

managing falls and fractures in care homes for older people

Good practice self assessment resource

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foreword

Falls are not an inevitable part of ageing. In many cases, taking the right steps at the right time can prevent falls and enable an older person to continue a physically active life. Care home staff have a key role to play in falls prevention, but they need to have the knowledge and understanding, and the support of the wider health and social care team.

Older people living in care homes are three times more likely to fall than older people living in their own homes, with the results of a fall often being much more serious; there are ten times more hip fractures in care homes than in other environments. Many factors can contribute to this heightened risk, such as physical frailty, the presence of long term conditions, physical inactivity, taking multiple medications and the unfamiliarity of new surroundings. For this reason, it is important that all care homes for older people implement a person centred process to manage and reduce falls and fractures. This will help to improve the overall quality of care for an individual and will have a huge impact on a person's independence and participation in life.

The 'Good Practice Self Assessment Resource – managing falls and fractures in care homes for older people', provides the direction, advice and support that staff in a care home need to make a difference in this area of care. The resource which is research based not only gives the guidance required, but offers tools which can be downloaded and used in a care home to help improve or change practice. Furthermore, the resource provides reassurance to care home staff that they do not have to address this issue in isolation as support is available from the wider health and social care team.

The 'Good Practice Self Assessment Resource' provides the answers to many of the questions care home managers have in relation to the prevention and management of falls and fractures and can act as an excellent educational tool for new or existing care home staff.

We are delighted to see this good practice resource focused on care homes being implemented nationally. It is extremely encouraging that the care home staff involved in testing the resource have found it helpful, comprehensive and easy to use. We are convinced that this has the potential to drive a real change in practice in the management of falls and fractures and will improve the overall quality of care for older people in care homes in Scotland.

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The prevention and management of falls and the prevention of fractures is an important issue in maintaining quality of life and independence for older people, particularly for older people in care homes.

The Delivery Framework for Adult Rehabilitation in Scotland¹, published in February 2007, is a joint document for health and social care. It gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation or re-ablement services to individuals and communities. The rehabilitation of older people is one of the three priority areas identified. In 2009, Rehabilitation Coordinators and Falls Leads in NHS board areas in Scotland mapped how falls and bone health services were organised and managed. The results suggested that care homes would benefit from some guidance and practical help to manage falls and fractures.

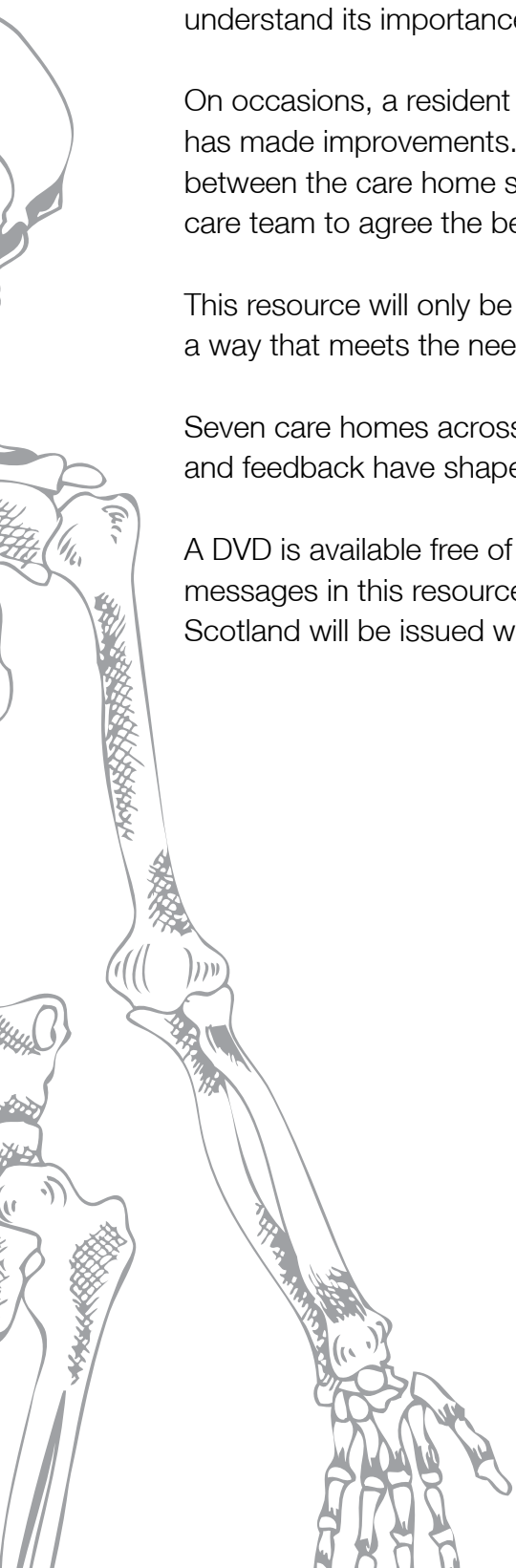
During inspections, Social Care and Social Work Improvement Scotland (SCSWIS) takes account of the National Care Standards². These are based on a set of principles that recognise that services must be accessible and suitable for everyone who needs them. The principles are dignity, choice, safety, realising potential and equality and diversity. Falls prevention and management and the prevention of fractures were part of the Care Commission's Inspection Focus Area during 2009/10. This helped to highlight the importance of person-centred falls prevention and management processes.

A group of key representatives and specialists from across all sectors developed this 'Good Practice Self Assessment Resource'. It will support care homes across Scotland to prevent and manage falls and prevent fractures with an emphasis on the need for continuous improvement.

This resource includes:

- 1. An introduction to falls and fractures in care homes.**
- 2. Self assessment guidance and form.**
- 3. Information, guidance and tools.**

This will help staff in care homes to assess how well falls prevention and management and the prevention of fractures is being addressed in their service and help staff to make improvements. It provides practical help, advice and guidance and signposts to resources available online. It is recommended that the resource is used along with regularly reviewed timed actions plans.



Services can use this resource during the induction of new staff to promote the importance of falls prevention and management, to support training and education in relation to good practice, to assist continuing professional development and most importantly to improve quality of care.

The care home manager or a senior member of staff should carry out the self assessment and decide on improvements along with other staff. All staff should be familiar with it and understand its importance.

On occasions, a resident will continue to fall frequently and sustain injuries even if the home has made improvements. These challenging and distressing situations require close working between the care home staff, the resident and their family and the wider health and social care team to agree the best solutions.

This resource will only be effective if all care homes implement the good practice identified in a way that meets the needs of the older people living there.

Seven care homes across Scotland have trialled the resource. Their helpful comments and feedback have shaped the content and design of the final resource.

A DVD is available free of charge to all care homes for older people which outlines the key messages in this resource. This can be used as a learning tool for staff. All care homes in Scotland will be issued with a DVD.

The senior team went through the resource first, then we shared it with the rest of the staff in manageable chunks.

Care home manager

Introduction to falls and fractures in care homes

Key messages in this section

- You should prevent falls while (a) preserving as much of the residents' independence as possible, (b) continuing to encourage safe physical activity, and (c) maximising quality of life.
- Falls can be a serious problem, resulting in suffering, disability, loss of independence and decline in quality of life.
- Do not accept falls as an inevitable part of getting older; many falls are preventable.
- A fall is nearly always due to one or more 'risk factors'. Recognising then removing or altering an individual's risk factors can often prevent a fall.
- If a person has osteoporosis, they are more likely to break a bone if they fall. Medication for osteoporosis can help strengthen the bones and reduce the risk of having a fracture.

Preventing falls while maintaining quality of life

When caring for older people, preventing falls and injuries from falls is a priority, however, services need to achieve this while still allowing the residents to be as independent as possible. You should continue to encourage safe physical activity and maximise quality of life. This can be a challenge but should be considered at all times.

Many actions residents and care home staff take to prevent falls also have wider benefits for the older person, such as improving physical and mental health, general well-being, independence and the ability to carry out activities important to them.

Definition of a fall

"An unintentional event that results in a person coming to rest on the ground or another lower level, not as a result of a major intrinsic event (such as stroke or epilepsy) or overwhelming hazard (such as being pushed)." (Gibson et al, 1987)³.

Why are falls a problem?

Each year around one third of people over 65 experience one or more falls. Almost half of people aged over 80 living in the community fall each year⁴. Falls rates among care home residents are much higher than among older people living in their own homes.

Falls can result in suffering, disability, loss of independence and a decline in quality of life.

Most people experience a fall at some point in their life which often results in little more than embarrassment. However, as we get older falls can become more common and the consequences of a fall can become much more serious. Injury caused by falls is the

leading cause of accidental death for people over 75. Falls can:

- result in injury, for example a fracture or broken bone, head injury, cuts and bruises, or even death
- cause the person to lose confidence and become anxious and fearful of falling again
- occur during ordinary and necessary daily activities and/or prevent a person carrying out daily activities, leading to loss of independence and/or quality of life,
- keep happening (recurrent falls).

Figure 1 shows some of the physical and psychological consequences of a fall and/or a prolonged length of time lying on the floor. There can also be unwelcome consequences for the care home, in the form of increased workload for staff, increased cost of care, litigation, complaints and staff anxiety.

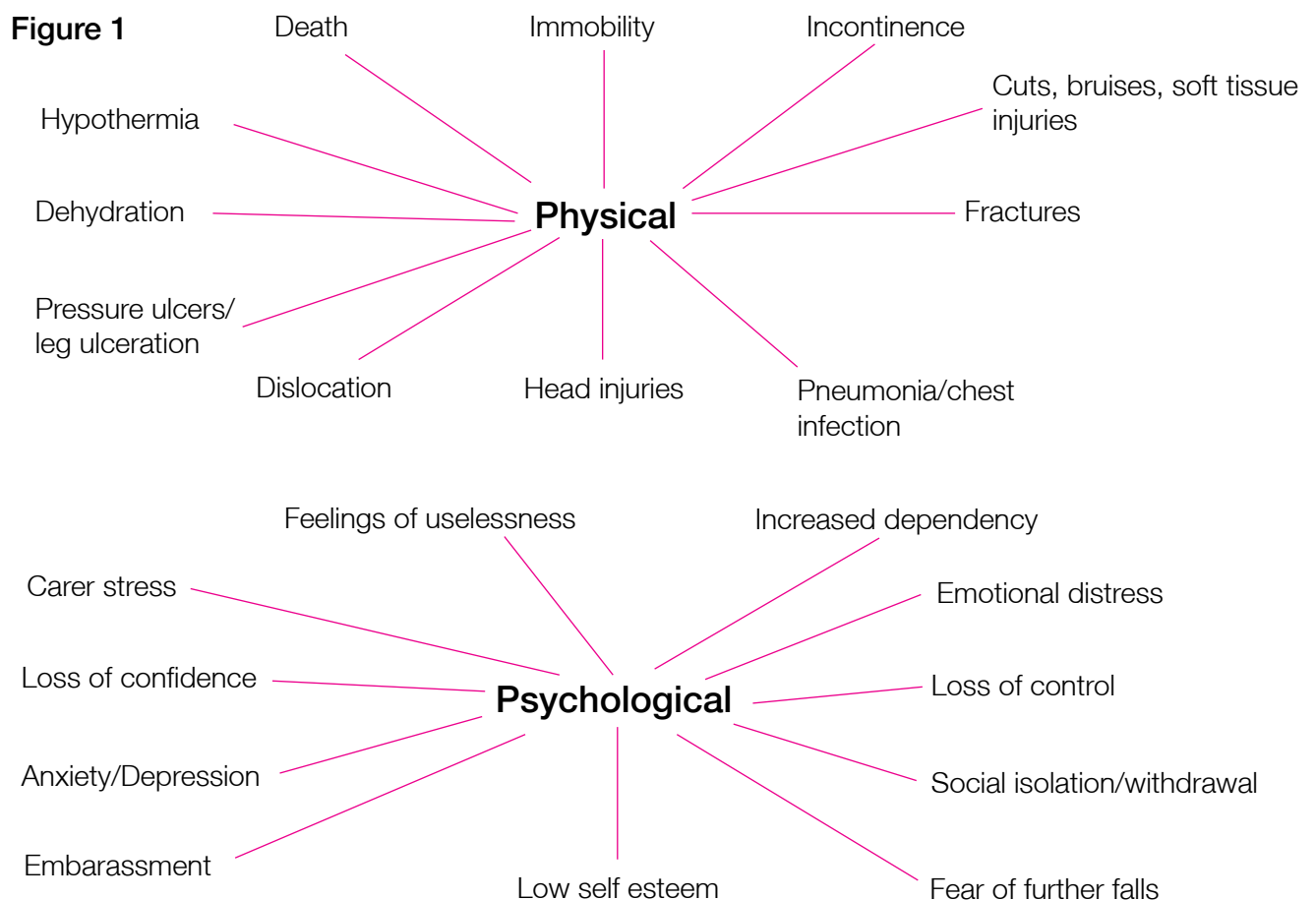


Figure 1: Physical and psychological consequences of falls and/or prolonged length of time lying on the floor, adapted from the Perth and Kinross Resource Manual for Care Homes.

