Falls Guidance for Care Homes for Older People

A guidance document to help reduce the risks of individuals falling and how to support them if a fall occurs

Produced by NHS Gloucestershire ICB

In partnership with:
South Western Ambulance Service NHS Foundation Trust (SWASFT)
Gloucestershire Hospital NHS Foundation Trust (GHFT)
Gloucestershire Health and Care NHS Foundation Trust (GHC)
Thomas Pocklington Trust

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Date approved:	01/09/2023
Last revised:	
Review date:	01/09/2024

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SECTION 1

1.1 Introduction

According to NICE "Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year."[1]

Falls are a major cause of disability, loss of independence and loss of life in older people. Injuries caused by falls are a leading cause of death among people aged over 75 in the UK. The fear of falling among people and those who care for them reduces quality of life and well-being.[2] Despite this, falling should not be seen as an inevitable part of ageing.

Most people over 65 do not fall each year. Falls are not an inevitable part of ageing. A fall is always due to the presence of one or more 'risk factors'.[3]This guidance aims to support homes in taking a "positive risk taking" approach to falls which recognises the importance of individual quality of life, choice, and independence. People who reside in Care homes are 3 times more likely to fall than people living independently in their own homes. They are also 10 times more likely to sustain significant injury as a consequence of falling.[4]

Falls prevention is the responsibility of all members of the Care Home team. There are several things that can be done to help individuals reduce their risks of falling, with an emphasis on preventing falls, not just managing falls once they have occurred.

Individuals should be encouraged to keep as active and independent as possible to maintain a good quality of life. Limiting physical activity or exercise reduces muscle

[1] NICE (2013) Falls in older people: assessing risk and prevention, p4
[2] University of Nottingham (2012) Action Falls: Manual for Care Homes, p17
[3] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p14
[4] Cooper, Rosie (2017) Reducing falls in a care home. BMJ Quality Improvement Programme. Reducing falls in a care home | BMJ Open Quality Accessed online 13 March 2023.

strength, affects balance, and leads to dependency, which may lead to an increase in the risk of falling.

Regular appropriate exercise designed to improve strength and balance has shown to have a significant benefit on an individual's mobility and independence. Social events such as tea dances help promote mobility in a gentle and enjoyable way. Targeted exercises given by trained professionals can be incorporated into an individual's daily routine to maximise their independence and confidence with mobilising and reduce the risk of falls.

The reasons why an individual may fall are multifactorial and a fall should not be looked at in isolation. There is not always a medical reason for why an individual should fall, just as there is not always a physical reason for an individual's fall. There may be an environmental factor associated with the risk of an individual falling or potentially a combination of medical, physical, and environmental factors.

Using a falls assessment tool and regularly reviewing individuals can help to identify factors putting them at risk of falling. If you can identify the risks, you will be in a better position to minimise those risks.

It is recommended that this guidance be used in conjunction with the Falls Training Programme freely available through the Care Sector Support Team.

1.2 Outcomes

Support homes in developing a "positive risk-taking approach" to falls.
Support homes to identify and support those at risk of falling without reducing individual quality of life, choice, or independence.
Reduce incidences of "long lies" by providing access to decision-making tools.
Provide recommended resources to support homes in risk assessing those at risk of falling, implementing appropriate interventions, and provide a clinically approved post falls response.
Signpost homes to further recommended guidance where appropriate.
Reduce incidences of falls within care homes.

