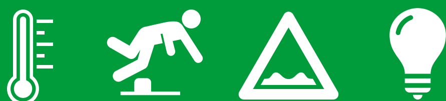
NHS England

Quick Guide:

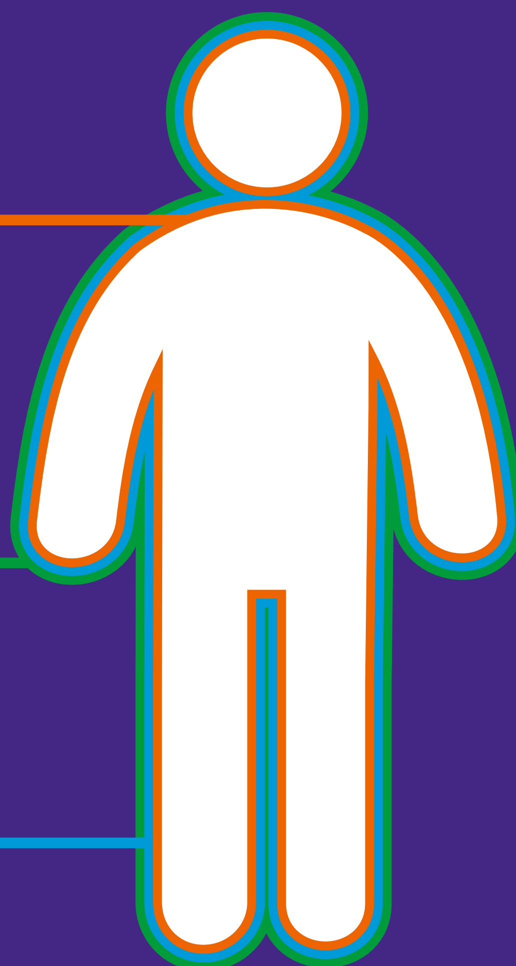
Falls Prevention and Management in Care Homes

PHYSICAL RISKS

ENVIRONMENTAL RISKS



BEHAVIOURAL RISKS



Annlouise Stephens, Independent Regulated Care Sector lead,
NHSE Lancashire and South Cumbria, March 2019
North of England Falls Prevention in Care Homes Programme

NHS England Publishing approval reference number 000324

Public Health England

Contents

Foreword from Margaret Kitching 5
Executive summary 6
Introduction 7

Section 1: Understanding falls and quality improvement 8
1.1 Definition 8
1.2 Context 8
1.3 Quality improvement 9

Section 2: Prevention of falls and fractures 11
2.1 Activity and Exercise 11
2.2 Provider responsibilities 12
2.3 Multi factorial risk assessment (MFRA) 13
2.4 Falls Risk Care Plan (Multifactorial intervention plan) 15
2.5 Update and review of the MFRS and care plan 16
2.6 Resident transfer between care home, the hospital and other settings 16

Section 3: Risk factors and how to prevent falls and fractures 17
3.1 Why do residents fall? 17
3.2 Physical risk factors – Things inside the individual 17
3.3 Behavioural risk factors – The way an individual interacts 18
3.4 Environmental risk factors – Things outside the individual 18

Section 4: Management of falls and fractures 20
4.1 Immediate care of a resident who has fallen 20
4.2 Equipment to aid residents' to get up 20
4.3 Learning from fall related incidents 21
4.4 Falls and safeguarding 21

Section 5: Partnership working and Education 22
5.1 Partners 22
5.2 Why education is important 22
Conclusion 23
References 24
Acknowledgements 25

Appendix 1 – Model for improvement resource 26
Appendix 2 – Care home residents falls and fracture risk/intervention tool 27
Appendix 3 – Environmental checklist 29
Appendix 4 – Adapted from the West Midlands Ambulance Service 33
Appendix 5 – Post Fall Assessment Tool 35
Appendix 6 – Service Directory 36
Appendix 7 – Medication increasing risk of falls and fractures 37

Version	Date	Author	Amendments
1	24.08. 18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Comments made from multiagency partners – amendments made to reflect safeguarding and medicine management guidance.
2	17.09. 18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Comments made from multiagency partners – additional guidance in respect of strength and balance to enhance prevention element.
3	4.10.18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Comments made from multiagency partners – Amendments made around pharmacy appendix.
4	26.10.18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Links to hydration added.
5	18.11.18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Revision made from comments made by the virtual development group
6	17.12.18	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Revision made from comments made by the virtual development group
7	13.01.19	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Amendments made to reflect recommendations made by NICE
8	21.01.19	A. Stephens – Independent Care Sector lead NHSE – Lancashire South Cumbria	Incorporation of the 'I STUMBLE' pathway

Publication Date	March 2019
Review Date	March 2021. Review dates may be altered to ensure that Links to best practice guidance and NICE quality standard updates are current.

This guide accurately reflects recommendations in the NICE guidance on falls in older people. It also supports statements 1, 2, 3, and 7 in the NICE quality standard for falls in older people.

National Institute for Health and Care Excellence
March 2019

Foreword from Margaret Kitching

Falls can have a devastating effect on the lives of individuals and their families. Physical injury can cause permanent disability and people's lives change as they lose their confidence and independence.

Falls prevention will help to assist frail and older people who reside in care homes to stay healthy and independent for longer and in return reduce avoidable hospital admissions, promoting preventative rather than reactive care.

National Health Service England's (NHSE) business plan highlights the need to free up hospital beds, reduce avoidable demand and promote better health. To enable this to be achieved we all need to work towards the aim of delivering the right care, at the right time to the right people.

The valued work in the care home sector cannot be underestimated. We need to work collaboratively between health and social care to reduce falls. This guide encompasses this ideal and is a valuable addition to the suite of NHSE Quick Guides and the 'React to' brand.

I welcome the work undertaken both from a North of England and national perspective on this key issue. The impact will be positive for residents, families, staff and the wider health and social care system.

Thank you to all the care sector staff colleagues in the NHS, Public Health England (PHE), National Institute for Health and Care Excellence (NICE), Yorkshire and Humber Academic Health Science Network, Nottinghamshire NHS Trust and Association of Directors of Adult Social Services (ADASS), for your help in developing this guide and your ongoing commitment to reducing falls amongst care home residents..

