yes (=1)</th>
<th>No (=0)</th>
<th>Yes (=1)</th>
<th>No (=0)</th>
<th>Yes (=1)</th>
<th>No (=0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the patient present to hospital with a fall or has he/she fallen on the ward since admission?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total score**

<table>
<thead>
<tr>
<th>Review date</th>
<th></th>
</tr>
</thead>
</table>

| Signature |   |

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* Transfer score:  
0 = unable  
1 = major help needed (1 or 2 people, physical aids)  
2 = minor help (verbal or physical)  
3 = independent  

**Mobility score:**  
0 = immobile  
1 = independent with aid of wheelchair  
2 = walks with help of 1 person  
3 = independent

**Maximum total score = 5**  
Total score of 2 or above = high risk of falls

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**Version No: 3. February 2nd 2012**
APPENDIX3

Guidelines for completing STRATIFY Falls Risk Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the patient present to hospital with a fall or has he/she fallen</td>
<td>Score 1 if the patient was admitted due to a fall, or has fallen on</td>
</tr>
<tr>
<td>on the ward since admission?</td>
<td>the ward since admission.</td>
</tr>
<tr>
<td></td>
<td>Score 0 if no to both.</td>
</tr>
<tr>
<td>2. Do you think the patient is agitated?</td>
<td>Based on your clinical judgement:</td>
</tr>
<tr>
<td></td>
<td>Score 1 if yes</td>
</tr>
<tr>
<td></td>
<td>Score 0 if no</td>
</tr>
<tr>
<td>3. Do you think the patient is visually impaired to the extent that</td>
<td>Based on your judgement</td>
</tr>
<tr>
<td>everyday function is limited?</td>
<td>Score 1 if yes</td>
</tr>
<tr>
<td></td>
<td>Score 0 if no</td>
</tr>
<tr>
<td>4. Do you think the patient is in need of especially frequent toileting?</td>
<td>Based on your judgement</td>
</tr>
<tr>
<td></td>
<td>Score 1 if yes</td>
</tr>
<tr>
<td></td>
<td>Score 0 if no</td>
</tr>
<tr>
<td>5. Combined transfer and mobility score of 3 or 4?</td>
<td>If transfer score + mobility score equals:</td>
</tr>
<tr>
<td></td>
<td>1 or 2, then score 0</td>
</tr>
<tr>
<td></td>
<td>3 or 4, then score 1</td>
</tr>
<tr>
<td></td>
<td>5 or 6, then score 0</td>
</tr>
</tbody>
</table>

Transfer score: e.g. moving from bed to chair or commode

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Unable</td>
</tr>
<tr>
<td>1</td>
<td>Major help needed e.g. 1 or 2 people, physically assisting</td>
</tr>
<tr>
<td>2</td>
<td>Minor help e.g. prompting or supervision</td>
</tr>
<tr>
<td>3</td>
<td>Independent e.g. does not move</td>
</tr>
<tr>
<td>1</td>
<td>Independent with aid of wheelchair</td>
</tr>
<tr>
<td>2</td>
<td>Walks with help of 1 person (including supervision) – with or without other aids</td>
</tr>
<tr>
<td>3</td>
<td>Independent – with or without aids</td>
</tr>
</tbody>
</table>

Mobility score: i.e. walking/moving around

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Immobile i.e. does not move</td>
</tr>
<tr>
<td>1</td>
<td>Independent with aid of wheelchair</td>
</tr>
<tr>
<td>2</td>
<td>Walks with help of 1 person (including supervision) – with or without other aids</td>
</tr>
<tr>
<td>3</td>
<td>Independent – with or without aids</td>
</tr>
</tbody>
</table>

Maximum total score (add questions 1-5) = 5
Total score of 2 or above = high risk of falls – ?/highlight within care plan, safety briefing/ refer to physiotherapy and consider additional preventive measures
### APPENDIX 4

#### Rapid Impact Checklist: Summary Sheet

<table>
<thead>
<tr>
<th>Positive Impacts (Note the Groups affected)</th>
<th>Negative Impacts (Note the Groups affected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>Possible issues with managing cultural change for staff and patients i.e. move to co-production</td>
</tr>
<tr>
<td>Improved Patient safety through assessment and interventions</td>
<td></td>
</tr>
<tr>
<td>More focus on prevention rather than crisis/incident management</td>
<td></td>
</tr>
</tbody>
</table>

**Additional Information and Evidence Required**

**Recommendations**

**Nil.**

**From the outcome of the RIC, have negative impacts been identified for race or other equality groups? Has a full EQIA process been recommended? If not, why not?**

There is no requirement for a full EQIA process as the implementation of this policy should support the inclusion of all staff.