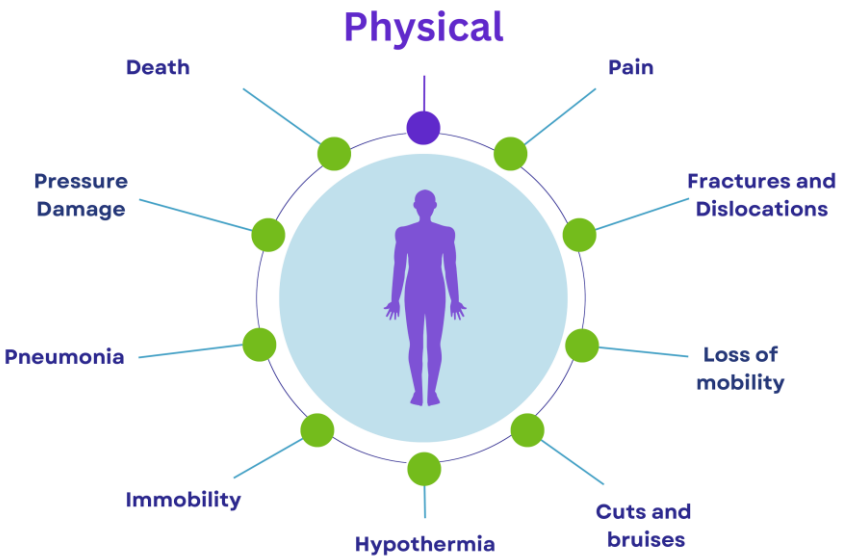
1.3 Definition of a fall

A fall 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)'.[5] This definition does not include 'trips' where a person successfully regains their balance and does not come to rest on the floor.

Everyone working in a care home has a key role in identifying and reducing the risk of falls as part of supporting the health and well-being of individuals. National guidelines (produced by the National Institute for Health and Care Excellence) and research literature emphasise the importance of reducing falls risks to prevent falls and serious injuries. Guidelines recommend that all care homes carry out a person-centred approach to prevent and manage falls for each care home individual.[6]

Figures 1 and 2 show some of the physical and psychological consequences of a fall and/or a prolonged length of time lying on the floor.

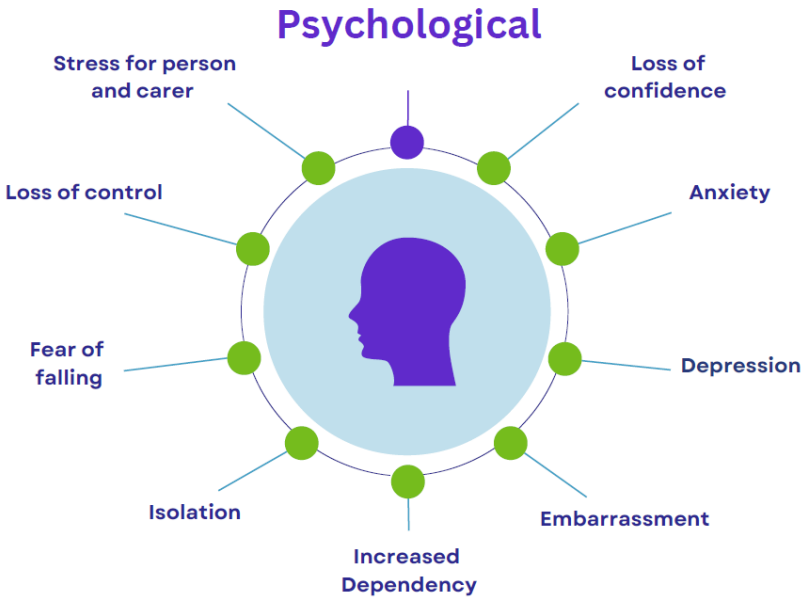
Figure 1: physical consequences of a fall and/or a prolonged length of time lying on the floor



[5] Public Health England (2022), Falls: applying All Our Health, Falls: applying All Our Health - GOV.UK (www.gov.uk) (accessed 20/04/2023)

[6] Nottinghamshire Healthcare NHS Foundation Trust (2019) React to Falls p2

Figure 2: psychological consequences of a fall and/or a prolonged length of time lying on the floor



1.4 Guidance statement

To be most effective, this guidance should be implemented in its entirety and is intended to be used in conjunction with the Falls Training Programme which can be freely accessed through the Care Sector Support Team. The training programme includes access to a Community of Practice which offers ongoing support for Falls Champions who have received the full programme of training as further CPD.