Margaret Kitching

Chief Nurse – North of England, NHS England/NHS Improvement

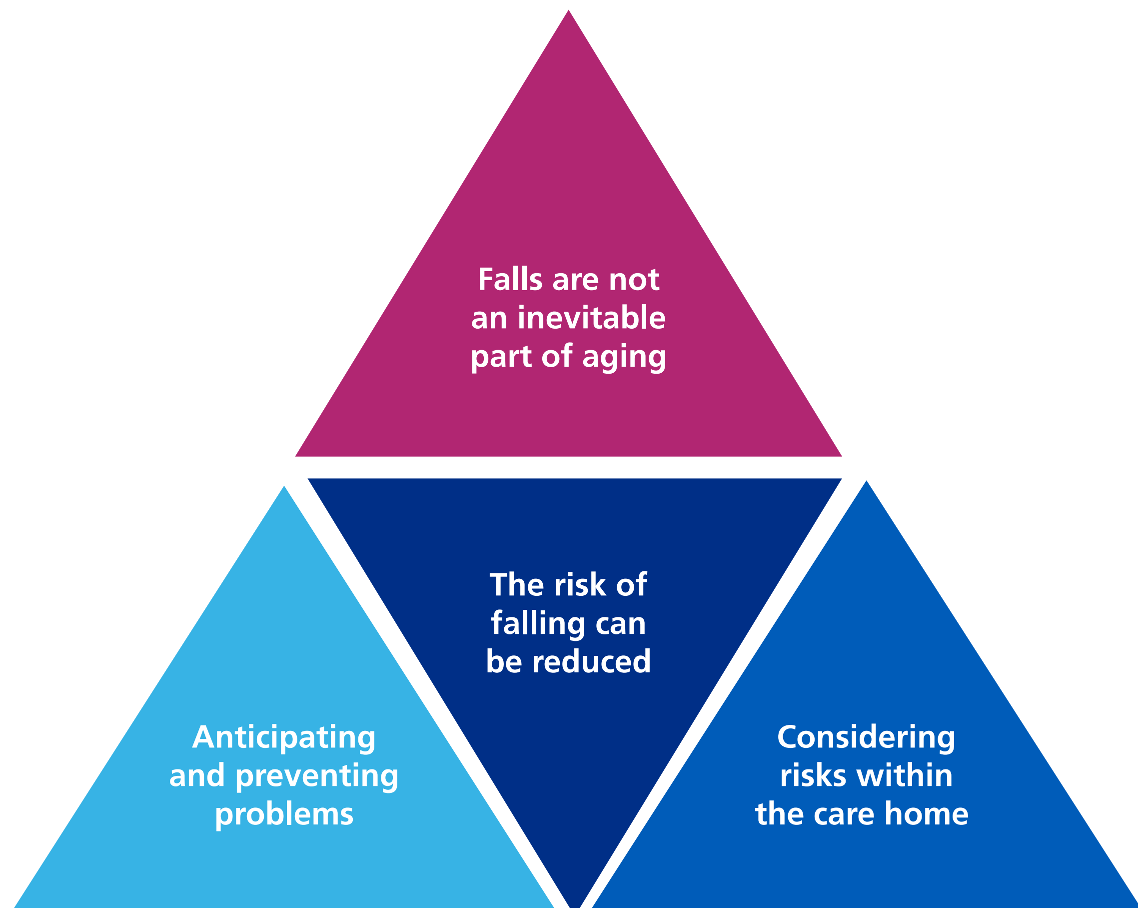
March 2019

Executive summary

As care providers, your role is to protect the residents under your care by identifying the risk factors associated with falls and ensure measures are taken to reduce identified risks to prevent a fall or reduce the nature of any injury as a result of an incident. It is important to acknowledge that from a resident perspective maintaining independence and an environment that feels as close to home as possible are important.

This guide is designed to assist you to think about falls, the complexity of the issue, some of the reasons for falls and the risk factors associated with falls. As you progress through the guide you will become aware of the consequences following a fall, the cost related to health and social care in addition to the pain, suffering and loss of independence for the individual resident. You will be able to consider measures that if addressed could reduce identified risks factors in order to ensure continuous improvement and improved quality of care for your residents.

NHS England is introducing a suite of initiatives under the 'REACT TO' brand. Acknowledgement should be made to Nottinghamshire Healthcare NHS Foundation Trust who agreed to share the brand designed by Crocodile House Design.



Introduction

Falls prevention via risk assessment and effective risk reduction strategies is everyone's responsibility, to reduce harm and create a safer environment.

Each care home should have a falls policy that sets out the organisation's approach to prevention and management of falls. This should include a strategy to reduce, as far as is reasonably practicable, the incidence of a fall. It should include what the organisation will do to increase staff and resident awareness of the risk and impact of falls and effective prevention strategies.

The prevention of falls should be the first priority and individualised care plans and risk assessments are key to the management and prevention of falls. The information gathering will guide the care staff to identify triggers or possible risk factors and implement measures that prevent falls for the individual rather than management of falls once they have occurred.

This guidance and associated tools have been produced for care home owners, managers and staff, it provides key references to national falls prevention in care homes best practice and National Institute for Health and Care Excellence (NICE) quality standards. It is highly recommended that this resource is used to benchmark existing policies and procedures within your organisation, to ensure that the care given reflects research based practice. The resource aims to provide the most up-to-date references and links and will be reviewed and amended to reflect future updates.

The main focus areas are:

- Prevention strategies
- Risk reduction
- Standardised assessment
- Management following a fall

As risk associated with falls covers a wide range of factors, this guidance has been produced in consultation with a wide audience of multiagency partners and regulatory authorities.

Several tools have been attached to assist in quality improvement, assessment of risk, audit implementation and management of an individual following a fall. These have been adapted from the NHS Scotland – Care Inspectorate 'Managing falls and Fractures in Care Homes for Older People-good practice resource', 2016.

http://www.careinspectorate.com/index.php/care-news-online/9-professional/2737-falls-and-fractures

The guidance is also reflective of the Falls in Older People Quality Standard – https://www.nice.org.uk/guidance/QS86

Falls in older people (NICE, 2017) http://pathways.nice.org.uk/pathways/preventing-falls-in-older-people

NICE impact falls and fragility fractures (NICE,2018) https://www.nice.org.uk/media/default/about/what-we-do/into-practice/measuring-uptake/nice-impact-falls-and-fragility-fractures.pdf

Section 1: Understanding falls and quality improvement

1.1 Definition

It is important to use a common definition within your care home to help everyone to understand what a fall is and to report and record incidents consistently

> ***A fall is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level***
>
> ***(WHO, 2018).***

Unexplained fall: A fall that has been unwitnessed, a cause cannot be identified or the person does not know how or why they fell.

Slip: To slide involuntarily and lose balance or foothold

Trip: An accidental miss step threatening or causing a fall

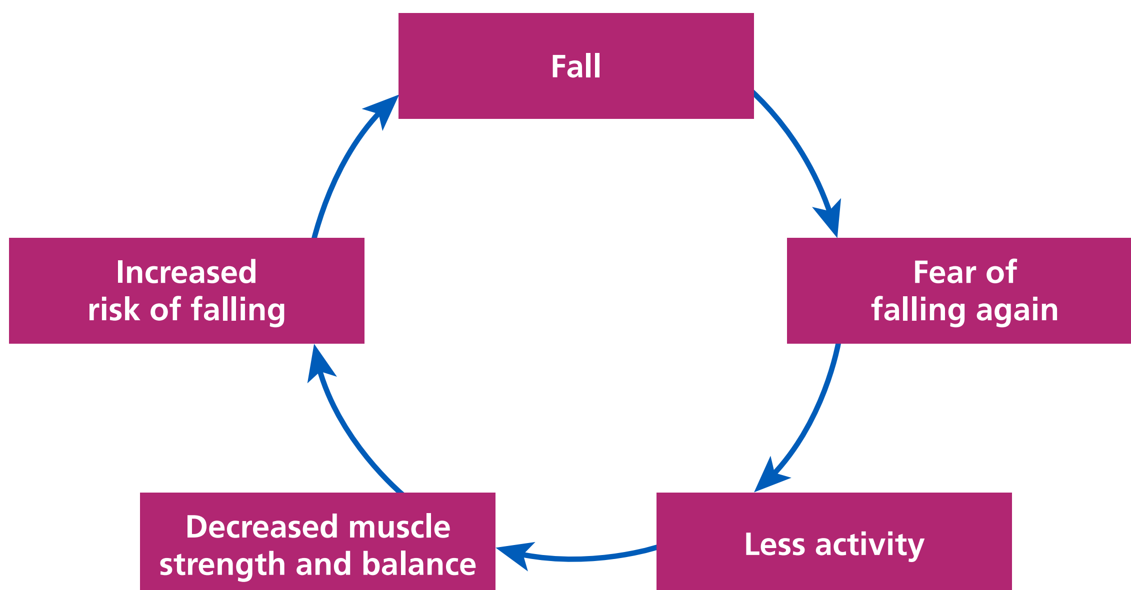
Stumble: To step awkwardly whilst walking and begin to fall

1.2 Context

Each year around one third of people over 65 experience one or more falls. A high rate of incidences increases the risk of serious consequences. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality, as well as the impact on the family members and carers of individual residents. The cost to the NHS is estimated at £2.3 billion per year. Falls related incidents represent one of the top 3 reasons for ambulance calls outs with a significant conveyance rate and admission to hospital. Therefore falling has an impact on quality of life, health and healthcare costs.

It is common for an older person who has fallen to become fearful of recurrence. A resident who has never fallen may also be frightened of falling. This often leads to avoidance of physical activity, reduced involvement in basic activities of daily living and ultimately a heightened risk of falling.

Cycle of falls



'Think about a resident you know who has fallen. What was the impact to them?'