Fear of falling

It is common for an older person who has fallen to become fearful of falling again. Those who are fearful about falls often avoid physical activity, become weaker, and may fall more as a result. Take fear of falling seriously and request advice from a health professional with knowledge of fear of falling, when required.

Many falls are preventable

As we get older, we often accept that falls are unavoidable, however this is not the case; most people over 65 do not fall each year. Falls are not an inevitable part of ageing, but may be the first sign of an underlying health problem. A fall is nearly always due to the presence of one or more 'risk factors'. Recognising then, where possible, removing or altering an individual's risk factors can often prevent a fall.

The risk of falling can never be completely removed, but by carrying out a falls risk assessment on a resident, (**see section B**) risk factors can be identified and action taken to remove or alter risk where possible. Considering risks within the care home environment is part of this process. There will be cases when an individual remains at high risk of falling despite thorough assessment and management. In these instances, the service can try to reduce the risk of harm from falls by using suitable equipment and alarm systems, and ensure residents take osteoporosis medications as prescribed.

The emphasis should be on anticipating and preventing problems rather than simply managing problems once they have occurred.

Risk factors for falling

Often an older person will have a combination of risk factors; the more risk factors present, the greater the risk of falling. Risk can relate to the individual and/or their surrounding environment.

Risks relating to the **individual** include:

- previous falls
- ageing - causing changes in the body
- certain medical conditions
- being less physically active
- side-effects of medications or a combination of many and/or excessive alcohol.

The above can result in many changes in an individual, including:

- weak muscles, unsteadiness and/or difficult walking and moving around
- slowed reactions
- foot problems
- numbness in the ankles and feet
- vision and hearing problems
- dizziness or blackouts
- continence problems
- fear of falling

- pain
- cognitive problems, such as memory loss, lack of awareness of safety, not knowing their own limits and risk, impulsive behaviour, confusion (acute or chronic) and reduced understanding.

Risks relating to the surrounding **environment** include:

- poor lighting, especially on stairs
- low temperature
- wet, slippery or uneven floor surfaces
- clutter
- chairs, toilets or beds being too high, low or unstable
- inappropriate or unsafe walking aids
- inadequately maintained wheelchairs, for example, brakes not locking
- improper use of wheelchairs, for example, failing to clear foot plates
- unsafe or absent equipment, such as handrails
- loose-fitting footwear and clothing.

A number of residents within a care home will need assistance with walking and other day-to-day activities, such as washing, dressing, getting in and out of a chair or bed and using the toilet. Therefore, staffing levels, staff work patterns and the staff's knowledge and awareness of falls prevention can affect the risk of falls in a care home.

Specific conditions can increase risk of falling

As well as the risk factors listed above, a number of acute or temporary medical conditions can increase the risk of falling. This is due to the effect of the condition on a resident's physical and mental function.

Conditions include:

- constipation
- acute infection including a urinary tract infection, chest infection or pneumonia
- dehydration
- delirium (sudden severe confusion and rapid changes in brain function that occur with physical or mental illness.)

Care home staff should know that there is increased risk if one or more of these conditions are present. In addition, staff should consider these conditions when trying to find the underlying cause of a resident's fall.

Dizziness, blackouts and palpitations

In some cases dizziness, blackouts or palpitations may occur before a fall. Always ask the resident if they had any of these symptoms before they fell. Sometimes a resident will not remember a blackout. If possible, speak to someone who witnessed the fall.

Orthostatic Hypotension (OH) also known as postural hypotension is a drop in blood pressure that causes an inadequate supply of blood to the brain, which results in dizziness and blackouts.

The fall in blood pressure may occur quickly and may happen at any time, for example, after getting up from either a lying or sitting position. Promptly going into a lying position relieves symptoms in most cases.

Staff should always report palpitations, dizziness and blackouts experienced by residents to their GP.

Resource:

Tool 1: Protocol for measuring lying/standing blood pressure (BP) (checking for OH)

Falls, broken bones and osteoporosis

A broken bone (also called a fracture) is one of the more serious results of a fall. A hip fracture caused by a fall can lead to considerable suffering for an older person, loss of the ability to get about on their own and greater dependence on others to carry out day-to-day activities. Shockingly, 20% of older people who have a hip fracture die within six months⁵.

Osteoporosis, or thinning of the bones, is a very common condition in older people. It occurs when there is a gradual loss of 'density' of the bones; the struts that make up the mesh-like structure within bones become thin. The loss of bone density means a person with osteoporosis is more likely to break a bone if they fall. For this reason, you need to consider falls prevention and the diagnosis and management of osteoporosis together.

Osteoporosis is very common. In the UK, one in two women and one in five men over the age of 50 will break a bone, mainly because of osteoporosis⁶. Most of these breaks are described as 'fragility fractures', which is a fracture occurring from a fall from standing height or less. Often a broken bone is the first sign that a person has osteoporosis. Other common signs include an outward curve of the spine (kyphosis), loss of height and sometimes back pain.

Who is at risk of osteoporosis?

Women are at greater risk of osteoporosis than men. This is because their bones are usually smaller, but also because levels of the hormone oestrogen reduce following menopause. The female hormone oestrogen has a protective effect on bones. Other factors that may increase the risk of osteoporosis are:

- Being elderly
- Previous fractures
- A history of osteoporosis in the family (genes)
- Thin body type and a body mass index of less than 19
- Lack of physical activity
- Smoking
- High intake of alcohol
- Some medical conditions:
 - Rheumatoid arthritis
 - Diabetes
 - Low levels of the sex hormone oestrogen in women because of early menopause, having a hysterectomy with ovaries removed (before the age of 45)
 - Low levels of the sex hormone, testosterone in men, following surgery for some cancers
 - Hyperthyroidism when levels of thyroid hormone are abnormally high
 - Parathyroid disease when levels of parathyroid hormone are abnormally high
 - Conditions that affect the absorption of food such as Crohns or coeliac disease
 - Conditions that cause long periods of immobility.
- Some medicines:
 - Taking corticosteroid tablets for other medical conditions for over three months
 - Anti epileptic drugs
 - Breast cancer treatments such as aromatase inhibitors
 - Prostate cancer drugs that affect either the production of the male hormone testosterone or the way it works in the body.

Information from 'An introduction to osteoporosis'. The Nation Osteoporosis Society (2010).

How is osteoporosis diagnosed?

The most accurate and reliable test for diagnosing osteoporosis is a bone density scan, called a Dual Energy X-ray Absorptiometry (DXA) scan. A bone density scan is recommended for people with a high risk of osteoporosis. In some cases, a scan may not be required. A doctor or osteoporosis nurse specialist can advise.

There are tools available to help find out if a person is at high risk of breaking a bone. One of the tools in use is FRAX⁷. FRAX uses a number of risk factors to calculate the likelihood of breaking a bone in the next ten years. To find out if the use of this tool is encouraged in your area, speak to your local GP or osteoporosis nurse specialist where available.

How is osteoporosis treated?

Medication for osteoporosis can help slow down bone loss and/or rebuild bone. It has been shown that some medications can reduce the risk of having a fracture considerably. For this reason, it is important to know if a resident has osteoporosis and what medication they should take. People with osteoporosis are usually prescribed calcium and vitamin D supplements as well as other medication for osteoporosis (**see section E**).

For those who do not have osteoporosis, keeping active, safe exposure to natural sunlight and taking a healthy balanced diet can help stop the bones weakening. Calcium and vitamin D supplements (as prescribed by a doctor) and regular exercise can also help.

Resource:

The FRAX tool can be found at www.shef.ac.uk/FRAX/
National Osteoporosis Society has more information about osteoporosis prevention and management
www.nos.org.uk

Falls in care homes

In 2006, Help the Aged published a booklet called 'Preventing Falls. Managing risk and effect of falls among older people in care homes'⁸. It identified the following reasons why falls in care homes are costly.

- Older people living in care homes are three times more likely to fall than older people living in the community.
- 25% of older people who fall in care homes suffer serious injuries.
- 40% of hospital admissions from care homes follow a fall.
- Litigation may suggest a breach of the duty of care.
- Complaints about falls create negative publicity.
- Emergency action after a fall diverts staff from planned care.
- Care to relieve injuries and anxiety from a fall increases workloads.

Falls and injuries from falls, including hip fractures, are more common in care homes because:

- residents of care homes are more likely to be physically frail
- residents may be physically inactive, resulting in weak muscles and poor balance
- many residents have long term medical conditions which can increase their risk of falling such as stroke, Parkinson's disease, arthritis, depression and dementia
- residents may be taking a number of medications
- newer residents are unfamiliar with their new surroundings.

Falls and dementia

Individuals with a level of cognitive impairment with or without the diagnosis of dementia are an increasingly large group of people within care homes. Due to the loss of a person's cognitive abilities, there can be an increased risk of falls. People with dementia experience changes to their physical, mental and emotional functioning that affects how they cope with day to day activities, relate to others and how they communicate. Confusion, disorientation, memory loss, restlessness, agitation, behaviour that challenges and lack of judgment and insight can contribute to their falls risk. Some individuals may require re-orientation regularly to their surroundings and may require visual cues to reduce their risk of falling, for example, pictures on doors to identify toilets or bedrooms. The physical environment generally can have a huge impact such as lighting, floor coverings and safe outside spaces. It is important to apply the same good practice in falls prevention and management as for older people in general. It is also essential that family and friends are involved in this process to help reinforce the principles.

Resource:

More information about dementia can be found at The Dementia Services Development Centre, Stirling
<http://dementia.stir.ac.uk/>

**It does change practice
and involves the
whole team.**

Care home manager

Using the good practice self assessment

What is the purpose of the self assessment?

The self assessment enables you to compare the working practices in the care home with what is considered good practice (determined by research and experts in falls prevention and management).

This will help you to:

- recognise quality care you are already giving the residents in the care home, which will reduce their risk of falling and harm caused by falling
- consider new ways of working, which both staff and residents will benefit from.

The National Care Standards principles are – dignity, privacy, choice, safety, realising potential and equality and diversity, and should be the underpinning values applied at all times when using the self assessment document.

Who should complete the self assessment?

The manager of your care home or a senior member of staff should complete the self assessment. If possible, complete the self assessment with a colleague, you can then decide together whether a measure is fully in place.

How do I use the self assessment?

Step 1: Complete the questionnaire

Each statement in the self assessment describes good practice you and your colleagues can introduce to help reduce the risk of falls and harm caused by falls. The statements listed in the self assessment are all important and achievable.

Work through the statements in the self assessment and consider whether this practice happens in the care home. In the first box write 'yes' if it does or 'no' if it does not. If it is partially in place, or you are planning to introduce the practice, mark it as 'no' until it is fully in place.

For question D4, respond yes or no to **each** part of the statement.

Sign and date the self assessment and ask your colleague to countersign.

It simplified the whole falls management process for staff

Care home manager

Step 2: Write an action plan to address a 'No'

Once you have completed the self assessment, list all identified gaps in good practice (for example, where a 'no' response is recorded) on the summary action plan (**see tool 21a**). Please do not be discouraged if you find you have a lot of 'no' responses. Following discussions with colleagues, and perhaps the wider multidisciplinary team, you can decide the order in which you will address these gaps or 'improvement areas' over a realistic time frame. Indicate this order on the summary action plan. Ensure all improvement areas have an approximate date for when they will be addressed (even if this is a few months away). A 100% score is achievable, but you may need a step-by-step action plan.

Starting with your immediate priorities, complete a separate action plan for each improvement area (**see tool 21b**), recording the date when you plan to have completed the actions.