This guidance does not replace any health and safety or moving and handling policies and should be used in conjunction with the home's own falls policy.

This guidance will be reviewed on a yearly basis or sooner if there is a change of legislation or regulation.

1.5 Clinical governance

According to CQC, "Under the Health and Social Care act 2008, it is understood that there are inherent risks in carrying out care and treatment and a post fall response will not be considered unsafe if providers can demonstrate that they have taken all reasonable steps to

ensure the health and safety of the person using their services, and to manage risks that may arise during care and treatment."[7]

This guidance has been produced by NHS Gloucestershire Integrated Care Board in partnership with South Western Ambulance Service NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, and Gloucestershire Health and Care NHS Foundation Trust and it is acknowledged that should the care home routinely follow the guidance, the above statement prevails.

This guidance must be used with common sense and in line with duty of care. If there are any clinical concerns regarding an individual, an appropriate clinician should be contacted.

SECTION 2

2.1 Falls risk assessment

The risk of falling can never be completely removed, but by carrying out a multifactorial falls risk screen (MFRS) with an individual, their risk factors can be identified, and action taken to remove or reduce risk where possible. Considering environmental risks within the care home is part of this process.[8]

Any new individual should have a MFRS conducted within 24 hours of admission to the care home including people admitted for respite. The MFRS should then be reviewed monthly or following an event such as an admission to hospital, change in the individual's condition or fall.[9]

For the purposes of this guidance, we recommend using the *Action Falls Checklist*. The Action Falls Checklist (formally GtACH) was devised by a group of falls experts from Nottinghamshire from a range of organisations including health, social care, the voluntary sector, university academics and individual groups. The Checklist was adapted for use in a Care Home environment through the Falls Research Project from 2008-2010 with care home staff helping to develop the wording and format. This was published in 2012 (Robertson et

[7] CQC (2023), Regulation 12: Safe care and treatment, Regulation 12: Safe care and treatment - Care Quality Commission (cqc.org.uk) (accessed 19/04/2023)
[8] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p14
[9] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p27

al, 2012). The research group undertook a clinical trial, the largest in the UK, and this trial found the Action Falls Programme, could reduce falls by 43%.[10]

A blank checklist for photocopying can be found in *appendix 1* and *appendix 2* and contains guidance notes as to how the checklist should be completed and used.

The *Action Falls Checklist* should then be incorporated into the individual's existing care plan.

2.2 Role of the multidisciplinary team (MDT)

"Each care home will be supported by a multidisciplinary team in its aligned Primary Care Network (PCN). Members of this MDT will deliver the weekly home round,… will be responsible for the development and maintenance of personalised care and support plans for care home individuals, and will make every reasonable effort to support delivery of these plans."[11]

Care homes are part of a wider health and social care system. By working together with health and social care practitioners with a wide range of specialisms, this can help to reduce falls within care homes.

If you feel you are not being supported by your aligned PCN and/or GP practice(s), please contact the Care Sector Support Team.

2.3 Referrals into community services

Due to the upcoming release of the refreshed Enhanced Health in Care Homes (EHCH) framework, the below referral routes are likely to change.

If an individual has had a fall/or is at risk of falling which may have a medical cause, liaise with/refer to their GP if appropriate. The GP can also refer onto the medical falls clinic if deemed appropriate.