1.3 Quality improvement

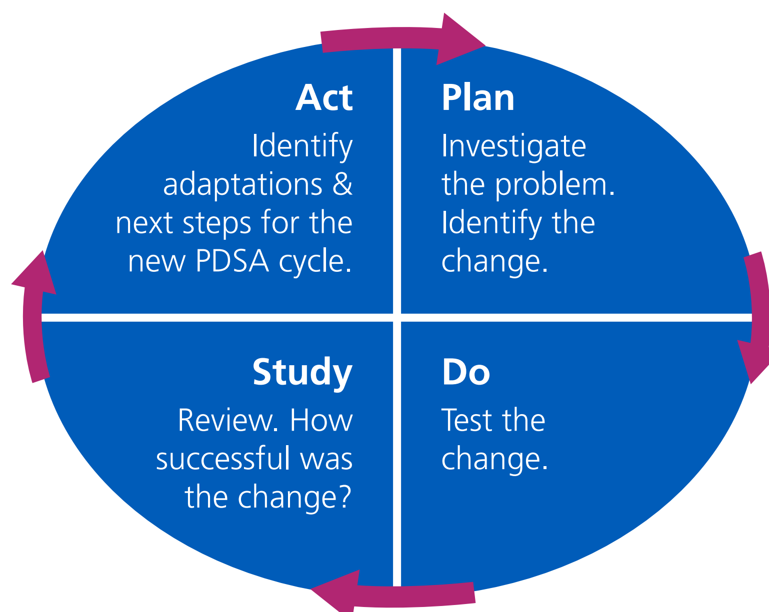
Our environment is constantly changing along with the needs of the residents, staff need to be able to support and deliver constant improvements to deliver high quality care. High quality care will ensure a safe (fewer errors, avoidable infections, falls), effective, efficient (less waste) or more person centred (caring, compassionate and appropriate based on the wishes of the individual resident and their family) care.

Quality improvement – the use of methods and tools to continuously improve quality of care and outcomes for residents needs to be the approach used when considering how to reduce falls. This should involve individuals, teams and organisations looking at how they can make changes to the way they work. Small changes can contribute to the improvement in care, often changing habits and embedded cultures that cannot be evidenced based and can make a huge difference to a person and those caring for them.

You may already know where changes need to be made, for example learning from work you have already done from incident reviews, complaints or inspection reviews. It is essential to gather data on the incidence of falls within your home. This will provide a baseline position from which you can identify any themes and trends connected to working practices which could be altered to make a real impact.

As a starting point to understand how your care home is preventing and managing falls it is recommended that you complete a self-assessment against the best practice guidance set out in this guide. This will help to systematically identify gaps in good

The PDSA cycle



practice and highlight areas for improvement. A self-assessment template will be available as part of the pack of resources.

Remember you know your care home best, so use your knowledge and experience to guide you. Gather together as many ideas as you can. These will form the basis for next steps- and your tests of change otherwise known as the PDSA cycle. You may want to use the resource in **appendix 1** in the first instance.

The Care Quality Commission (CQC) uses a framework to assess the quality of adult social care services, using key lines of enquiry (KLOE's) and prompts where they are appropriate across 5 key questions: domains; safe, effective caring, responsive and well-led. https://www.cqc.org.uk/guidance-providers/adult-social-care/key-lines-enquiry-adult-social-care-services

In terms of falls prevention the following are key characteristics of an outstanding service:

- Safe

Individuals' are protected by a strong empowered and distinctive approach to safety and a focus on openness, transparency and learning lessons from incidents. The service enables positive risk taking to maximise individuals' control over their lives. The service seeks ways to continually improve and put changes onto practice and sustains them. Staff proactively anticipate and mitigate risks to individual safety.

- Effective

The service works in partnership with other services and organisations and keeps up to date with new guidance, research and development in practice.

- Caring

The service has a strong visible person centred culture.

- Responsive

The service ensures that the individuals' care plan fully reflects their physical, mental and emotional needs.

- Well led

The service has a strong framework of accountability with clearly identified leadership to monitor performance and risk leading to delivery of demonstrable quality improvements to the service.

Key points to remember

- Environment and the needs of the residents are constantly changing.
- Maintain a culture where continuous improvement is supported.
- Complete a self-assessment to identify a starting point.

Section 2: Prevention of falls and fractures

2.1 Activity and Exercise

Muscle weakness and poor balance are key risk factors for falls and there is strong evidence that strength and balance falls prevention exercise programmes are effective in preventing falls. NICE recommends that as part of the multifactorial approach assessment strength and balance training can benefit older people living in the community with a history of recurrent falls and/or balance and gait deficit. For this group muscle-based strength and balance training should be offered. For those living in extended care settings NICE recommends an exercise component be included an as part of the multifactorial risk assessment for those who are at risk of falling (NICE, 2013).

While strength and balance can be developed via evidence based strength and balance falls prevention programmes such as Otago and FaME there are also a number of simple exercises that improve muscle strength and balance including what are known as the 'Super 6'. These should be carried out under the supervision of a suitably qualified instructor.

https://www.uhb.nhs.uk/Downloads/pdf/PiOtagoStrengthBalance.pdf

https://www.csp.org.uk/news/2017-09-27-csp-launches-video-demonstrate-six-simple-exercises-stop-falls

https://www.nice.org.uk/sharedlearning/oldham-exercise-falls-prevention-service

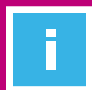
A review of the evidence for falls prevention exercise programmes carried out by Age UK, 2013 found that in order to be effective, they must:

- be continued over a duration of at least 50 hours
- be carried out two to three times a week
- challenge balance and improve strength through resistance training and exercise in a standing position
- be sufficiently progressive
- be tailored to the individual; pitched at the right level, taking falls history and medical conditions into account
- be delivered by specially trained instructors

Given that muscle weakness and poor balance are key risk factors for falls, all physical activity programmes in care homes should ensure that they include muscle strengthening and balance improving activities.

The report goes on to say that:

- For those with a falls history and/or frailer older adults – structured exercise programmes that incorporate progressive resistance training (PRT) with increasing balance challenges over time are safe and effective if performed regularly, with supervision and support, over at least six months.
- For those with a high risk of fracture (poor balance, frailty, vertebral fractures), supervised structured exercise programmes were most appropriate.
- For those in transition to frailty who have poor strength and balance, exercises that are known to help maintain strength and balance (such as Tai Chi) were effective in reducing falls risk.



Key points to remember

- A tailored exercise programme can reduce the number of falls by around 30%.
- Whatever your care setting, try and include regular strength and balance training that is appropriate for your residents.
- Assess your residents needs and tailor the exercise sessions according to the above criteria.

2.2 Provider responsibilities

Residents in care homes are a vulnerable group and the care provider is responsible for their wellbeing. This must be reflected in effective safety management, risk assessment and individual care planning arrangements. Good standards of health and safety do not happen of their own accord. Safe systems of work have to be devised and implemented; staff, environment and equipment have to be effectively maintained. In other words, health and safety has to be managed as much as any part of the business. The safety management model is explained in more detail in the Approved Code of Practice that accompanies regulation 5 of the Management of Health and Safety at Work Regulations 1999 http://www.hse.gov.uk/pubns/hsc13.pdf

Every member of staff within your home has a crucial role in prevention of falls.

Everyone should:

- Have an awareness of the risks of falls
- Continually consider potential risk
- Continually carry out actions to reduce the risk
- React to any changes observed in your residents
- Report and record trips and falls

The care home manager should:

- Ensure there is a clear definition of what is considered a fall for reporting
- Have a system in place for the recording of individual's resident falls
- Review falls data to identify any patterns of falls across the home and implement any action required
- Audit implementation of best practice
- Ensure staff have the relevant training and maintain competence in the assessment of falls risk.

Key points to remember

- There are legal obligations to providing effective care planning and falls management.
- There are general and specific legal duties placed upon employers to safeguard the health and safety of employees and others (including residents, the public and contractors).
- Each member of staff has a responsibility to be aware of the risks associated with falls.

2.3 Multi factorial risk assessment (MFRA)

NICE recommends that older people in contact with healthcare professionals (which include those in a setting such as a care home) should always be asked, whether they have fallen in the past year, the frequency, context and characteristics of the fall. Care home colleagues should routinely ask these screening questions as part of the pre-admission and admission process.

On admission to the home those who have reported a fall or are considered at risk of falling should be assessed for balance and gait deficits by an appropriately trained staff member in accordance with locally agreed guidelines, those residents could benefit from interventions to improve strength and balance.

Appendix 2 is a care home resident falls and fracture risk screen and prevention strategy tool, which provides a list of factors to be considered to enable measurement of the individual's risk and the requirement to refer to a specialist service.