Guidance, information, resources and things to consider for each statement in the self assessment provided later in the pack should help decide your actions. The section letter followed by the statement number, for example A1, in the resources section, refers to each self assessment statement.

Step 3: Review the action plan regularly and keep it updated as work progresses.

How often should I review or repeat the self assessment?

You should carry out the self assessment annually; however, in some circumstances you may want to repeat it sooner, if for example, you have had an increased number of falls in the care home.

Resource:

Tool 21a: Falls prevention and management - Summary action plan

Tool 21b: Falls prevention action plan and example

Using the tools

There are a number of tools included in this resource. They can be used to help you to improve the management of falls in your care home. We would not expect you to use all the tools unless you see it necessary. You can download the tools and use them freely.

How do I select which tools to use?

The tools are all linked to the statements in the self assessment. Once you have completed the self assessment and identified any gaps, this may direct you to the tools that would be appropriate and helpful.

A tool in the pack may be similar to one that you use in your care home already. It may be useful to compare the two. As a result you may continue to use your existing tool or change to the new tool.

Self assessment form

		Date assessed	Date reviewed
A. Supporting documentation			
1	There is written guidance on falls prevention/reduction, which includes reference to the involvement of local services with individual residents.		
2	There is written guidance on the safe and appropriate use of equipment to prevent falls and injuries such as bedrails, lap straps, harnesses, specialist seating and hip protectors.		
3	There is written guidance on the use of low-profiling beds.		
4	There is written guidance on the use of assistive technology and alarms.		
5	There is written guidance on how to record, report and monitor falls.		
6	There is written guidance on immediate essential care when a resident has fallen or has been found on the floor.		
7	There is written guidance on further actions to be taken after a resident has fallen.		
8	There is written guidance on medication reviews.		
9	There is written guidance on sight and hearing tests.		
10	There is written guidance on diet, food and water intake.		
11	There is written guidance on pre-admission falls risk assessment (including bone health).		
B. Falls and fracture risk assessment and care planning			
1	The admission assessment includes a multifactorial falls risk assessment, using an agreed tool or proforma.		
2	The multifactorial falls risk assessment includes an osteoporosis risk screen.		
3	The multifactorial falls risk assessment has a linked care plan, tailored to the individual resident, which links any risks identified with suitable actions (for inclusion in the care plan).		
4	The multifactorial falls risk assessment and care plan are updated monthly and reviewed formally on a regular basis (for example, every six months or according to local policy).		
5	The multifactorial falls risk assessment and care plan are updated after every fall.		
6	The multifactorial falls risk assessment and care plan are updated after any significant change in a resident's condition.		
7	The multifactorial falls risk assessment and care plan are updated on re-admission to the care home following discharge from another setting, for example discharge from hospital.		

C. Actions triggered by a fall			
1	Following a fall, the possible reasons for the fall are reviewed.		
2	Following a fall, the multifactorial falls risk assessment is updated and care plan is revised as indicated by the assessment.		
3	Following a fall, there is an environmental check of the site of the fall.		
D. Recording and reporting falls: gathering and analysing information			
1	There is a written definition of a fall for the purposes of reporting.		
2	There is a system in place and used routinely to record resident falls (falls diary or database).		
3	There is a system in place and used routinely to report resident falls (incident/accident form or database).		
4	<p>The report of a fall includes:</p> <ul style="list-style-type: none"> • time and place of the fall • a description of the fall, including the activity at the time of the fall • possible causes • cognitive assessment • any injury/injuries suffered at time of fall • if a doctor or ambulance was called • if the resident attended A&E • if the resident was admitted to hospital • if the next of kin has been informed • what has been learned from the fall • what actions have been triggered by the fall, for example, changes in procedures and/or policies. 		
5	There is a mechanism for identifying recurrent fallers.		
6	There is a system in place and used routinely to analyse resident falls (in order to establish causes and guide management).		
7	The care home routinely reviews the overall pattern and trends for resident falls to inform revisions in policy, protocols and procedures and/or staff training on falls.		
E. Falls and fracture prevention actions			
1	Residents have opportunities for suitable exercise (either in a group or on a 1:1 basis; in the care home or outside locally), which includes strengthening exercises.		
2	Vitamin D and calcium are provided for residents with increased risk of falls and/or suspected/confirmed vitamin D deficiency (unless unsuitable for medical reasons).		
3	Medication for osteoporosis is administered as prescribed, using correct protocols to ensure maximum benefits and prevention of side-effects where possible.		

4	Environmental checks/audits are carried out and documented on a regular basis, for example, monthly, or according to local policy.		
5	Walking aids are checked for wear and tear on a regular basis, for example, monthly, or according to local policy, and this is documented.		
6	Wheelchairs are checked for wear and tear on a regular basis, for example monthly, or according to local policy, and this is documented.		
7	Resident foot health and footwear assessments are carried out on a regular basis, for example, monthly, or according to local policy, and this is documented.		
8	Risk of falls and falls prevention is discussed with the resident and the resident's family.		
9	There is a system in place and used routinely to provide information about a resident's falls risk and linked plan of care when a resident is transferred from the care home to hospital or another care setting.		
10	There is a system in place and used routinely to receive information about a resident's falls risk and linked plan of care when a resident is discharged from hospital back to the care home.		

F. Service provision to the care home

1	There is written information on local services, which may be involved in falls and fracture prevention and management, and how to access them (for example direct referral or through the GP).		
2	Residents have regular (at least annual) medication reviews by a GP or pharmacist, which considers falls and bone health.		

G. Education and training

1	Falls prevention and bone health awareness is included in staff induction training. (The self assessment resource pack may form part of the induction.)		
2	Identified members of staff (for example falls champion or link) receive regular training (at least annually, or according to local policy) on falls and bone health.		
3	The organisation supports all staff to access regular falls and bone health awareness training (at least annually, or according to local policy) to enable staff to feel confident and competent in promoting falls prevention and management in their role.		

Develop an action plan to address any gaps identified (see tool 22a/22b).

Assessment:

Signed:

Designation:

Date:

Review:

Signed:

Designation:

Date:

Section A – supporting documentation

This section outlines good practice relating to supporting documentation. Supporting documentation includes policies, protocols and other written guidance. It is important to give care home staff guidance in aspects of falls prevention and management and the prevention of fractures. You can use the information to help address any gaps identified from the self assessment.

Introduction

Supporting documentation includes existing policies, guidelines and any additional written guidance that may be required to support the best practice statements in this section.

Most organisations will already have policies in place that will address the best practice statements in this section, for example moving and assisting, nutrition, use of restraint, care and support and health and safety. We suggest care homes review existing supporting documentation where possible and identify and cross reference information relevant to A1-11 in the self assessment, where appropriate. Section A of the self assessment also acts as a prompt to review and update documentation.

A1 There is written guidance on falls prevention/reduction, which includes reference to the involvement of local services with individual residents.

The aim of having specific guidance on falls prevention/reduction is to:

- support staff to comply with best practice in falls prevention and management and the prevention of fractures
- identify individual residents at risk of falling in a care home and implement a care plan to address the risk
- reduce the risk of residents falling in a care home
- reduce the risk of serious injury as a consequence of falling
- promote greater communication between staff and the multidisciplinary team members in relation to falls
- involve the resident and family whenever possible in falls risk reduction, and
- increase awareness of falls risk among staff, residents and relatives by educational and other means.

Resource:

NHS Greater Glasgow and Clyde Policy and Guidelines for the Prevention and Management of Adult In-patient Falls

To get a copy of this document email gg.fallsadmin@nhs.net

Multifactorial falls risk assessment and care planning will identify individual resident's risks and actions to help reduce risks. However, here are some basic safety precautions appropriate for all residents.

- Ensure the resident can reach a call bell.
- Check the resident has the manual dexterity and cognitive ability to operate the call bell.
- Explain the importance of getting help.
- Ensure the resident's chair is suitable (see guidelines on selecting suitable seating).
- Discuss the resident's walking ability with them and agree when assistance is required.
- Ensure the resident's walking aid (if used) is within reach.
- Ensure the bed is at a level to suit the resident.
- Assess that the resident's environment is free of hazards.
- Ensure personal effects regularly used are within easy reach.
- Check footwear and clothing fit properly and do not create a risk.
- Do not leave residents with cognitive impairment unattended on commodes, in toilets, baths or showers.
- Do not leave residents with poor mobility, who you know do not ask for assistance, unattended on commodes, toilets, baths or showers.

Adapted from: NHS GGC Policy and Guidelines for the Prevention and Management of Adult In-patient Falls.

A2 There is written guidance on the safe and appropriate use of equipment to prevent falls and injuries, such as bedrails, lap straps, harnesses, specialist seating and hip protectors.

Residents in care homes may be at risk of falling from beds and/or chairs. This may be for many reasons including poor mobility, dementia or delirium, visual impairment or side effects of medications. There are pieces of equipment available that can reduce this risk in certain circumstances. Guidance will help residents, staff and family to make individual decisions about using equipment to prevent falls and harm from falls.

Considerations for the guidance on the use of bed rails

Bed rails are also known as: side rails, bedside rails, cot sides and safety sides.

There are two types of rigid bedrails:

- integral - these are incorporated into the bed design and supplied with/or offered as an optional accessory by the bed manufacturer, to be fitted later.
- third party - these are not specific to any particular bed model. You can attach or detach when needed. They fit a wide variety of metal framed beds from different suppliers.

Resident's ability to remain safely in the centre of the bed can be affected by stroke, paralysis, epilepsy, muscle spasms, or other conditions. This puts them at risk of falling from bed.

Bedrails reduce the risk of residents accidentally slipping, sliding, falling or rolling out of bed. They will not prevent a resident leaving their bed and falling elsewhere and should not be used for this purpose. In addition, bedrails are not for residents to manoeuvre themselves, for example, sitting forwards in a bed or rolling over.

We recommend you do not use bedrails:

- if a resident is agile and confused enough to climb over them.
- if a resident would be mobile if the bedrails were not in place.

Decisions about bedrails are a balance between competing risks. The risks for individual residents can be complex and relate to their physical and mental health needs, the environment, their personality and their lifestyle. Staff should use their professional judgement to consider the risks and benefits for individual residents. We recommend you review risk assessments after each significant change in a resident's situation, for example, if a resident attempts to climb over the bedrail or out of the bottom of the bed – remove bedrails. As a minimum requirement, you should review the use of bed rails weekly.

Based on current evidence, it is not appropriate to have either a policy of not using bedrails or one for routinely using them. Best practice is to carry out an assessment of the risks and benefits for each resident, and decide along with the resident and/or their family on the use of bedrails.

At all times, you must respect residents' rights and involve them in all decisions about their care. The resident should decide whether to have bedrails if they have the capacity to do so. Capacity in this context is the ability to understand and weigh up the risks and benefits of bedrails once they are explained to them.

Resources:

MHRA Device Bulletin 2006(06): safe use of bed rails

www.mhra.gov.uk/Publications/Safetyguidance/DeviceBulletins/CON2025348

Device Alert 2007/009: Bed Rails and Grab handles

www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON2025839

NPSA safer practice notice; using bed rails safely and effectively

www.nrls.npsa.nhs.uk/resources/?EntryId45=59815

NPSA bedrails literature review

www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61400&type=full&serviceType=Attachment

NHS Greater Glasgow and Clyde Policy and Guidelines for the Prevention and Management of Adult In-patient Falls. To get a copy of this document email: gg.fallsadmin@nhs.net

Mental Welfare Commission publication:A34426:Consent to treatment:

www.mwscot.org.uk/web/FILES/Publications/MWCCConsenttotreatment.pdf

GMC (2008) Consent: patients and doctors making decisions together

www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

Tool 2: Bedrail risk assessment

Considerations for guidance on specialist seating

Falls can occur when a resident finds it difficult to get up from a chair, sit down safely or when a chair does not provide adequate support.

To decide if a chair is suitable for an individual resident, consider the following:

- The seat should be wide enough to support body mass but not too wide, causing the resident to lean to one side of the chair.
- Seat depth is correct when the resident's bottom is at the back of the chair and their feet are flat on the floor. The resident's knees and ankles should be at 90 degrees. The seat should fully support the resident's thighs but not touch the back of their knees.
- Residents should be able to support their head and neck themselves or the chair back should be high enough to support the head and neck when required.
- Resident's shoulders should not be hunched when their arms are on the armrests.
- The base of the chair should be firm.
- The resident feels comfortable.