The Falls Assessment and Education Service accept referrals for individuals if they meet the criteria for 2 or more falls in a 6-month period. You do not need to refer to the Falls

[10] University of Nottingham (2012) Action Falls: Manual for Care Homes, p6
[11] NHSE (2020) The Framework for Enhanced Health in Care Homes V2, p13

Assessment and Education Service if you consider that you have completed a multifactorial falls assessment and that you have the relevant action plans in place. The s service provides telephone support to assist in identifying support already in place for the individual and support if there are any gaps. The service will then refer or signpost to other services such as the Integrated Community Team for physiotherapy input or the Care Sector Support Team if more general support is required.

https://www.ghc.nhs.uk/our-teams-and-services/falls/
Falls@ghc.nhs.uk
0300 421 6241

Please contact the Care Sector Support team on glicb.caressectorsupportteam@nhs.net for ongoing support with training and advice.

For physiotherapy and occupational therapy support, contact the Integrated Community Teams using the below contact details. Please contact the team appropriate to your area.

Cheltenham:	ICTReferrals.Cheltenham@ghc.nhs.uk
Cotswolds:	ICTReferrals.Cotswolds@ghc.nhs.uk
Gloucester:	ICTReferrals.Gloucester@ghc.nhs.uk
Forest of Dean & TNS:	ICTReferrals.ForestTNS@ghc.nhs.uk
Stroud & Berkley Vale:	ICTReferrals.Stroud@ghc.nhs.uk

2.4 Risk factors

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.[12]

Postural (orthostatic) hypotension

Orthostatic hypotension, sometimes known as postural hypotension, is a drop in blood pressure that causes an inadequate supply of blood to the brain. This can result in dizziness, feeling faint, unsteadiness or confusion. All of these symptoms can result in a fall. If severe it can cause a faint.

[12] NICE (2013) Falls in older people: assessing risk and prevention, Clinical guideline [CG161], p4

The drop in blood pressure usually occurs shortly after getting up from a lying or sitting position or after the person has been on their feet for some time. Sitting down again or going into a lying position relieves symptoms in most cases. Dehydration, medication, and illness may cause or worsen postural hypotension. Often people with postural hypotension 'just go down' or may be found on the floor with no explanation. In severe cases it can occur while sitting. Bathing or a hot shower may also bring on the symptoms.[13] Asking the individual to drink as large a glass of water as they can manage in a single sitting or encouraging the person to squeeze their buttocks or move their legs such as marching prior to getting out of bed can reduce incidence of orthostatic hypotension as can maintaining adequate hydration throughout the day. Seek advice from the individual's GP prior to implementing.

Hydration and nutrition

It is important to eat well and stay hydrated with dehydration being well recognised as a cause of drop in blood pressure on standing up, frequent urine infections and general ill health.[13]

It is important to consume a wide variety of food and fluids. Individuals should aim to drink about 6-8 glasses of fluid each day, which can be from a variety of drinks, hot or cold, not including alcoholic drinks.[14] If individuals are well hydrated it can help to reduce falls.

Individual therapeutic dietary advice may be required from a dietician for individuals who have specific medical conditions such as stroke, diabetes, and coeliac disease.

A referral to speech and language therapy should be sought for advice regarding swallowing and functional difficulties with eating and drinking.

A well-balanced diet and good hydration are essential to maintain good health of individuals.[15]

Any concerns regarding poor oral intake and unexplained weight loss should be discussed with the GP or an appropriate healthcare professional.

The Gloucestershire Nutritional care pathway can be found on G-care or in the CSST resource pack. The CSST also host a monthly Dietitian Peer Group Support forum for Nurses, Care Leaders and Chefs. The Dietitian Peer Support Group is an informal group

[13] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p54
[13] University of Nottingham (2012) Action Falls: Manual for Care Homes, p21
[14] British Nutrition Foundation (2021) Healthy hydration for older adults with poor appetites
[15] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p68

where care home staff have the opportunity to ask non individual specific queries to a Dietitian and share best practice/experiences with each other.

For further advice of hydration, please see *appendix 3*.

Alcohol

Alcohol can affect certain medication and has a more intense effect on someone who is dehydrated or frail. Staff should have an awareness of the interactions of alcohol with the medication(s) that the individual is prescribed and complete a risk assessment as appropriate.