Individuals who have been identified as;

- Presenting for medical treatment following a fall
- Recurrent falls in the past year
- Or those who have demonstrated abnormalities of gait and/or balance

should be referred to a specialist falls prevention service for a multifactorial risk assessment. It should be noted that some localities have commissioned enhanced primary care home services, which may include the services of physiotherapists, occupational therapists and community

pharmacists, which would support the care home staff.

A multifactorial falls risk assessment allows interventions to be targeted at a person's specific risk factors to help prevent future falls. This assessment is often carried out by a specialist falls service, but it can also be undertaken in other settings that have appropriate governance arrangements and professionals with skills and experience in falls prevention. Individual components of the assessment may be undertaken by different healthcare professionals, but each element has to be combined to form a single multifactorial assessment. This assessment should form part of an individualised multifactorial intervention plan to prevent further falls.

NICE quality standards make reference to the fact that Clinical Commissioning Groups (CCG's) commission services that perform multifactorial falls risk assessments in appropriate care settings with local referral pathways to support specialist assessment when needed, using professionals with skills and experience in falls prevention working in a collaborative local context.

A good example of a risk assessment tool is the 'steady on' model used in Lancashire, this assists in the identification of risk factors associated with falling. The use of STEADY is a prompt or reminder for people to think about things they can do to reduce the risks associated with falling.

http://www.innovationagencynwc.nhs.uk/media/documents/Case%20Studies/Steady%20On.5.6.17.pdf

Slippers, feet and footwear	**S**upportive and suitable
Tables and medication	**T**ake time to have a review
Environment and lighting	**E**xtra lighting and handrails are helpful
Activity and exercise	**A**ctivity and exercise can be good for mind and body
Does your resident fall?	**D**o please let someone know when you fall
e**Y**esight and hearing	**Y**our eye test and hearing test are important

Key points to remember

- Prior to admission to the home, as part of the pre-assessment, falls history should be seen as a routine question, this includes those residents on respite and those returning to the home following a hospital admission.
- Only those staff that have completed appropriate falls prevention and management training should complete the initial risk assessment.
- Referral to specialist falls service should be made where risks have been identified.
- Each care home should be aware of the local falls prevention services and referral process.

2.4 Falls Risk Care Plan (Multifactorial intervention plan)

The care home staff are expected to ensure the safety of the resident by providing an appropriate individualised falls prevention strategy whilst awaiting the outcome of the MFRA process completed by the falls specialist service.

Following on from the MFRA a multifactorial intervention plan will be put in place as directed by the specialist falls prevention team.

In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- strength and balance training
- environmental hazard assessment
- vision assessment and referral
- medication review with modification or withdrawal.

It is important to remember that whilst specialist services develop the multifactorial intervention plan, it is the care providers who would be involved in the delivery of individual components of the plan with support and input from multiagency healthcare professionals.

Screening and creating a care plan does not prevent falls: **it is following the falls care plan that will make the difference.**

The multifactorial intervention plan should focus on enabling and empowering the resident to keep active whilst minimising the risk. Account should be taken on the importance of choice, rights and independence and personal outcomes for an individual at all times. Any support required should be clearly recorded. It is often difficult to balance choice and empowerment with keeping an individual safe. This can be particularly difficult when an individual appears unable to make decisions about maintaining their own safety. It should be assumed that an individual has the capacity to make their own decisions unless proven otherwise. Where capacity to decide about a particular aspect of care is absent, residents should be supported to make decisions about their care. Reference should be made to the Mental Capacity Act Code of Practice 2013. Best interest decision making takes into

consideration the burdens and benefits of particular aspects of care, taking into account the residents expressed wishes and may also involve others including family members, advocates and those with legally valid powers of attorney for making welfare decisions. Further consideration should be made to Deprivation of Liberty Safeguards (DoLs), care plans should demonstrate least restrictive practices. Refer to https://www.scie.org.uk/mca/dols/at-a-glance for more information. https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Individuals at risk of falling, and their carers should be offered information orally and in writing about

- what measures they can take to prevent further falls
- how to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- the preventable nature of some falls
- the physical and psychological benefits of modifying falls risk
- where they can seek further advice and assistance
- how to cope if they have a fall, including how to summon help and how to avoid a long lie

2.5 Update and review of the MFRS and care plan

- Monthly
- After a change in medication
- After every fall
- Where there is a significant change in a person's condition, for example during or following an episode of illness or change in cognition for example as a result of delirium.
- On re-admission to the care home following discharge from another setting for example discharge from hospital
- During periods of respite care

2.6 Resident transfer between care home, the hospital and other settings

When a resident is transferred to and from the care home it is important that information about the risk of falling is part of the transfer documents and is clearly communicated to the receiving care provider. Utilisation of a hospital transfer pathway scheme (Red Bag) would assist with this. https://www.england.nhs.uk/publication/redbag/

Section 3: Risk factors and how to prevent falls and fractures

3.1 Why do residents fall?

There are lots of reasons why older people fall and it is often a combination of factors that result in a fall. It is important to consider each resident individually and look at the whole person to identify risk factors that are relevant to them.

A good way of thinking about the risk factors for falling is to group them into three main areas:

- Physical – Things relating to the residents body
- Behaviour – The way a resident does things
- Environmental – Things outside the resident

Key points to remember

- Falls can be a serious issue, resulting in suffering, disability, loss of independence and decline in quality of life.
- Aim to prevent falls while (a) preserving as much of the residents independence as possible (b) continuing to encourage safe physical activity (c) maximising quality of life.
- Do not accepts falls as an inevitable part of getting older.
- A fall is nearly always due to one or more ‘risk factors’.
- If an individual has osteoporosis they are more than likely to break a bone if they fall. Falls and bone health need to be considered together.

3.2 Physical risk factors – Things inside the individual

Medicines and impact on falls:

- 4 or more medications
- high risk medication (**see appendix 7**)
- recent change to medication

Continence:

- adequate hydration
- appropriate toilet routine and use of continence products as required
- accessibility of facilities

Foot health and footwear:

- regular podiatry
- use of appropriate well-fitting footwear
- consideration of the presence of prosthetics
- foot deformity
- foot sensory and proprioception loss

Mobility and balance:

- unsteadiness/unsafe walking
- difficulty with transfers (getting on and off the toilet/bed/chair)
- recent changes to mobility

Osteoporosis:

- history or at risk of osteoporosis
- prolonged steroid use
- recurrent fractures

Sensory:

- poor vision
- poor hearing

Dizziness and fainting:

- dizziness on standing
- sensation of room spinning when moving their head or body
- blackouts
- heart palpitations

Nutrition:

- lost weight unintentionally
- little appetite
- constipation

Medical history:

- medical conditions
- recent surgery
- pain and arthritis
- deformity

3.3 Behavioural risk factors – The way an individual interacts

Mild cognitive impairment and dementia:

- more confused, disorientated, restless, highly irritable or agitated than normal
- reduced insight and/or judgement and/or more uncooperative with staff

Night patterns

- unsettled at night getting in and out of bed
- ability to get in and out of bed safely

3.4 Environmental risk factors – Things outside the individual

An assessment (**see Appendix 3**) of the general environment should be carried out by a member of staff who is trained and is competent to assess risks associated with falling. The outcome and actions taken to address areas of concern should be documented on a regular basis, for example monthly or according to local policy.

Hazards in the environment could include;

- Poor lighting – for example dull lighting, lights that cause shadows, dark places, bright lighting that causes glare.
- Extreme temperatures – high temperature can cause fainting or low temperature can affect muscle function.
- Floor surfaces – for example high thresholds, poorly fitted or/or patterned carpets, changes in floor covering/slippery floors and rugs.
- Clutter and obstacles – for example furniture, clothing, medication/food trolleys, wheelchairs, low level tables and trailing leads to electrical appliances.
- Poorly maintained equipment – for example commodes, toilet seats, wheelchairs, walking aids, grab rails and shower seats
- Access and communal areas – for example poorly lit hallways, uneven paths, steep stairs and thresholds at doorways.
- Outdoor areas – for example grass, stones, uneven and/or poorly maintained paths and poorly maintained gardens.
- Interactions with other residents and staff should also be considered as environmental falls risk factors which can be modified.