Take care when additional pressure relieving cushions are used. Re-check the suitability of the resident's seat with a cushion in place. Do not use pillows.

Consider seeking advice from an occupational therapist if:

- the available standard chairs do not fit the resident according to the above guidelines
- the resident cannot maintain their own posture in the chair
- the resident keeps slipping out of the chair
- the resident is complaining of discomfort.

Considerations for guidance on restraints

The definition of restraint is 'the intentional restriction of a person's voluntary movement or behaviour' (Queensland health 2003)⁹.

Restraints are designed to protect residents from falls and harm. However, the risks associated with restraints may outweigh the benefits. Rather than protecting residents, restraints can place them at risk of physical and psychological harm. Best practice is to perform an assessment of the risks and benefits for each individual resident, and decide along with the resident and/or family if restraint is appropriate.

When a person is restrained and denied the ability to get up, sit down or walk about freely, their quality of life and psychological wellbeing may be affected. In addition, limiting a

resident's freedom of movement can lead to muscle weakness and reduces physical activity, which in turn increases the risk of falling.

Care homes should have a restraint reduction policy in place that provides step by step guidance related to restraint decisions for their residents.

The policy should address the following.

- What is a mechanical restraint?
- The type of situations when a restraint may be appropriate to be used.
- The risks involved and alternative measures.
- The assessment procedure for using/discontinuing use.
- Involving resident and/or family in any decisions regarding restraint.
- Documentation and monitoring.
- Procedure if resident/relative refuses restraint.

All staff should be aware of the policy and the care home should regularly update it.

Administering medication for behavioural issues including mood, agitation and purposeful walking can itself place residents at increased risk of falls or harmful consequences.

Drugs are considered inappropriate chemical restraints when they are:

- given without specific indications
- prescribed in excessive doses which affects the resident's ability to function
- used as a sole treatment without investigating an alternative non pharmacological or behavioural intervention
- administered for purposes of discipline or convenience to staff.

Alternatives to using restraint

- Additional supervision/observation of activities.
- Involving family members or volunteers.
- Daily physical activity or exercise.
- Structured activity.
- Day to day activities.
- Instruction on safe transferring.
- Appropriate toileting.
- Orientation to environment.
- Obstacle free environment.
- Different seating options.
- Bed and chair alarms.
- Falls detector alarms.
- Accessible call buttons.

It alerted us to other aspects of care we could usefully have tools and guidelines for.

Care home manager

- Moving and handling alternatives for example, lower height bed, mattress on the floor.

Considerations for guidance on hip protectors

Hip protectors are either padded or plastic devices that are fitted into special underwear and usually sit over the top of the thigh bone. Depending on the design of the hip protectors, they aim to either absorb the energy of a fall, or divert the impact of a fall from the bone. Both aim to reduce the risk of a hip fracture.

A Cochrane Collaboration¹⁰ review in 2010 highlighted that early studies, mainly from the early 90's and some since then, have suggested that providing hip protectors to older people in care homes can reduce their risk of breaking their hip in a fall by more than half. However, a number of later studies have not confirmed this finding. Many people offered hip protectors refused to wear them, as they were uncomfortable. Current evidence now suggests that hip protectors for frail older people in care homes 'may' reduce the risk of fractures. The size of any reduction in risk seems to be much less than suggested in earlier studies.

It may be that older people willing to wear hip protectors all the time may benefit. In many cases, the resident or their family will need to pay for hip protectors. The decision to use hip protectors must always be based on an assessment of an individuals' needs, as well as their wishes. At all times you must respect residents' rights and involve them in the decision.

When using hip protectors:

- ensure they fit the resident properly. Check the manufacturers guidance on measurement, positioning and use
- check the hip protectors are comfortable and not harming the skin
- if the resident dresses and uses the toilet independently, check he or she is able to remove the hip protectors and replace them correctly.

A3 There is written guidance on the use of low-profiling beds

Low beds help prevent injuries because they are as low as 14 inches to the ground. If a resident did fall out of bed, injuries would be minimal.

Considerations for guidance

Assess each resident individually to ensure this is the most appropriate method of preventing falls from bed or harm from falls. The assessment should include:

- physical stature
- psychological illness or distress
- discomfort or pain

- disabilities/capabilities
- resident's wishes
- previous accidents/injuries
- any variation in status over 24 hour period for example, nocturnal confusion.

A4 There is written guidance on the use of assistive technology and alarms.

See section E

A5 There is written guidance on how to record, report and monitor falls.

See section C

A6 There is written guidance on immediate essential care when a resident has fallen or has been found on the floor.

Immediately following a fall, safe moving and handling and prompt appropriate care and attention can be critical to a resident's chance of making a full recovery. An inappropriate response can delay the diagnosis and treatment of serious injuries. The responses made should be in keeping with an individual's Palliative Care Summary (PCS), Anticipatory Care Plan (ACP) including Verification of Expected Death and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision recording and guidance.

A clear, concise and easy to follow protocol should be readily accessible to all staff in a care home including for example housekeeping, maintenance and administrative staff. A laminated version should be put on a wall where all staff can see it.

Considerations for developing a post fall protocol

The development of the protocol should involve care home staff and appropriate members of the wider multidisciplinary team. There may be local variations depending on the skills and competence of the care home staff and the support that can be provided by the wider team in an emergency situation.

The National Patient Safety Agency (NPSA) (see bibliography) and guidance recently developed in a number of care homes suggest the following are important components to be included in a post fall protocol.

When a resident has fallen or has been found on the floor

- Check first for ongoing hazards or dangers
- Check if the resident is responsive
- If responsive, provide reassurance and comfort to the resident who has fallen

- Summon help from other members of staff.
- If unresponsive, check the resident's airways, breathing and circulation (see section on unconscious and unresponsive).
- Do not move the resident before checking for pain, loss of sensation (feeling), loss of movement in arms and/or legs, and observe for swelling, visible injury and deformity. Shortening and outward rotation of the leg can indicate a hip fracture.
- Check for nausea, confusion, drowsiness, delirium and agitation.
- Commence routine observations such as resident's temperature, pulse, BP and respirations as appropriate.
- Call the emergency GP, NHS24 or an ambulance if appropriate.
- If the decision is taken to move an injured resident from the floor, ensure staff have the expertise and equipment to do so safely, and that moving and handling guidelines are followed.
- Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.

If unconscious or unresponsive

The response should be in keeping with the recorded DNACPR decision for the individual, their ACP including Verification of Expected Death and care home policy and their PCS:

- undertake Cardio Pulmonary Resuscitation (CPR) if necessary and appropriate
- if appropriate call an ambulance and inform ambulance staff of the ACP or PCS
- commence neurological observations ie Glasgow Coma Scale (GCS)
- record resident's temperature, pulse, BP and respirations:
- complete accident/post falls report form, record in the care plan and inform next of kin as agreed.

NB: Only undertake procedures if trained to do so

If injury or change in health suspected

- If head trauma, spinal damage or lower limb fracture is suspected make the person comfortable on the floor. **DO NOT MOVE THE PERSON**
- If there is a suspected head or spinal injury begin neurological observations ie GCS
- If there is a suspected upper limb fracture, immobilise the limb (if trained and confident to do so) and return the person to bed/chair. If not trained and confident to immobilise the limb make the person comfortable on the floor.
- Ascertain if the resident has a completed ACP or PCS
- According to local agreement call emergency GP or NHS 24 (if out of hours) or an ambulance as appropriate and inform emergency staff of the ACP or PCS

- Complete accident/post falls report form, record in the care plan and inform next of kin as agreed
- Continue to follow stage 2 of Tool 8: Pathway for managing a resident who has fallen or who has been found on the floor.

If minor injuries are apparent

- If minor injuries are apparent such as bruises, cuts or abrasions provide appropriate care, continue routine observations and inform the resident's GP as per care home policy
- Seek advice from GP or NHS 24 (if out of hours) at any point if there are concerns
- Complete accident/post falls report form, record in the care plan and inform next of kin as agreed
- Continue to follow stage 2 of Tool 8: Pathway for managing a resident who has fallen or who has been found on the floor.

If no injury or change in health suspected

- If no apparent injury and no signs of a change in health, assist the resident to the bed or chair via a safe means according to moving and handling guidelines. If the resident can get off the floor independently allow them to do so.
- Continue to monitor for symptoms of nausea, atypical confusion, drowsiness, delirium, agitation and pain through a proportionate schedule of observation. This observation may require to be more intensive for those who are at a higher risk of bleeding such as people taking warfarin or residents with cognitive impairment or communication difficulties. Continue to observe residents where head injury cannot be excluded (for example, following an unwitnessed fall).
- Perform and record appropriate measurements: for example pulse, blood pressure, temperature, respiratory rate and blood glucose.
- Some injuries may not be apparent at the time of the fall therefore continue to monitor the resident regularly. Observe for changes in mobility or difficulty taking weight through the legs.
- Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.
- Continue to follow stage 2 of Tool 8: Pathway for managing a resident who has fallen or who has been found on the floor.

NB: Only undertake procedures if trained to do so

Throughout all stages of the process explain to the resident what is being done and why.

New staff should be made aware of the protocol at induction and existing staff should update their knowledge annually.

A7 There is written guidance on further actions to be taken after a resident has fallen.

See section D

A8 There is written guidance on medication reviews.

Considerations for guidance

Certain medications can contribute to the risk of falls.

Thorough assessment, taking into consideration the residents fall history and skillful medication management by a GP and/or pharmacist may help reduce risk. Regular medication reviews by a GP or pharmacist provide an opportunity to check that all the medications a resident is taking are necessary and of the correct dose.

It may be useful to establish how often local GPs and/or pharmacists carry out routine medication reviews. In between these routine reviews, if you see any of the unwanted effects, it is useful to check the 'Patient information leaflet', supplied with the medication, to find out whether or not the effect is likely to occur. Further advice is available from your local GP or pharmacist.

Further information about medication can be found in F2.

A9 There is written guidance on sight and hearing tests.

Considerations for guidance

Eyesight

Visual problems can contribute to a resident's risk of falling. Visual problems increasing falls risk include:

- slower adjustment to environmental light changes
- a restriction of visual field leading to an inability to see some objects
- loss of visual acuity and contrast sensitivity, which can make perception of objects in the environment more difficult.
- Problems with balance.

Visual problems are also common following a stroke. Further information is available in the Stroke Association factsheet 'Visual problems after stroke'. You can find this at

www.stroke.org.uk/information/our_publications/factsheets/visual_problems.html

Some people with dementia experience problems with vision. Some suffer from double vision and difficulty with depth perception and judging distances from objects. More information is available at www.alzscot.org

It is important to ensure that resident's eyesight is at its optimum by ensuring:

- regular eye tests take place, preferably once a year
- separate glasses for distance and reading are worn as they are safer than bifocals or varifocals
- the older person is wearing their own glasses
- glasses are cleaned regularly
- rooms, walkways and stairs are clutter free
- a good overall level of lighting – use 100 watt bulbs if possible. Natural daylight is very important. Ensure windows are kept clean and pull back curtains
- edges of steps or stairs where accidents could happen are highlighted.

Hearing

Hearing problems can contribute to a resident's risk of falling.

Refer a resident to an audiologist if their hearing has not been assessed within 12 months.

If a resident uses a hearing aid, ensure they wear it and it is cleaned regularly and the batteries work.

It may be necessary to communicate using common gestures, cues and instructions.

If a resident is hard of hearing it may be helpful to minimise excess noise when communicating important information.

Resource:

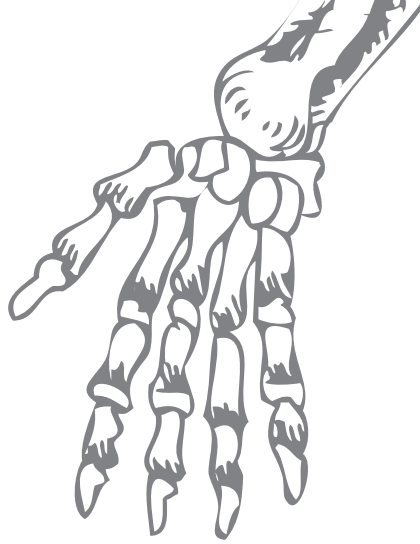
HIS – Maximising communication with older people who have a hearing disability
<http://tinyurl.com/5tqsfqd>

A10 There is written guidance on diet, food and water intake.

Considerations for guidance

Food gives us energy for life and all the things we want to do. If we eat well we are likely to feel healthier and stay active for longer. We also protect ourselves against illness. Eating a balanced diet rich in calcium reduces the risk of falls and fractures.

It is also very important to keep hydrated and drink at least six to eight cups of liquid every day. These should include water, fruit juice, milk, tea and coffee.



Resources:

Adult care home model food, fluid and nutrition -

<http://tinyurl.com/643fz4s>

Food Standards Agency, Eat well, be well -

www.eatwell.gov.uk/agesandstages/olderpeople/

Caroline Walker Trust, Improving public health through good food

www.cwt.org.uk/

UK Water – water for health -

www.water.org.uk/home/water-for-health/medical-facts/adults

UK Water, hydration best practice toolkit for care homes

<http://tinyurl.com/68d3uxz>

A11 There is written guidance on pre-admission falls risk assessment (including bone health).

Considerations for guidance

Staff in a care home should make themselves aware of the pre admission falls and bone health status of all residents to ensure that an appropriate care plan and falls management can be put in place.

Pre-admission assessment should include:

- past history of falls
- past history of fractures
- current strategies for managing risk of falls
- osteoporosis risk
- current management of osteoporosis, including medication
- mobility aids /specialist equipment to be in place prior to admission, such as a raised toilet seat, a low-profiling bed and appropriate seating.

Resource:

Tool 3 Falls Questionnaire



Section B - Falls and fracture risk assessment and care planning

This section outlines good practice relating to falls and fracture risk assessment and care planning. It provides two examples of multifactorial risk assessments, which include suggested actions for the care plan.

Introduction

There are general measures you can take to reduce risk of falling and harm from falls for all residents of a care home. However, you must also consider each resident's individual risk.

Assessing a resident's risk of falls and fractures followed by personalised care planning to manage risk, is key to fall and fracture prevention and management in a care home. It also contributes to residents' well being and quality of life.

There is evidence that residents are particularly at risk from falls and fractures in the first few months after admission to a care home. This is likely to be due to the change of environment and/or a period of ill health prior to admission. It is therefore essential that you assess residents for their risk of falling and put care plan into practice to manage risk as soon as possible.

How to assess a resident's risk of falling

A fall is nearly always due to the presence of one or more risk factors. Recognising then removing or altering an individual's risk factors can often prevent a fall. Often an older person will be exposed to a combination of risk factors for falling; the more risk factors present, the greater the risk of falling. Risk factors can relate to the individual and/or their surrounding environment.

Risks relating to the individual (also called 'intrinsic' factors) include:

- previous falls
- fear of falling
- changes in the body caused by the ageing process
- certain long term medical conditions present
- being less physically active
- side effects of some medications.

Risks relating to the surrounding environment (also called 'extrinsic' factors) include:

- poor lighting
- wet, slippery or uneven floor surfaces
- clutter
- chairs or beds being too high or low

The ideas for actions on the multifactorial falls risk assessment Tool 5 are really helpful.

Care home staff member

- unsafe or absent handrails
- loose-fitting footwear and clothing.

A number of residents within a care home will need assistance with walking and other day-to-day activities, such as washing, dressing, getting in and out of a chair or bed and using the toilet. For this reason risk of falls in a care home can also be affected by staffing levels, staff work patterns and the staff's knowledge and awareness of falls prevention.

A multifactorial falls risk assessment will consider all of these risks when you assess the individual. In addition, it will consider the resident's bone health. If there is weakness of the bones present, such as osteoporosis, the resident is more likely to break a bone if they fall. For this reason, you need to consider falls and bone health/osteoporosis together.

The resident's journey

In terms of falls risk assessment, care planning and risk management, there are a number of key points in a resident's journey of care.

Key points include:

- pre-admission to the care home
- admission to the care home
- at any point when a resident's needs change, for example, during or following illness
- after a fall
- after a change in medication
- on transfer from another care setting, such as on discharge from hospital
- at the routine review as per local policy, minimum six month review.

Pre-admission to the care home

Prior to admission to the care home, it is important to establish the following.

- Past history of falls.
- Past history of fractures.
- Current strategies for managing risk of falls.
- Osteoporosis risk.
- Current management of osteoporosis, including medication.
- Mobility aids/specialist equipment to be in place prior to admission, such as a raised toilet seat, a low-profiling bed and appropriate seating.

Admission to the care home

On admission to the care home, it is important to:

- orientate the new resident fully to their new environment and unfamiliar surroundings
- identify and address any environmental risk

- carry out a multifactorial falls risk assessment, which includes a bone health assessment
- carry out an assessment that identifies behavioural and psychological issues relating to falls risk
- devise a care plan to manage any risks identified in the assessment.

Management should ensure all staff involved in the resident's care are aware of the new resident's falls risk, mobility status and any prevention strategies.

For further information on maintaining a safe environment, go to page 48.

Resources:

Tool 4: Resident environment and orientation check

B1 The admission assessment includes a multifactorial falls risk assessment, using an agreed tool or proforma.

Carry out a multifactorial falls risk assessment for everyone new to the care setting within 24 hours of admission. Use the information from the assessment to complete the care plan. A comprehensive multifactorial falls risk assessment aims to identify all key falls risk factors a resident may be exposed to. For further information on risk factors go to **Tools 5 and 6**.

There are some tools and proformas that suggest actions you can take to address identified risks. You must consider which actions are appropriate in relation to each resident. No tool totally removes the need for common sense and judgement.

B2, 3 The multifactorial falls risk assessment includes an osteoporosis risk screen.

A multifactorial falls risk assessment must include an assessment of the resident's bone health. This is because a fall is more likely to result in a fracture if a resident has bone health problems, such as osteoporosis.

The bone health assessment aims to answer the following questions.

- Has the resident been diagnosed with osteoporosis?
- If osteoporosis has been diagnosed, what medication is prescribed and is it being taken regularly and correctly?
- Are there any other treatments recommended, such as a calcium-rich diet or hip protectors?
- If osteoporosis has not been diagnosed, is the resident at risk of osteoporosis?
- Should the resident be referred to their GP for further assessment and/or treatment?

For further information on risk factors for osteoporosis, visit the National Osteoporosis Society website at www.nos.org.uk

Resources:

Examples of multifactorial falls risk assessment and management tools

Tool 5: Multifactorial falls risk assessment and management tool

Tool 6: Care home resident falls and fracture risk/interventions tool

Please note, Fife Managed Care Network for Falls and Bone Health have developed a falls and bone health checklist and care plan, which all care homes in Fife are encouraged to use. To get a copy of this email: fife-uhb.fbhfmcn@nhs.net

All examples include an osteoporosis risk screen.

A word of caution about using falls risk 'scores'

Falls risk scores are paper-based tools that give a numerical value to various risk factors. A resident's scores are added together to predict whether he or she is at high, medium or low risk of falling. Examples include the Canard (or FRASE), Stratify and Morse. If a tool like this is used, consider the following.

- Falls risk scores, also called risk assessment tools, do not consider all the important risk factors.
- There is no tool to predict risk of falling accurately or consistently; it may under or over predict falls risk.
- Having a total score does not itself lead to interventions. For example, a resident can have a 'low risk' score of falls because he or she has only one or two risk factors present. As the score was low, the tool indicates no action is required. However, in reality, taking action to address any risk identified could still contribute to a reduction in risk for that individual.
- Some organisations use falls risk scores to identify who should go on to receive a comprehensive multifactorial falls risk assessment. You can argue that in the care home setting, where the majority of residents will be at risk of falling, every resident should receive a comprehensive multifactorial falls risk assessment, therefore a falls risk score is not necessary.
- If a risk score is used, a further multifactorial risk assessment that identifies risk factors that you can modify is still required. This risk assessment will help to identify all actions you need to take to reduce risk of falls and harm from falls.
- There are some benefits to using a falls risk score, for example, it may raise awareness of the problem of falls, but you must also consider the limitations of these tools.

B4, 5, 6, 7 Falls and fracture risk assessment and care planning

When you have assessed risk, you should complete a personalised care plan to inform all staff of the risks identified and the actions required to reduce risk. The care plan will state

clearly the measures the care home staff and wider multidisciplinary team need to take. Agree the plan with the resident with input from the team and/or the resident's family.

The care plan will focus on enabling and empowering the individual to maintain safe mobility whilst minimising the risk of falling.

Discuss and set achievable goals with the individual, and clearly define the support required to achieve these goals.

The care plan is a working document, which you review and update regularly following assessment; continually identifying and responding to any change in the resident's condition or care needs. The care plan should include a falls diary recording frequency of falls (see **tools 10a** and **10b**) and raising awareness of any factors contributing to a fall.

A care plan can only be effective if you carry out the actions identified in the plan. **Tool 7** is useful to help check if care plans are being 'actioned'.

Resource:
Tool 7: Falls Management checklist

B4, 5, 6, 7 Reassessment, updates and reviews

Repeat and update the multifactorial falls risk assessment as required.

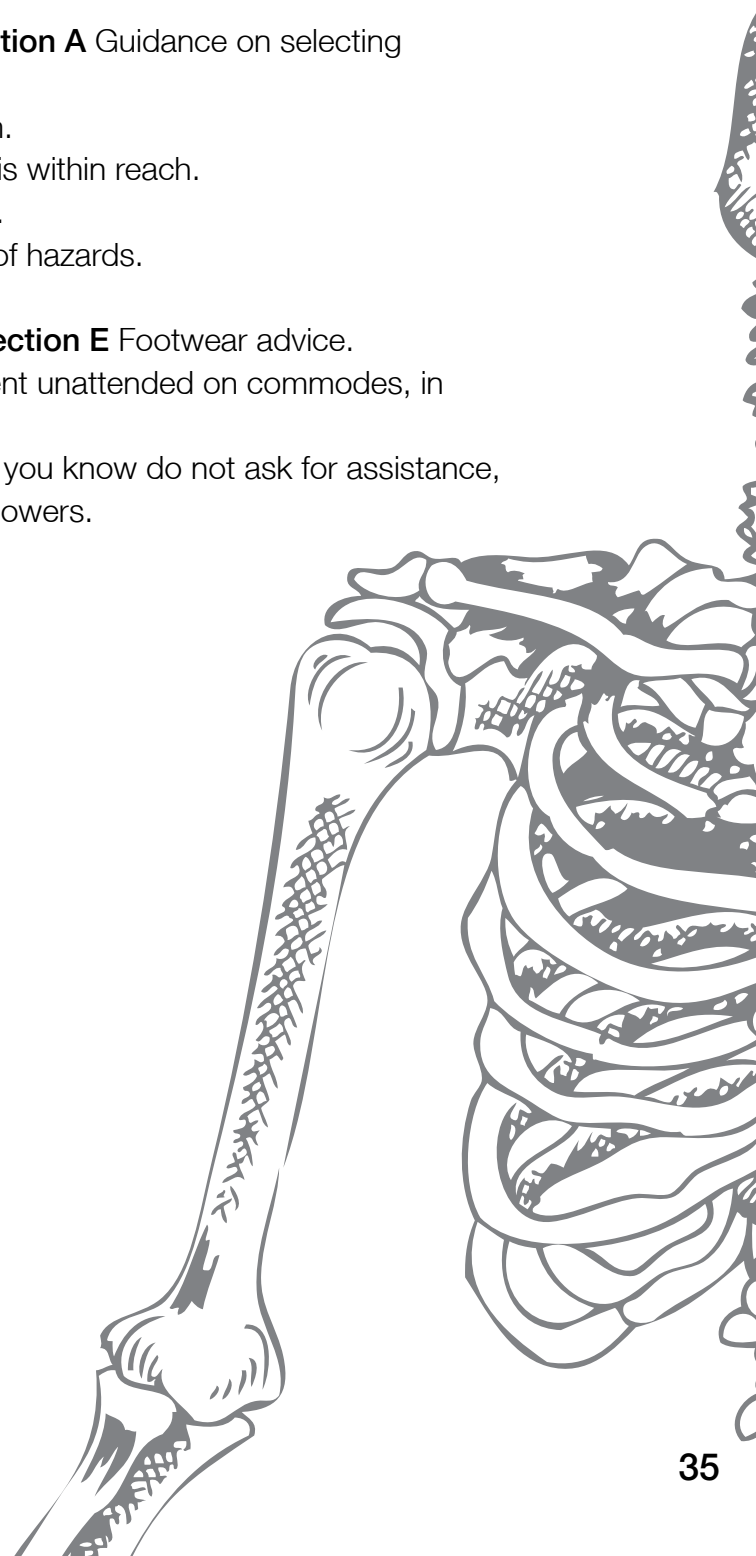
Good practice suggests:

- updating the assessment and care plan every month
- reviewing the falls risk assessment and care plan every six months as a minimum
- that there must be a complete review of both the assessment and care plan:
 - following a fall,
 - when there is a significant change in the person's condition, for example, during/ following illness, and
 - on transfer from another care setting, such as on discharge from hospital.
- completing the falls diary for each fall, the person in charge of care should examine and analyse the information that in the event of a fall, you should complete all relevant documentation including an accident form, Reporting Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) notification as required, and regulatory notification
- that all members of the immediate care team should be aware of, and involved in, the assessment, care planning and evaluation of the individual's risk of falls
- involving appropriate health professionals for example, GPs, nurses, falls clinic, physiotherapist, occupational therapist, and dietician, as required, and follow their advice.