Key points to remember

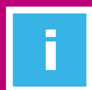
- Falls can be reduced by maintaining a safe environment.
- Falls tend to increase when there are new or unfamiliar care home staff in attendance, during respite stays and in the first three months of admission to a care homes.
- When there are new members of staff, residents or relatives it is important to orientate them quickly to the care home environment.
- To reinforce good practice there should be written guidance on the use of bedrails, restraints, low profile beds, walking aids, movement sensors and other equipment used around the resident.

Section 4: Management of falls and fractures

4.1 Immediate care of a resident who has fallen

The reaction of care home staff at the time of a fall is really important. Safe moving and handling, to avoid causing pain and/or further injury is critical to ensure that the resident's chances of full recovery are maintained. The immediate care of a resident following a fall should include safety at the scene and addressing any injuries sustained. A delayed response can delay diagnosis and treatment of injuries. The response made should be in line with any palliative care summary, anticipatory care plan (ACP) and any do not attempt cardio pulmonary resuscitation (DNACPR) decision recording.

The Welsh Ambulance Service piloted the use of the 'I STUMBLE' falls flowchart (**see Appendix 4**) in 10 care homes, which were identified as having high level of ambulance calls related to falls. Over a 12 month period the data indicated that there was a 43% reduction in hospital conveyances. Qualitative data indicated that care home staff reported feeling more confident and safer using the tried and tested falls tool and were able to safely manage residents who had fallen within the care home setting.



Key points to remember

- It is important to have a post fall pathway that members of staff are familiar with.
- Action taken at the time of the fall is critical to a resident's wellbeing and future risk of falling.
- Use fall data to have improvement conversations with the staff and wider health and social care team.

4.2 Equipment to aid residents' to get up

For those who do fall, getting up off the floor can be the greatest challenge. Equipment to assist people up into a sitting position usually comes in one or two forms;

- Inflatable devices
- Lifting devices

Many local areas have commissioned response and lifting services which accept direct referrals from care homes which have shown to reduce calls to ambulance services and conveyances to hospital. Details of any local services can be added to the service directory (**appendix 6**).

There are a wide range of technological solutions available to prevent falls and lessen their impact. The best place to start is to discuss concerns with a GP who will refer to a local falls prevention service. This service will be able to fully assess the individual resident's needs and advise about the best support. There are also private physiotherapists who specialise in falls prevention and balance retraining; details can be found on the Chartered Society of Physiotherapy website, https://www.csp.org.uk/, along with a number of resources and animations around falls prevention. Other suppliers of advice and equipment include Age UK, https://www.ageuk.org.uk/search/?q=Falls+prevention+resources and local mobility equipment suppliers.

4.3 Learning from fall related incidents

Collecting and analysing data on falls within the home can assist in the reduction of further incidents and limit repetitive falls from the same resident. Analysis can highlight themes and trends around incidents that may influence routines, staff deployment and environmental issues. This will include any un-witnessed falls. Data should be collated routinely within a given interval (quarterly, monthly) and include number of falls, numbers of individuals who have multiple falls, numbers of falls related injuries resulting in fracture and the numbers of falls resulting in hospital admission.

Care homes should have a system in place to record incidents, investigate the event and implement any lessons learned to reduce further occurrence. Where necessary external reporting should be completed to commissioning authorities and regulatory bodies as per local policy.

4.4 Falls and safeguarding

In some cases it is necessary to make a safeguarding alert following a fall.

When to raise a safeguarding alert

- Where there is a concern about possible abuse or neglect, as a result of a fall.
- Where a resident sustains a physical injury due to a fall, and there is a concern that a risk assessment was not in place or was not followed.
- Where an individual has a physical injury (other than minor) and appropriate medical attention has not been sought.

Section 5: Partnership working and Education

5.1 Partners

It is essential that care home staff work alongside health and social care colleagues. Many areas have a multidisciplinary team in the local community that will assess an older person with falls related issues and provide advice and treatment. Some areas have dedicated falls services or care home support teams. As integrated care systems and primary care networks become established more widely across the England, care homes will be supported increasingly to prevent and respond to falls without the need for unwarranted hospital admission.

Appendix 8 – Service Directory may assist you in formulating a local service contact list. The range of services may include;

- Falls prevention leads/co-ordinators
- Allied health professionals for example physiotherapists, dietician, occupational therapist, podiatrist, speech and language therapist, orthoptist for splints, prosthetist for residents with amputations
- Continence services
- Audiology
- District Nursing team
- Fracture liaison service
- Primary care services/GP
- Mental Health Services
- Optician
- Pharmacy
- Local ambulance services
- Local lifting services
- Voluntary sector organisations
- Nurse practitioners
- Practice based pharmacists, care home pharmacists and technicians

5.2 Why education is important

Education and training for staff, residents and their families is crucial to the early identification of the risks associated with failing to help prevent avoidable falls and fractures. Ensuring everyone involved in the care of older people has the right knowledge and skills is essential.

Basic falls prevention training should be included as part of the induction process for new staff. Existing staff should complete a refresher course annually or in accordance with local policy. In depth training in falls prevention and bone health should be completed by identified members of staff for example falls champion or link person, at least once per year.

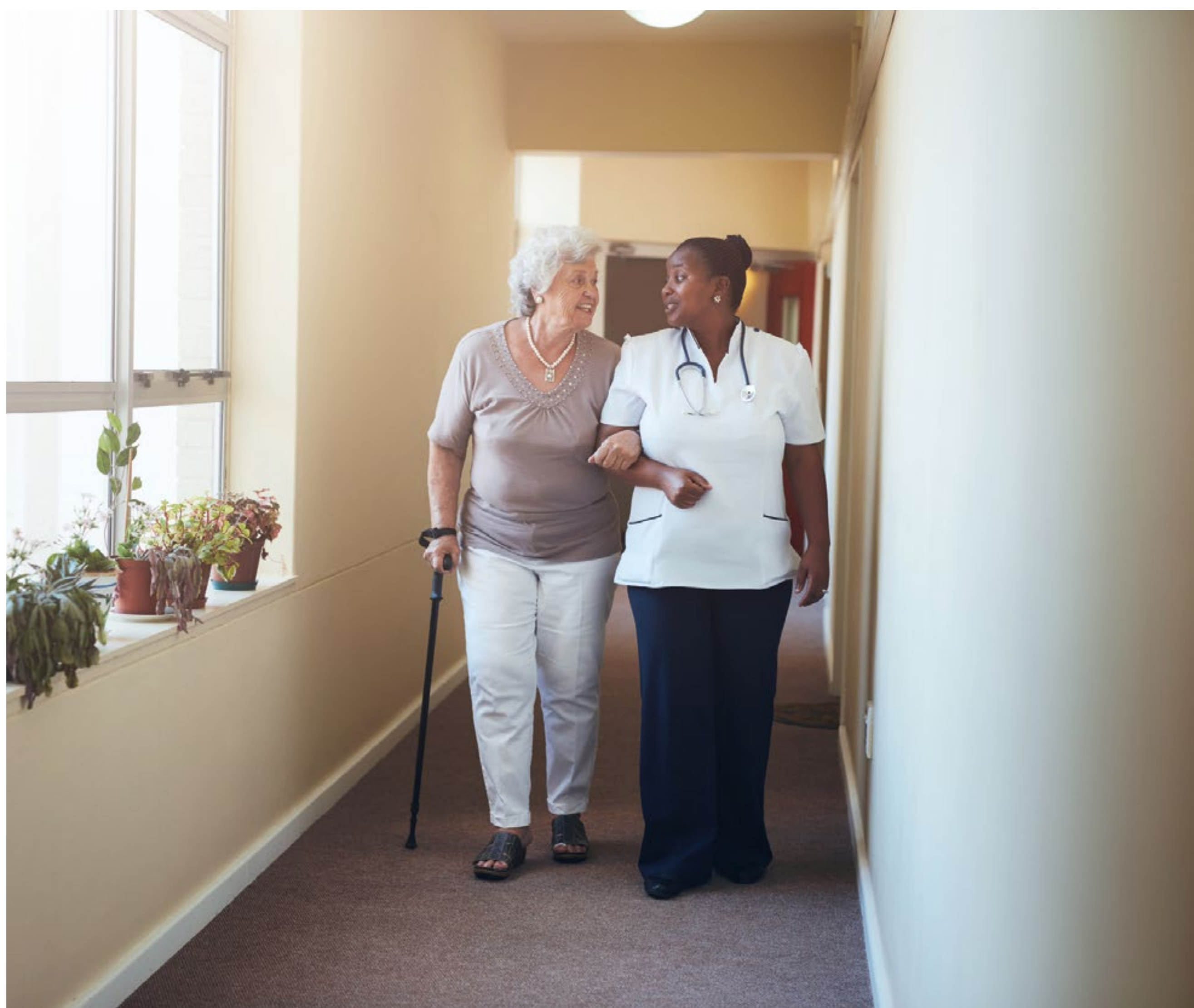
Some areas adopt a 'Champion' type model where one member of staff acts as the point of contact, and disseminates out new guidance and best practice.