Safety precautions for all residents

Multifactorial falls risk assessment and care planning will identify individual's risks and actions that can reduce risk. However, some basic safety precautions are appropriate for all residents.

- Ensure the resident has a call bell to hand.
- Check the resident has the manual dexterity and cognitive ability to operate a call bell.
- Explain the importance of getting assistance.
- Ensure the resident's chair is suitable: **see section A** Guidance on selecting suitable seating.
- Discuss the resident's walking ability with them.
- Ensure that the resident's walking aid (if used) is within reach.
- Ensure the bed is at a level to suit the resident.
- Assess that the resident's environment is free of hazards.
- Ensure personal effects are within easy reach.
- Check footwear/clothing is not ill fitting: **see section E** Footwear advice.
- Do not leave residents with cognitive impairment unattended on commodes, in toilets, baths or showers.
- Do not leave residents with poor mobility, who you know do not ask for assistance, unattended on commodes, toilets, baths or showers.



Section C - Actions triggered by a fall

This section summarises the actions that should follow a fall and outlines expected outcomes. It also provides a flowchart describing the steps you should take after a fall.

The actions taken after a fall are critical to a resident's well being and future risk of falling.

Tool 8: Pathway for managing a resident who has fallen or who has been found on the floor provides a step by step guide to caring for a resident who has fallen, from finding them to raising family awareness and monitoring.

The process includes:

- assessing for and attending to obvious injury
- asking for additional help as indicated
- safely moving the resident from the floor (where appropriate)
- reporting and comprehensively recording the fall and the consequences of the fall, including completing:
 - an accident/incident report form required by the organisation
 - a post falls report
 - the falls diary/updating the database
- analysing the causes and compiling and implementing an action plan to prevent recurrence
- reviewing the falls multifactorial risk assessment and care plan
- referring to other services as required
- discussion with the resident and the resident's family around the circumstances and consequences of the fall, and the action plan to reduce further risk (including referral to other services).

Refer to section A6 for further information

C1 Following a fall, the possible reasons for the fall are reviewed.

See section D

C2 Following a fall the multifactorial falls risk assessment is updated and care plan is revised as indicated by the assessment.

See section B

C3 Following a fall there is an environmental check of the site of the fall.

Tool 9 – Generic falls environmental risk assessment

Expected outcomes

- Collate and analyse all falls data and use the information to produce an action plan to address identified issues.
- Falls statistics and actions necessary should form part of regular health and safety meetings and procedures.
- Dealing with identified issues will lead to continuous service improvement by ensuring a safer environment for everyone.

Resource:

Tool 8 – Pathway for managing a resident who has fallen or who has been found on the floor

Tool 9 – Generic falls environmental risk assessment

Completing the post fall incident report form helped to fill in the formal accident report form in a more informative way and discuss incidents with staff.

Care home staff member

Section D - Recording and reporting falls: gathering and analysing information

This section outlines good practice in relation to recording and reporting falls and ideas for gathering and analysing information. It provides examples of supporting paperwork, and provides ideas and tools for analysing information.

Introduction

Gathering and analysing information on falls helps to anticipate and prevent falls rather than just manage problems once they have occurred.

D1 There is a written definition of a fall for the purposes of reporting.

To enable consistent reporting and recording of falls, a care home must define and agree what they mean by a fall.

For example, a definition widely used is:

“An unintentional event that results in a person coming to rest on the ground or another lower level, not as a result of a major intrinsic event (such as stroke or epilepsy) or overwhelming hazard (such as being pushed)” (Gibson et al, 1987).

This definition excludes ‘trips’, which do not result in a person coming to rest on the ground because balance is regained successfully.

D2, 3, 4, 5, 6, 7 Systems to record and report resident falls, identify frequent fallers and analyse the information gathered

Care homes should have a system in place to report and record all falls experienced by residents. This allows staff to follow the correct procedure after a fall. It also allows staff to monitor the frequency of falls over time, review the overall pattern and trends for falls and identifies any recurring factors, for example, time of falls or location. There will be an increased awareness of residents who fall frequently; staff can then take appropriate action. This information may also be useful in informing policy and/or reviewing guidelines and when compiling annual reports.

Suggestions for recording falls for analysis

- Complete a Post Fall Incident Report Form.
- Record in a resident’s care plan.

- Record on a central electronic or written database - for example, the care home monthly falls overview report. This can also be adapted to record and monitor an individual's falls history.
- Plot on a measles chart.
- Record on a safety cross.

Resources:

Tool 10a – Guidelines for completing a post fall/incident report form

Tool 10b – Post fall/incident report form

Tool 11a – Care Home Monthly Falls Overview guidance

Tool 11b – Care Home Monthly Falls Overview form

Tool 12 – The Abbreviated Mental Test

Tool 13a – Procedure for the use of measles chart/falls plotting

Tool 13b – Measles chart example

Tool 14a – Guidance on completing the falls safety cross

Tool 14b – Falls Safety Cross

D6, 7 Analysing information gathered on falls

Identifying causes of a fall

It is very important to try to establish all the causes of a fall so that you can take action to reduce the risk of further falls. Some of these may not be immediately apparent however, staff need to clarify the facts:

- **what** exactly happened
- **where** (exact location)
- **when** (day, date and time of day)
- **who** was involved
- **how** did it occur.

The 'post falls incident report' acts as a trigger for staff to consider what aspects might have contributed towards the fall. It is also important however to consider other possible causes and one way to do this is to keep asking the question 'why'. You can do this informally with an individual or as a group. When the member(s) of staff are satisfied that the root cause(s) they identified are valid, devise an action plan to address the cause.

I had a lightbulb moment about the importance of collecting good information – it helped spot patterns and the causes of falls.

Care home staff member

Practice examples

Mr A - involving the service user and family

Mr A was recently admitted to the care home following a hospital admission relating to aspiration (inhalation) of cake on his birthday. Night staff found him at the side of his bed when they heard him calling as they passed his bedroom. He was feeling cold and said he had been on the floor for hours before anyone had heard him. He had no obvious injuries and when asked he said he had got up to go to the toilet and tripped over his bed sheets. He was returned to bed and given a call system buzzer to summon assistance if he needed up again. No further falls occurred that night.

The member of staff recorded the fall the following day through the accident recording system and the circumstances reviewed.

They identified the following issues.

- There was no light on in the room.
- Mr A was unfamiliar with the call system.
- Mr A was unfamiliar with the layout of his room, bedside furniture and location of en-suite toilet.
- Mr A was unfamiliar with the bedding (sheet and duvet).
- Mr A was unsteady on his feet during the day.

Actions taken

- The home met Mr A's daughter to discuss the incident and what action they would take to reduce the risk of a further fall.
- Staff spent time with Mr A to ensure he was familiar with his bedroom layout and moved his bedside furniture to suit him.
- It was agreed that the light in his en-suite bathroom would be left on at night giving a little light into his bedroom.
- The top sheet was removed from his bed.
- His walking stick was left within easy reach when going to bed.
- Staff put a pressure pad by his bed as an interim measure so that staff could monitor his ability to manage independently and respond if necessary. This was later removed with the agreement of him and his daughter.
- His medication and health condition were reviewed, and a referral made to an occupational therapist for any further advice or equipment.
- Mr A's care plan was amended to include the actions agreed.
- A meeting was arranged to review the situation after two weeks.

Mrs B – procedural issue

Mrs B fell from a set of sit-on weighing scales while a member of staff was weighing her. She had tried to push herself back in her seat by pushing her feet against the footrest. This tipped the scales and she fell forward. She was not badly injured.

Actions taken

- The member of staff reported what had happened to her manager.
- They recorded the accident and a memo issued for the attention of all staff using weighing scales.
- They also sent it to other care homes, the organisational safety section, and the manufacturer and distributor of the equipment.
- A safe procedure for using sit-on scales was introduced specifying that care staff need to take care to support residents getting on and off scales and to ensure breaks are on.
- Mrs B's care plan was amended to include the actions taken.

Miss C – environmental issue

Miss C fell in the toilet and called for help, staff found her trying to get up from the floor. She has advanced dementia (Alzheimer's disease). As she had not apparently hurt herself, staff helped her up and took her back to the lounge. They advised her to use the call system to get help rather than try to get off the toilet independently. They recorded the fall in the accident record and recorded the action they took in the individual's risk assessment and care plan.

Later that day she fell again.

Following this fall, another member of staff brought the matter to the attention of a senior member of staff. The second fall had happened in the toilet again. On this occasion, a member of staff had taken the lady to the toilet and waited outside but was called away before the lady was finished.

Actions taken

- The senior member of staff questioned the value of advising the resident to call for assistance.
- She also reviewed the individual's care plan and observed that the lady was in many ways independent in toileting and dressing. She looked for a change in the individual's well-being and environment.
- She also noticed from the measles chart that there had been a number of falls in the toilet over the past few days.

- She observed that the toilet the lady normally used had just been redecorated and was now looking much fresher with lightly patterned pastel wallpaper, nice white porcelain, toilet seat and handrails, and light coloured non-slip polished vinyl.
- During the refurbishment, the lighting was upgraded and the room was much brighter.
- She brought the issue to the manager's attention.
- Mrs B's care plan was amended to include actions taken.

Example case study – Mrs D

Mrs D lives in a care home. She moved into the care home several weeks ago because her family did not think she could manage on her own anymore, as her mobility had decreased over the past year. Mrs D also has impaired vision due to cataracts.

Falls History

The multifactorial falls risk assessment revealed that Mrs D has had several minor falls over the past year. These have not resulted in injury except for one when she went to answer the door and tripped on a rug and badly bruised herself and cut her head. She blamed her failing eyesight for this fall. Since then, Mrs D was frightened to go outside even with supervision. She confined herself to her house and restricted her mobility and activities because of anxiety about falling. Due to this, she was admitted to residential care.

Description of recent fall

Mrs D sometimes has to get up to the toilet during the night. She often does not drink fluids in the evening to avoid this. Recently she has had to pass urine more frequently. Mrs D does not sleep with the light on in her bedroom, but has a bedside light. On the night of the fall, she had to get up quickly at about 2am to go to the toilet. It was dark, but she did not put a light on in her haste to get to the toilet. She rushed into her en-suite and turned hurriedly to sit on the toilet. Mrs D had misjudged the position of the toilet and sat down to the side of it. She was unable to prevent herself from falling and landed heavily on her left hip. She alerted staff by crying for help. Following assessment staff made her comfortable and assisted her in getting back into bed. The following day staff repeated the multifactorial risk assessment and updated her care plan.

Event: Resident fallen and badly bruised her left hip in en-suite of care home.

Why? She misjudged the position of the toilet and fell.

- Why? She was rushing.
- Why? Experiencing urgency due to possible urinary tract infection.
- Why? Was restricting her fluids.
- Why? So she did not have to get up in night.
- Why? Fear of falling after previous falls.
- Why? Impaired vision.
- Why? Cataracts.

Example action plan for Mrs D

Action	Timescale	Person(s) responsible
Referral to GP for assessment and treatment of possible urinary tract infection.	Immediate	Named nurse
Encourage Mrs D to increase her fluids.	Immediate	All care home staff
Place a commode at bedside for night time toileting.	Immediate	All care home staff
Arrange appointment with ophthalmologist for cataract assessment and eyesight test.	Immediate	Named nurse
Organise more suitable, easy to operate night lighting.	Immediate	Named nurse
Referral to community physiotherapist for mobility assessment and intensive physiotherapy to build up strength, balance, co-ordination and generally improve confidence with mobility.	Immediate	Named nurse
Referral to community occupational therapist for a transfer assessment.	Immediate	Named nurse
Staff to reinforce the use of Nurse Calls System.	Immediate	All care home staff
Include Mrs D in the residents falls awareness education programme to fully inform her about falls risk management to prevent further falls.	As soon as possible	Named nurse

The above actions were recorded in Mrs D's care plan.

Section E - Falls and fracture prevention actions

This section outlines some measures that you can take to reduce risk of falls and harm from falls. It provides examples of tools, checklists, handouts, and links to some useful websites.

Introduction

Following the assessment process, there is a lot the care home can do to reduce the risk of residents having falls and fractures in care homes. Research suggests falls prevention programmes in care homes can be effective if they target each resident's risk factors and are provided by a coordinated multidisciplinary team¹¹.

E1 Residents have opportunities for suitable exercise (either in a group or on a 1:1 basis; in the care home or outside locally), which includes strengthening exercises.

What do we mean by physical activity?

You can define physical activity as 'any bodily movement produced by skeletal muscles that results in energy expenditure'. It is a broad term covering all types of movement and includes basic activities, such as getting in and out of a chair, on and off a bed, washing, dressing and walking (with or without a walking aid).

For older people, physical activity can play an important role in:

- delaying the ageing process
- reducing the risk of developing long term conditions, such as diabetes, heart disease, obesity, lung disease and osteoarthritis
- managing the above conditions when present
- improving or maintaining mobility
- keeping active socially
- helping in major depression
- helping older people to maintain their ability to carry out day-to-day activities and participate as fully as possible in life.

Physical activity is of equal value to care home residents. It is important that physical activities are suitable and safe for the individual and that staff or the resident's family and friends provide adequate support and/or supervision. For example, walking to the dining room or toilet, with a walking aid, supervision or assistance as required, is beneficial, even if the distance is short.

What do we mean by exercise?

Exercise is a physical activity that is planned and structured, may involve repetitive bodily movements, and is done to improve or maintain an aspect of fitness.

Research has shown that certain types of exercise can reduce risk of falling¹². In particular, exercise which improves a person's muscle strength and standing balance. However, these types of exercise must be 'tailored' to the individual to ensure they are safe and effective. Knowledge of exercise and falls prevention, usually gained from training and experience, is necessary to teach this type of exercise, whether it is on a one-to-one or group basis. Specialist trained professionals, such as physiotherapists and specialist exercise instructors, usually deliver balance and strength exercise programmes.

Individual exercise programmes

In some cases, a physiotherapist will provide a resident with their own programme of exercises to carry out. The physiotherapist selects these exercises for the individual, following an assessment. Care home staff are often asked to assist a resident with their exercise programme, to ensure it is carried out regularly, correctly and safely. The physiotherapist should always provide written instruction on the exercises to be done, and should provide contact details if any further advice is required.

General exercise programmes

Although not all exercise prevents falls, there are still many benefits from carrying out regular, safe general exercise. Chair-based exercise classes provide frailer residents with an opportunity to exercise in a group or one-to-one session. Group exercise has wider benefits, including prevention of constipation, improved social interaction, sleep and wellbeing.

Care homes should consider whether it is possible to arrange regular exercise sessions for residents. It is important to ensure the person leading the session has appropriate training, knows what they are doing and is confident that the participants can manage the exercises. Contact their GP if in doubt about someone's health and safety.

In the booklet, 'Preventing falls: Managing the risk and effect of falls among older people in care homes'⁸ Help the Aged outlined low cost and high benefit exercise initiatives some care homes introduced.

- Trained care home staff work with physiotherapists to define one-to-one exercise plans, exercise classes and activity sessions.
- Care home staff are trained to support residents who have experienced a fall to complete an individual exercise programme defined by a falls clinic or community physiotherapy therapy service.

- External trainers provide regular armchair exercise, or tai chi classes in care homes.
- Residents who have fallen attend outpatient 'balance' classes or physiotherapists' 'falls prevention classes'.

E2 Vitamin D and calcium are provided for residents with increased risk of falls and/or suspected/confirmed vitamin D deficiency (unless unsuitable for medical reasons).

It is important to take sufficient calcium to help maintain healthy bones. However, as we get older, calcium can be absorbed less efficiently. Many older people also have smaller appetites so may benefit from supplements if they are getting insufficient calcium from food. Vitamin D is vital to help the body absorb calcium. It also helps muscles to work effectively. The main source of vitamin D is the sun. Older people can become deficient of vitamin D, especially if they do not go outdoors very often.

Safe sun exposure

The following guidance is provided by the National Osteoporosis Society.

- Exposure to sunlight everyday between May and September will increase vitamin D and keep bones healthy.
- Try to get 10 minutes of sun exposure to bare skin, once or twice a day (depending on skin type), without sunscreen and taking care not to burn.
- Always take care not to burn, especially during the strong sunshine in the middle of the day.
- Even on cloudy days the body can still produce Vitamin D from sunshine, but it can take a little longer.
- The body needs direct sunlight to produce vitamin D. Make sure the resident is sitting outside on a sunny day and not just next to a window or in a conservatory.

Calcium and vitamin D supplements can be used to help prevent hip fractures in frail older people who live in care homes. Guidelines published in 2009¹³ recommended that we should give calcium and vitamin D to residents with increased risk of falls and/or suspected/confirmed vitamin D deficiency (unless this is unsuitable for medical reasons). For residents who have already suffered a fracture it is likely that the doctor will want to consider an osteoporosis treatment in addition to calcium and vitamin D.

E3 Medication for osteoporosis is administered as prescribed, using correct protocols to ensure maximum benefits and prevention of side-effects where possible.

When a doctor diagnoses a resident with osteoporosis, they usually prescribe medication that aims to reduce the risk of broken bones. Research shows there are a range of medicines that do this¹⁴. Most drugs work by slowing down the breakdown of old bone; others

stimulate the formation of new bone. All the drugs help to increase the strength of bone and therefore lower the risk of fracture by about fifty percent.

For these medications to be effective, the resident must take them as prescribed.

Resource:

Information from: Drug treatments for osteoporosis, produced by the National Osteoporosis Society and available at:
www.nos.org.uk/~document.doc?id=385

Alendronate

One of the most common medicines used in the treatment of osteoporosis is alendronate (also known as alendronic acid).

To be effective and prevent side effects alendronate must be taken on its own at least 30 minutes before the first food or drink of the day, other than plain tap water (other medications must not be taken at the same time). These instructions are important because alendronate will only be effective if taken on an empty stomach. Tablets must be swallowed whole and taken with a glass of plain water. It is necessary to stay upright (sitting, standing or walking) for at least 30 minutes after taking the tablet. This prevents irritation of the gullet (oesophagus).

If the resident is unable to take the alendronate as described above, discuss alternative drug treatments that may be available with their GP. Some medicines for osteoporosis can now be given via a drip.

E4 Environmental checks/audits are carried out and documented on a regular basis, for example, monthly, or according to local policy.

Environmental hazards in the care home can contribute to the risk of falling. Risks relating to the surrounding environment include:

- poor lighting, especially on stairs:
 - poor lighting in the bedroom and bathroom at night
 - difficulty reaching a bedside light switch
- low temperature
- wet, slippery or uneven floor surfaces:
 - unsecured carpet edges, some rugs
 - spills not cleaned immediately
 - changes in level on flooring
 - raised thresholds
- clutter and obstructions

- trailing wires
- chairs, toilets or beds being too high or low or unstable:
 - bed clothes trailing on the ground
 - commode breaks not operating properly
- inappropriate or unsafe walking aids
- improper use of inadequately maintained wheelchairs, for example, brakes not locking
- improper use of wheelchairs, for example, failing to clear foot plates
- lack of equipment in the bath or shower (if required)
- unsafe or absent equipment, such as handrails
- loose-fitting footwear and trailing clothing.

Managing the environment

A good management system will help identify problem areas, decide what to do, act on decisions made and check that steps taken have been effective.

- Plan and identify areas of risk. Staff, residents and visitors can be involved in this.
- Staff must be committed to reducing risk, should be continually looking out for hazards, and must take action to remove them.
- Delegating someone to do a regular environmental risk assessment to ensure areas are always safe. Formally record the findings on a hazard checklist.
- Check to ensure staff are carrying out working practices and processes properly. Keep a record.
- Monitor and review: re-examine your approach in the light of experience. Consider Root Cause Analysis and Significant Event Analysis reports and take any necessary action.

Action

The Health and Safety Executive in its booklet 'Preventing slips, trips and falls at work'¹⁵ suggests a five step action plan to protect residents, staff and visitors from the risk of slips, trips and falls.

1. Look for slip and trip hazards around the home and its grounds, for example, uneven floors, trailing cables, spillage on floor.
2. Decide who might be harmed and how – who might be at risk?
3. Consider the risks – are precautions already taken enough to deal with the risks?
4. Record your findings.
5. Regularly review the assessment.

Where possible remove hazards at once.

You can consider the care home environment in general, or in relation to a specific resident and their needs. For information on assessing and managing the environment in relation to an individual resident **see section B**.

Resources:

Tool 4 – Resident environment and orientation

Tool 9 – Generic falls environmental risk assessment

E5, 6 Walking aids and wheelchairs are checked for wear and tear on a regular basis, for example, monthly, or according to local policy, and this is documented.

Walking aids

A walking aid aims to assist walking and balance and reduce the risk of falls. A physiotherapist can assess a resident's gait and balance to determine the most suitable aid for them. The physiotherapist will also instruct the resident and staff on the proper use of the aid.

Care and maintenance

Staff should regularly maintain walking aids by:

- replacing worn ferrules (rubber stoppers). You can usually get ferrules from a good pharmacy or by contacting the local physiotherapy department
- checking bolts on frames and visually inspect all components to ensure they are safe for use
- clean and wipe down walking aids regularly or as required
- retrieve and remove faulty walking aids immediately. For a replacement walking aid, contact the local physiotherapy department.

Wheelchairs

See **Tool 15a** for care and maintenance of wheelchairs

Resources:

Tool 15a – Wheelchair safety inspection guide

Tool 15b – Wheelchair safety inspection record

Tool 16 – Falls Prevention Monitoring form (walking aids/footwear/wheelchairs/commodes/chairs)

E7 Resident foot health and footwear assessments are carried out on a regular basis, for example, monthly, or according to local policy, and this is documented.

Foot health

Helping residents to look after their feet is very important. Do not ignore minor foot troubles, as they may get worse if proper attention and treatment is not given.

It helped me to raise an issue relating to a falls risk and it meant I got the resources to deal with it.

Care home staff member

Look out for:

- persistent pain
- soreness
- redness.

Considerations for foot health

To look after feet:

- buy shoes that fit properly
- make sure that socks and stockings fit properly and are not too tight
- change socks and stockings everyday
- keep feet clean to prevent infections
- file toenails regularly.

Resource:

For more information, download Age UK's leaflet, "Fitter Feet Guide" from www.ageuk.org.uk/health-wellbeing/keeping-your-body-healthy/fitter-feet/

Footwear

Footwear affects the way we walk. Good fitting, supportive footwear can improve walking whereas poor fitting or unsupportive footwear can make walking difficult, for example, cause a shuffling walking pattern, and add to the risk of falling.

Considerations for supportive and good fitting footwear

- Shoes should feel safe and secure when walking and should fit properly. Laces or velcro fastenings will help keep the heel to the back of the shoe and allow for changes associated with swollen foot or ankles or dressings.
- Soft but firm leather shoes with a man-made thin sole and a low/flat heel with good grip are best.
- A large area of contact between the sole and the ground is safer and a broad heel base with a rounded edge to the heel is best. Falls are often the result of a sharp heel edge striking a wet or shiny surface.
- Avoid wearing ill-fitting slippers, high heels, peep-toe, sling-backs, thick trainers and shoes on which the heel has worn down.
- Residents should not wear slippers for long periods, as they do not provide as much support as shoes.
- If possible, avoid seams particularly inside the shoe where they may rub, for example, corns or callous.
- Check footwear regularly for wear and tear.