Support for training can come from a number of sources including local community health services, specialist falls services, ambulance service and social care teams.

A falls prevention training programme for care homes has been piloted in the North East and North Cumbria during March 2018. The North East Ambulance Service (NEAS) NHS Foundation Trust and North Cumbria Urgent and Emergency Care Network were commissioned by NHSE to deliver bespoke Falls Prevention training to a target set of care homes throughout the North East and North Cumbria. The data indicated that in those homes where staff received training there was a 32% reduction in 999 calls and 63% of the homes reported a reduction in their falls occurrence.

Conclusion

Falls in the older population have wide ranging effects on the individual, their families, care providers and the wider health and social care services. Many slips, trips and falls in care homes are preventable and injuries sustained as a consequence can be reduced. Post-fall assessment, review and remedial action can reduce the likelihood of further falls. It is important that residents who have fallen and those who may be at risk from falling in the future have regular reviews of reversible risk factors. It is you and your care home team who will be undertaking falls prevention measures and interventions in your day to day activities. It is the small interventions, consistently delivered that will ensure the safety and wellbeing of the residents under your care.



References

Age UK (2013) **Falls Prevention Exercise – Following the evidence**.
http://www.ssehsactive.org.uk/userfiles/Documents/FallsPreventionGuide2013.pdf

Department of Constitutional affairs (2007) Mental Capacity Act; Code of Practice. TSO; London

International Osteoporosis Foundation: Studies have shown that Vitamin D supplementation could be cost effective to help prevent falls and fractures in older adults. December 2015
https://www.iofbonehealth.org/news/vitamin-d-falls-and-fracture-prevention

Management of health and safety at work. Management of Health and Safety at Work Regulations 1999. Approved Code of Practice L24 (twelfth edition). HSE Books ISBN 0 7176 0413 6

NICE (2013) **NICE Guidance cg161**. https://www.nice.org.uk/guidance/cg161

Nice Guidance (2017) Falls in Older People – Quality Standard [QS86] Published date January 2017

PHE (2017) Falls and Fracture consensus statement.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586382/falls_and_fractures_consensus_statement.pdf

PHE & Centre for ageing better (2018) Muscle and bone strengthening and balance activities for general health benefits in adults and older adults: Summary of a rapid evidence review for the UK Chief Medical Officers' update of the physical activity guidelines.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721874/MBSBA_evidence_review.pdf

Word Health Organisation 2018. Falls fact sheet
https://www.who.int/news-room/fact-sheets/detail/falls

Acknowledgements

- North of England falls Programme Virtual Development Team
- Helen Kleiser; Falls Co-ordinator/Clinical Educator – Gateshead Health Foundation Trust
- Helen O'Higgins; Falls Prevention Commissioner Manager – NHS Derbyshire County
- NHS Scotland and Care Inspectorate
- The prevention and Management of Falls in the Community – Scottish Government
- Nottinghamshire Healthcare NHS Foundation Trust
- Lancashire County Council – Falls Prevention and Bone Health Training Package
- Newcastle/Gateshead Enhanced Health in Care Homes Vanguard programme
- North West Ambulance Service
- Yorkshire Ambulance Service
- North East Ambulance Service
- Welsh Ambulance Service
- West Midlands Ambulance Service

Appendix 1 – Model for improvement resource

Developing objectives for improvement work

You will find it useful to identify what you want to achieve from your improvement work. The improvement model's three fundamental questions for achieving improvement provide useful framework for developing your objectives.

Q1. What are we trying to accomplish?

What is the overall aim of what we are doing? What can we improve?

Example *Complete an agreed Multifactorial falls risk assessment (MFRS) for each resident as part of the admission assessment*

Q2. How will we know that a change is an improvement?

What will tell us that our changes make things better than we were before? What can we measure that will demonstrate that our changes are actually an improvement?

Example *The numbers of MFRS completed in care plans; staff being aware of the importance of preventing and managing falls; reduce the number of falls*

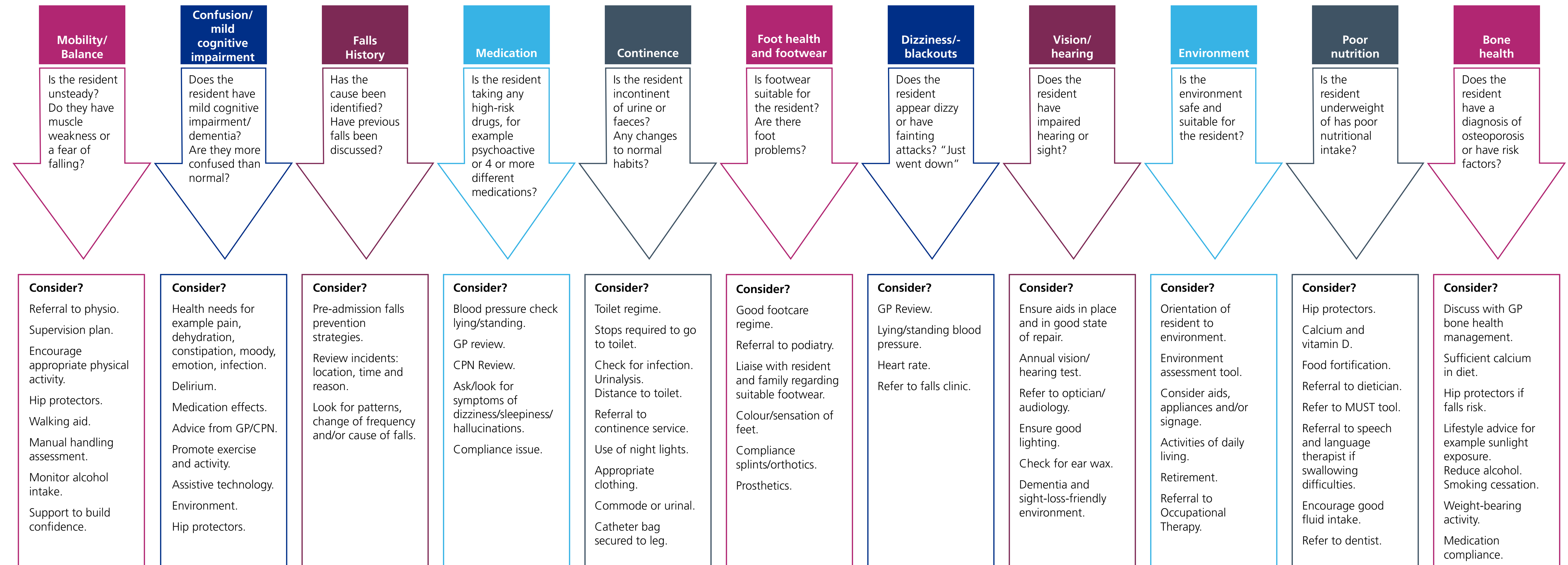
Q3. What changes can we make that will lead to improvement?

Include all the ways that you can work towards your objective, so that you can develop plans for PDSA cycles. Think about what has worked for other people.