Some examples of good footwear:



Considerations for slippers:

Slippers should be snug fitting, sturdy and offer stability and support. They should also have a:

- supportive back
- flat or low heel
- rounded toe
- firm, anti-slip sole
- smooth inside with no rough areas or sharp objects.

Guidance for E6 adapted from the following

1. The Perth and Kinross Falls Resource Manual for Care Homes, produced by Carolyn Wilson, Falls Service Manager.
2. The Good Slipper Guide, produced by Diabetes UK.
3. Bring suitable footwear to hospital, produced by NHS Greater Glasgow and Clyde.

E8 Risk of falls and falls prevention is discussed with the resident and the resident's family.

Whenever appropriate, it is important to involve the resident's family principal carer and/or anyone else who may have welfare attorney or guardianship in deciding on their care.

Resources:

Tool 17 - Falls Prevention Leaflet: Let's talk about the f word

E9, E10 Falls and fracture prevention actions

When a resident is transferred to or from the care home, it is very important that information about their risk of falling is transferred with them. It is useful to have a procedure in place to ensure this happens.

On discharge from hospital, advice for ongoing rehabilitation, re-ablement and recovery for example, following a fracture, should be requested if not provided.

Other useful information

The use of telehealthcare in the care home

Telehealthcare is a term that covers a range of devices and equipment that use developing technology to enable people to live with greater independence and safety in their home setting. Telehealthcare is not an alternative to direct care by carers, although it can reduce the need for checks and/or supervision.

Telehealthcare can be effective when it forms part of a personalised programme of care and support. For telehealthcare to work well, it is important for it to be accepted by the resident, their relatives and staff.

To be effective, telehealthcare requires:

- skilled assessment of needs and risk
- resolution of ethical dilemmas around capacity, informed consent and choice (for each individual in each situation)
- the resident, staff and relatives need training in how to use the equipment and how to test and maintain it.

Examples of devices include:

- movement detectors
- bed or chair occupancy sensor
- falls detector.

Resources:

National Telecare Programme website:

www.jitscotland.org.uk/action-areas/telecare-in-scotland/

‘Telehealthcare and falls’, produced by the Dementia Services Development Centre, the Joint Improvement Team and the University of Stirling.

<http://www.jitscotland.org.uk/publications-1/telecare/>

Section F - Service provision to the care home

This section provides suggestions for developing or improving links with local services, which may have a role to play in the management of a resident at risk of falling or fracturing. It provides a suggestion for building a directory of local services.

Introduction

There are different steps you and your care home colleagues can take to reduce the risk of residents falling or injuring themselves because of a fall. These actions should be part of the normal day-to-day risk assessment and care planning process. However, there will be times when you require help from outside services to prevent or manage falls or prevent injuries from falls.

The following list shows a range of services that may be involved in falls prevention and management. Availability and access to these services varies in different Community Health (and Care) Partnerships (CH(C)Ps) in Scotland. Very few areas have a dedicated 'falls service or team', but many areas have a multidisciplinary team in the CH(C)P or nearest hospital which will assess an older person with a falls-related problem and provide advice or treatment.

Services involved in falls prevention and management and fracture prevention include:

- multi-disciplinary teams that provide multifactorial falls risk assessment. Teams can be based in day hospitals, hospital outpatient clinics, or the community (such as the community rehabilitation team, rapid response team or integrated care team)
- audiology
- community exercise services (including those provided by local authorities)
- continence services
- dietetics
- district nursing
- fracture liaison service (and other osteoporosis services)
- GP
- mental health services
- occupational therapy
- optician
- pharmacy
- physiotherapy
- podiatry
- prosthetic services (for residents with amputations)

- psychology services
- speech and language therapy
- Telehealthcare services (often provided by local authorities).

This list is a general guide only - some of these services may not be available in your area. Contact your local CH(C)P to find out services available in your area, and what they provide.

F1 There is written information on local services, which may be involved in falls and fracture prevention and management, and how to access them (for example direct referral or through the GP).

It may be helpful to build a directory of useful falls prevention and management services in your area. You can use the directory as part of the induction of new staff and to keep all staff up-to-date with what services are available locally.

The directory may include the following information about each service.

- What the service provides. Is it emergency care, advice, assessment, equipment and/or treatment? Do they provide services to care homes?
- Who can refer to this service? Can you refer a resident or contact the service directly or do you have to ask the residents' GP to consider/make a referral?
- If you can refer directly, how do you refer? Is it by telephone, fax or e-mail? What information do they want when you make the referral; do you have to fill in a form, if so, where do you get the forms?
- Does the service have an inclusion or exclusion criteria, for example, is the service for a specific age group or condition or is it only for people living in a specific postcode.
- The contact details of the service.

Make sure you keep the directory up to date as and when you receive new information about a service.

Other contacts:

Some Community Health Partnerships have a Falls Lead or Co-ordinator.

Resources:
Tool 18 – Service directory

F2 Residents have regular (at least annual) medication reviews by a general practitioner (GP) or pharmacist, which considers falls and bone health.

The use of certain medication/s is just one of the many factors that can contribute to the risk of falls.

In theory, any medication that causes any of the following side effects can increase a resident's risk of falling.

- Drowsiness.
- Dizziness.
- Hypotension (low blood pressure).
- Parkinsonian effects (such as slowness of bodily movement, difficulty starting movement, tremor, shuffling walking pattern).
- Walking disorders.
- Vision disturbance.
- Dehydration.


In addition, theoretically any drug that causes the following effects can increase the risk of serious harm if the resident falls.

- Osteoporosis or reduced bone density (increases the risk of fracturing if a fall occurs) for example, corticosteroid tablets, anti epileptic, some breast cancer and prostate cancer drugs.
- Bleeding risk (increases the risk of cerebral haemorrhage or subdural haematoma if a fall occurs) for example, warfarin.

When considering risk of side effects from medications, you need to consider both the number and type of medications. Dose can also be a factor, but low doses of some medications can still cause side effects. Older people may be more sensitive to adverse medication effects because of alterations in the way the body absorbs, distributes and eliminates the medication.

Examples of types of drugs that can increase the risk of falling.

- Hypnotics and sedatives.
- Anti-depressants.
- Anti-psychotics.
- Anti-hypertensives.
- Anti-parkinsonian medications.
- Diuretics.



Note: These are some examples; many other medications can cause unwanted side effects.

Thorough assessment taking into consideration the residents fall history and skillful medication management by a GP and/or pharmacist may help reduce side effects. Regular medication reviews by a GP or pharmacist provide an opportunity to check that all the medications a resident is taking are necessary and of the correct dose. This should always be recorded in the resident's care plan.

It is useful to establish how often local GPs and/or pharmacists carry out routine medication reviews. In between these routine reviews, if you observe any of the above effects, it is useful to check the 'Patient Information Leaflet', supplied with the medication, to find out whether the effect is likely to occur.

Further advice is available from your local GP or pharmacist.

Section G - Education and training

This section outlines good practice in relation to education and training. It provides links to online training and a tool to support monitoring of staff training.

Introduction

Promoting the prevention and management of falls and the prevention of fractures is an important issue in maintaining quality of life and independence in older people. To enable staff in a care home setting to support the prevention and management of falls and the prevention of fractures confidently within their own role, education and training is key.

G1 Falls prevention and bone health awareness is included in staff induction training (the self assessment resource pack may form part of the induction).

Staff can complete various levels of training. The induction process for all new staff should include general falls and bone health awareness training and existing staff should complete a refresher course annually or in accordance with local policy.

G2, 3 Training in falls and bone health

Identified members of staff should complete more in depth training on falls and bone health regularly, at least once per year or according to local policy. Training of this type may be accessed locally via health and social care depending on your local arrangements, may be accessed online, for example Kiss of Life training or may be brought in and delivered via various companies who provide this type of training.

NHS Education Scotland (NES) along with a group of specialists from across Scotland have developed falls training resources which will be accessible to health and social care. This will help provide a consistent approach to delivering learning programmes. It provides a framework for designing training that delivers key messages at an introductory level.

Good practice suggests that you keep a database to monitor when staff have completed training or when training is required according to local policy – see tool 19 for an example.

As well as supporting people in care homes to live a good quality of life, falls prevention and bone health training will help staff to develop professionally in line with the continuous learning framework. It could provide underpinning knowledge for SVQ work and will reinforce any previous knowledge gained in this area. More information about SVQ's is available on the Scottish Social Services Council (SSSC) website.

Falls Awareness DVD

A DVD is available free of charge to all care homes for older people which outlines the key messages in this resource. This can be used as a learning tool for staff. The DVD will be issued to all care homes for older people in Scotland.

Resources:

Tool 19 – Training Matrix

Preventing falls and fractures in older people – www.sqa.org.uk/carescotland

Kiss of life – www.medicaleducation.co.uk

Scottish Social Services Council – www.sssc.uk.com

The following will provide some guidance to support implementing improvements in care. To implement improvements in the management of falls successfully each care home must recognise that falls are a problem worth solving. Leadership is fundamental in providing oversight, giving guidance and direction, monitoring and sustaining the implementation process. If possible, access support from a clinical champion, such as a Falls Lead/Coordinator. You need to address any resource implications adequately prior to the implementation process taking place.

Steps to implementation

1. Identify the team

- Care staff in care home
- Wider Multi Disciplinary Team (MDT)
- Family and friends
- Local community
- Other.

2. Identify resource requirements

- Time
- Staff
- Finance
- Administration
- Equipment
- Training
- Improvement tools, for example, Plan Do Study Act – a process used in continuous improvement (**see tool 20a, 20b, 20c**).

3. Define roles and responsibilities

- Implementation lead
- Self assessment assessor
- Identify champions
- Specific aspects of falls prevention and management
- General responsibilities.

4. Raise awareness of good practice self assessment resource

- Existing team
- New team members.

5. Decide on implementation process

- What will happen
- How will it happen
- Where will it happen
- When will it happen
- Set review dates.

6. Review progress

- Use of tool
- Identify areas for improvement with timed action plan (**see tool 21a, 21b**)
- The affect on falls prevention and management
- Team feedback
- Share learning.

7. Sustain implementation

- Provide ongoing supportive leadership
- Embed continuous improvement into the culture of the care home
- Embed falls prevention and management into the induction process
- Ensure robust communication systems are in place
- Embed falls prevention and management into quality improvement monitoring
- Embed falls prevention and management in health and safety monitoring
- Review improvements and celebrate success.

Resources:

Tool 20a – Model for improvement guidance

Tool 20b – The improvement model proforma

Tool 20c – Model for improvement example

Tool 21a – Falls prevention and management - summary action plan

Tool 21b – Falls prevention and management action plan and example

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NHS Health Scotland (2008), Energising Lives. A guide to promoting physical activity in primary care.
www.healthscotland.com/documents/2759.aspx

Quality Improvement Scotland (2010), Up and About: Pathways for the prevention and management of falls and fragility fractures.
www.healthcareimprovementscotland.org/default.aspx?page=13131

Useful websites

The Dementia Services Development Centre
<http://dementia.stir.ac.uk/>

Age UK
www.ageuk.org.uk

National Osteoporosis Society
www.nos.org.uk

Alzheimer Scotland
www.alzscot.org/

Diabetes UK
www.diabetes.org.uk/

The Stroke Association
www.stroke.org.uk/

SCSWIS (Social Care and Social Work Improvement Scotland)
www.scswis.com

The Scottish Online Falls Community
www.fallscommunity.scot.nhs.uk

Useful leaflets

Produced by Age UK:

Fitter Feet guide, endorsed by the Society of Chiropodists and Podiatrists
www.ageuk.org.uk/health-wellbeing/keeping-your-body-healthy/fitter-feet/

Caring for your eyes
<http://tinyurl.com/62zk2ff>

Better hearing Guide
<http://tinyurl.com/6d8vd8v>

Preventing Falls. Managing the risk and effect of falls among older people in care homes,
<http://tinyurl.com/6l5pve8>

Produced by the National Osteoporosis Society

Introduction to osteoporosis

All about osteoporosis

Drug treatments for osteoporosis

Healthy bones: facts about food

Exercise and osteoporosis

Hip protectors and osteoporosis

Living with broken bones

All available from: <http://www.nos.org.uk/page.aspx?pid=1024>

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