Example *Introduce MFRS form into admission assessment documents/process; train staff to use correctly; monitor implementation form*

Appendix 2 – Care home residents falls and fracture risk/intervention tool

(Managing Falls and Fractures in Care Homes for older people – good practice resource Tool 4b – http://www.careinspectorate.com/index.php/care-news-online/9-professional/2737-falls-and-fractures



If issues are unmanageable – consider onward referral via local pathway

Risk factors identified	Action required	Date and signature	Actions completed	Date and signature

Adapted from a too developed by Lynn Flannigan, NHS Lanarkshire

Appendix 3 – Environmental checklist

(Managing Falls and Fractures in Care Homes for older people – good practice resource Tool 12 http://www.careinspectorate.com/index.php/care-news-online/9-professional/2737-falls-and-fractures)

Tool 12: Generic falls environmental risk assessment

	Area of consideration			Remedial action required to address significant finding
Bathroom and shower rooms	Yes	No	N/A	
Are floor coverings of bath/shower rooms a different colour from wall coverings?				
Are floor coverings provided with a non-slip surface?				
Are floor coverings free of defects?				
Is a system in place to ensure spillages are cleaned up without delay to prevent slippage risks?				
Are handrails positioned properly and securely next to toilet, shower and bath?				
Are raised toilet seats available which are well fitting and secure?				
Are non-slip mats used in bath/shower?				
Are receptacles for soap/shampoo easy to reach and do not require user to bend over?				
Do all shower chairs have adjustable legs, armrests and rubber stoppers on legs?				
Do commode chairs have wheels, castors, brakes that work smoothly and effectively?				
Do all shower chairs and commode chairs have seat belts or safety bars?				
Are areas immediately around bath and sink marked in contrasting colours?				
Is there room for a seat in/near shower?				
Are call buttons accessible from a sitting position in the shower?				
Is suitable transfer equipment (side loading trolley, hoist, etc) provided for users?				
Is bathroom/shower room free of stored materials that could present a tripping risk?				
Is bathroom/shower room door able to be opened/closed easily by user?				
Is bathroom/shower room free of a change in floor level?				
Is bathroom/shower room provided with adequate lighting?				
Passageways	Yes	No	N/A	
Are passageway floor coverings a different colour from wall coverings?				
Are floor coverings in passageways free of defects?				

Tool developed by Carolyn Wilson, NHS Tayside

Passageways	Yes	No	N/A	
Is a system in place to ensure any spillages are cleaned up without delay?				
Are passageways provided with adequate lighting?				
Are passageways free of a change of floor level?				
Are adequate handrails provided along length of the passageway?				
Are passageways wide enough to allow people to pass each other?				
Are passageways maintained free of stored materials?				
Are doors across passageways maintained in the open position by hold open devices connected to the fire alarm?				
Are all cables positioned so that they do not present a tripping hazard to users?				
Common dining area				
Are floor coverings of dining area a different colour from wall coverings?				
Are floor coverings in dining area free of defects?				
Is a system in place to ensure any spillages are cleaned up without delay?				
Is the dining area provided with adequate lighting?				
Is floor covering in dining area free of change of floor level?				
Is dining area maintained free of stored materials?				
Are all cables positioned so that they do not present a tripping hazard to users?				
Common lounges				
Are floor coverings of the lounges a different colour from wall coverings?				
Are floor coverings in lounges free of defects?				
Is a system in place to ensure any spillages are cleaned up without delay?				
Are the lounges provided with adequate lighting?				
Are floor coverings in lounges free of change of floor level?				
Is lounge area maintained free of stored materials?				
Is furniture in lounge area arranged so that tripping hazards are minimised?				
Are all cables positioned so that they do not present a tripping hazard to users?				

Stairs and internal ramps	Yes	No	N/A	
Is the height of the steps the same throughout the whole length of the stair or stairwell?				
Are the nosings (edge of step) square edged, highly visible and provided with a non-slip finish?				
Are steps of stairs free of defects and provided with a non-slip finish?				
Are suitable handrails provided on stairs?				
Are stairs provided with adequate lighting?				
If an internal ramp is provided has it been clearly identified?				
Is the floor covering on the ramp free of defects?				
Is the slope of the ramp suitable?				
Is ramp provided with adequate lighting?				
Is ramp provided with suitable handrails?				
Lifts				
Is the lift floor covering a different colour from the wall coverings?				
Is floor covering in lift free of defects and provided with a non-slip finish?				
Are suitable handrails provided in lift?				
Are call buttons arranged so that they can be easily reached by users?				
Does the lift stop level with floor landing?				
Is the lift provided with adequate lighting?				
External				
Are external footpaths/areas used by residents (for example, car park) even and free of defects?				
Is a system in place to ensure external routes are maintained free of slipping/tripping hazards for example, falling leaves, moss, uneven paving, pot holes?				
Is a winter maintenance procedure in place that monitors footpaths/roadways to ensure they remain free of contaminants eg ice?				
Are footpaths/roadways free of a change of level that present a tripping hazard?				
If a ramp is provided is the slope of the ramp suitable?				
If a ramp is provided is the surface free of defects?				
If a ramp is provided are suitable handrails provided?				
Are external footpaths, roadways and ramp provided with suitable lighting?				
Are door mats to remove possible contaminants from feet suitable?				

References

- Queensland Health general environmental checklist – www.health.qld.gov.au/fallsprevention/best_practice
- All Wales Falls Framework - falls prevention document (draft)
- Minimising the risk of falls & falls related injuries – Victoria Quality Council

Generic Environmental Checklist

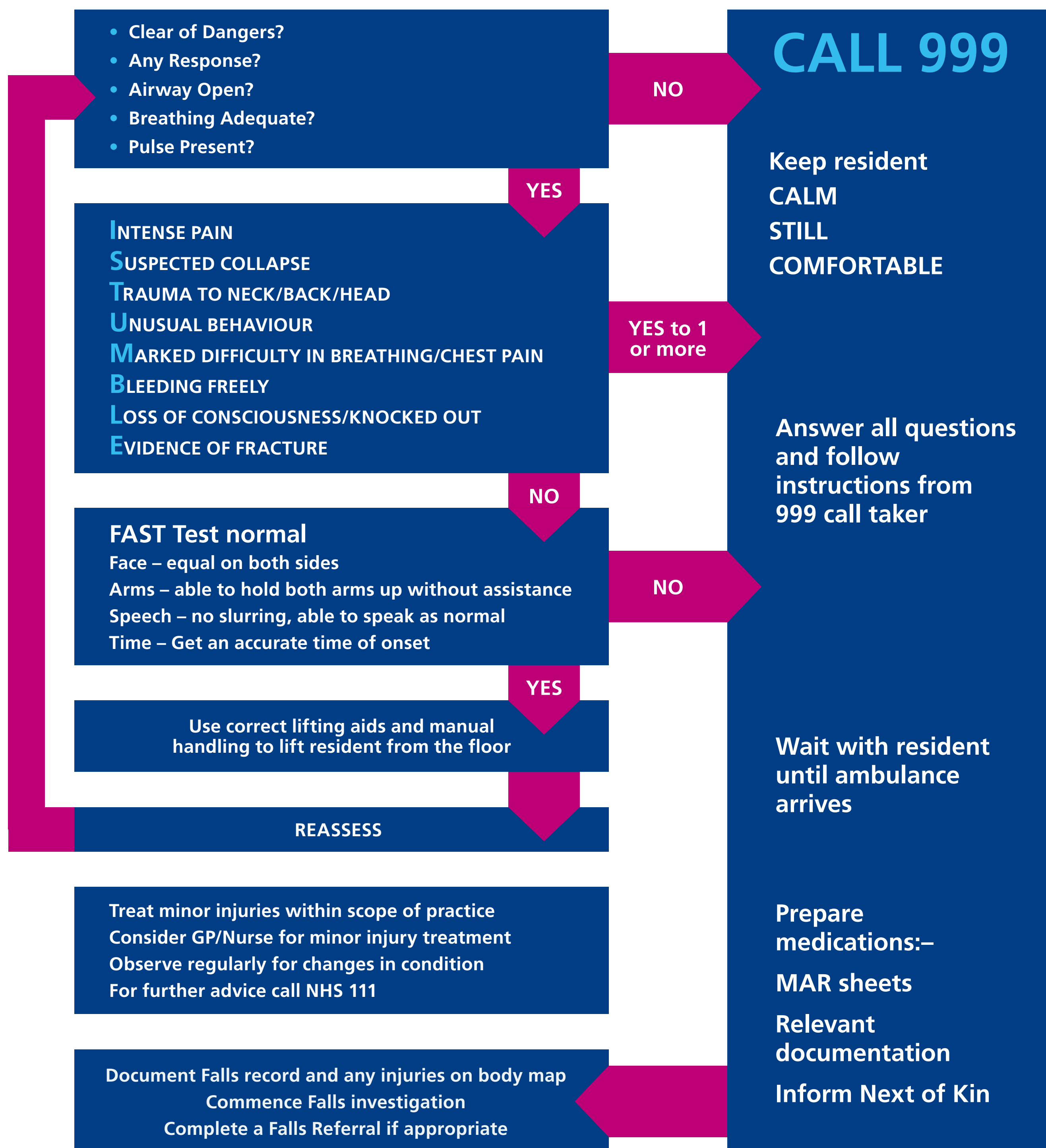
The Generic Environmental Checklist pertains to the entire environment within the care home and its grounds where residents might spend some of their time.

Instructions for Use:

- Overall responsibility to ensure the completion of the environmental checklist lies with the home manager. This is necessary as remedial action may involve major and/or costly modifications to the area or changes in the operational activities within the area.
- The checklist should be carried out at least annually.

Appendix 4 – Adapted from the West Midlands Ambulance Service

"I STUMBLE" Algorithm for Falls



Intense Pain

- New Pain since Fall
- Includes Headache, Chest Pain and Abdominal Pain
- Consider both pain from injury caused by fall or medical causes

Suspected Collapse

- Ask resident if this was a trip or collapse (do they remember falling)
- Any dizziness, sudden nausea or pain before the fall
- Includes "near fainting" episodes

Trauma – to Head/Neck/Back

- New pain in Head/Neck or Back following the fall
- New visible or physical injury, lump or dents to head – with or without bleeding
- Any new numbness or paralysis in any limbs or face

Unusual Behaviour

- New Confusion
- Acting Different to Normal Self e.g. agitated, combative, aggressive, sleepy, quiet
- Difficulty Speaking e.g. Slurred Speech, words mixed up, unable to verbalise objects, stuttering

Marked Difficulty in Breathing/Chest Pain

- Severe shortness of breath, not improved when any anxiety is reduced
- Unable to complete full sentences
- Blue/Pale lips or fingers, becoming lethargic or confused
- New Onset of inability to mobilise/lay still without difficulty in breathing

Bleeding Freely

- Free flowing, pumping or squirting blood from a wound
- Widespread swelling and bruising to face/head or injured limb
- Apply constant direct pressure to injury with clean dressing, elevate if possible
- Try to "estimate" blood loss, in mugful's (often difficult)

Loss of Consciousness

- Knocked Out
- Drifting in and out of consciousness
- Limited memory of events leading up to, during or after fall. (unusual for resident)
- Unable to retain or recall information, repetitive speaking (unusual for resident)

Evidence of Fracture

- Obvious Deformity – e.g. shortened and rotated limb, bone visible, severe swelling
- Reduced range of movement in affected area
- Unusual movement in affected area

In all 999 cases remember to keep resident: Calm, Still & Comfortable
If any bleeding is present, apply constant pressure with a clean dressing

Appendix 5 – Post Fall Assessment Tool

Name of resident: .... Date of Birth:...

Name of staff member .... Signed (staff member): ....

Date of Fall		Time of Fall	
Location of Fall:			

Primary Symptom prior to fall: (please tick one)	Unable to identify		Unwell (detail in 'other')		Behavioural change	
	Visual impairment		Dizziness/loss of balance		Dementia (Usual state)	
	Other		Details:			

Assessment of Injury		Tick & Initial
Level of consciousness	Responsive as normal	
	Less responsive than usual	
	Unresponsive or unconscious **DIAL 999**	
Pain/Discomfort	No evidence of pain/discomfort	
	Mild pain/discomfort	
	Severe pain/ discomfort	
Where is the Pain (if any)?		
Injury or wounds	No evidence of injury, bleeding or wounds	
	Slight or mild injury	
	Evidence of significant swelling, bruising, bleeding, or deformity of limbs	
Where is the injury?		
Movement/mobility	Able to move all limbs as normal for the resident	
	Able to move limbs but has pain on movement	
	Unable to move limbs or there is a major change in mobility	

Observations							
Pulse		Blood pressure		Blood sugar			Tick & sign

Conclusion of assessment		Tick & Initial
No apparent injury or minor injury	Seek or provide appropriate treatment	
	Commence observations	
	Inform relatives	
	Complete incident form	
	Review Falls Assessment	
Major injury	Give first aid/ resuscitate CALL 999 DO NOT MOVE	
	Commence observations	
	Inform relatives	
	Complete Incident form	

INDICATE OUTCOME:	999	Urgent Care		Urgent Care		Self-managed		Other:	

Self-Management

Consider Assistance (Urgent Care/G.P)

Call 999

Appendix 6 – Service Directory

Service	Contact details	What does the service provide	Who can refer	Referral Criteria	How to refer

Appendix 7 – Medication increasing risk of falls and fractures

The older an individual gets, the more likely it is they will be prescribed multiple medications for multiple long term conditions and/or taking over-the-counter medicines. In an older individual, medications can take longer to break down and leave the body. Multiple medications when prescribed together can also interact with each other in ways that are unexpected and harmful. Certain medications strongly increase the risk of falling. These include medicines which affect alertness or can cause or worsen confusion such as sedatives, sleeping pills, antidepressants, or antipsychotics. Additionally, medication for high blood pressure and heart conditions often lower blood pressure in ways that can increase the risk of falling. Some medications including those prescribed for urinary incontinence and some antidepressants can affect the control of blood pressure and/or brain function to increase the risk of having a fall. Additionally, drinking alcohol with or without medications can significantly increase the risk of a fall.

There is evidence that Vitamin D deficiency and insufficiency are common among older people and that, when present, can impair muscle strength and possible neuromuscular function. In addition, the use of combined calcium and Vitamin D3 supplementation has been found to reduce fracture rates in older people living in residential/nursing homes.

The following list is by no means comprehensive but gives some idea of the range of medicines that should be regularly reviewed (at least annually) in a person at risk of falls and/or fractures or who suffers from frequent falls.

Sedation

Sedation is one of the most common causes of drug induced falls. Older people are more susceptible to central nervous system side effects of excessive sedation, increasing body sway and slowing reaction time.

Classes of Medications	Common examples
Anxiety/sleeping tablets	Nitrazepam, Zopiclone
Antidepressants	Amitriptyline, Mirtazepine, Fluoxetine, Citalopram
Antipsychotics	Chlorpromazine, Risperidone
Drugs for Dementia/Alzheimer's	Donepezil, Galantamine
Anticonvulsants	Carbamazepine, Phenytoin, Topiramate, Gabapentin
Analgesics	Co-codamol, Co-dydramol
Sedating antihistamines	Chlorphenamine, Cetirizine
Anti-Parkinson agents	Co-Beneldopa, Co-Careldopa, Cabergoline
Antimuscarinics	Tolterodine, Oxybutinin
Antiemetics	Metoclopramide, Prochlorperzine
Muscle relaxants	Baclofen, dantrolene

Postural hypotension (Blood pressure)

Control of blood pressure at rest and movement is already impaired in the older person therefore they are more susceptible to low blood pressure which can cause blurred vision/confusion in an individual that may already have impaired vision due to cataracts. It can also cause unsteadiness, particularly when a person first stands up and blackouts.

Classes of Medications	Common examples
Anti-Parkinson agents	Co-Beneldopa, Co-Careldopa, Cabergoline
Diuretics	Furosemide, Bendroflumethiazide
Beta blockers	Propranolol, metoprolol, atenolol, bisoprolol
ACE inhibitors	Ramipril, Candesartan
Alpha blockers	Doxazosin
Vaso dilators	Isosorbide Mononitrate
Calcium channel blockers	Amlodipine, Diltiazem
Antipsychotics	Chlorpromazine, Risperidone, haloperidol

General medical conditions

Classes of Medications	Common examples
Drugs for heart failure	Digoxin
Muscle relaxants	Baclofen
Hypoglycaemics (Diabetes)	Insulin
Corticosteroids (anti-inflammatory)	prednisolone
Anticonvulsants	Vigabatrin
Eye drops for glaucoma	Timolol
Non steroid Anti Inflammatory	Ibrufen, Naproxen

Bone Strength

Several medications can affect the strength of bones by impacting on the absorption of essential minerals; this can mean increased risk of fracture.

Psychotropic medications

Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce the risk of falling.

Medication Reviews

Regular medication reviews and modification should be undertaken by specialist health professionals such as community pharmacists and General Practitioners. Following any review the risk should be reassessed and care plan updated.