Where there is a concern around an individual's wishes to partake of alcoholic beverages, advice should be sought from their GP.

Continence

Urinary incontinence is of significant concern to older adults and can lead to isolation and reduced self-worth. Those with urgency incontinence are at a higher risk of falls.[14]
Factors relating to continence which may increase a person's risk of falling:

- Difficulty accessing the toilet
- Urgency
- Needing to use the toilet overnight
- Difficulty managing commode
- Catheter
- Constipation
- Difficulty managing clothes.

A continence assessment should be completed and a referral to the community continence service if required.

Other actions that may support your individuals could include:

- Agreeing a toileting routine/use of continence products;
- Considering a commode;
- Considering equipment e.g., raised toilet seat;
- Ensuring a safe environment e.g., night light or signs;
- Regularly checking to see if someone needs the toilet;
- Ensuring use of mobility aids when required to access the toilet

[14] Moon, S., Chung, H. S., Kim, Y. J., Kim, S. J., Kwon, O., Lee, Y. G., Yu, J. M., & Cho, S. T. (2021). The impact of urinary incontinence on falls: A systematic review and meta-analysis. PloS one, 16(5), e0251711. https://doi.org/10.1371/journal.pone.0251711

Careful consideration needs to be made when installing or using equipment in communal areas that, whilst meeting the needs of a particular individual, may increase the risk for others. For example, using a raised toilet seat which may then make the toilet too high for other users.

Being unwell

It is essential that staff are able recognise the sick and deteriorating individual and any concerns are escalated to the appropriate clinical service. Should an individual become unwell, for example with a chest infection, urine infection or delirium, their risk of falling increases.

We would recommend that care staff complete *Recognition of the Acutely Unwell and Deteriorating Individual* training which is freely available via the Care Sector Support Team.

Pain

It is important that pain is managed effectively as the link between pain and increased falls risk is well documented. Staff should ensure that medication is given as prescribed and any concerns regarding the management of pain are reported to the individual's GP.
Pain management should be assessed and documented as part of an individual's falls risk assessment and care plan.

Medication and polypharmacy

An individual who takes 4 or more medications has an increased risk of falls. A medication review should be completed by the individual's GP or Pharmacist on a yearly basis and after a fall or hospital admission.

Care staff should be aware of any side effects of medication and report these to the GP and pharmacist, particularly when a medication has been started, stopped, or changed in the last 2 weeks.

Some medication is time critical, for instance Parkinson's Disease medication therefore it is important that staff follow the advice given as delays to medication administration will have a significant impact on health and wellbeing. Guidance from CQC can be found here Time sensitive medicines - Care Quality Commission (cqc.org.uk).

Where individuals wish to partake in alcohol, staff must be aware of the potential interactions on any medication that they are taking, incorporate this into their risk assessments and seek further advice if required.

Guidance on deprescribing and polypharmacy is under review as of September 2023. The current Gloucestershire guidance can be found in *appendix 10* but please be aware this is likely to change, and the new guidance will be circulated when available.

Feet and footwear

Individuals' feet and nails need to be monitored to ensure they are in good condition and pain free. Regular chiropody visits are essential. Ensure feet are washed and dried well. Any concerns regarding feet should be referred to podiatry for assessment.

Footwear should have a flat non-slip sole, adjustable fastening and be well fitting.
The Care Sector Support Team offer free training on Basic Footcare. For further information, please refer to www.rcpod.org

Clothing

The types of clothing worn by an individual may put them at risk of falls. Staff may need to advise individuals and/or families on the appropriate length of clothing to purchase. Staff should also support individuals to ensure that belts and buttons are properly fastened. During dressing and undressing, some individuals may be prone to losing their balance. It is important to risk assess factors that may increase the risk of falls during self-care activities and ensure that any recommendations or provisions are documented in Care Plans and risk assessments.

Sensory impairment

Visual impairment is a risk factor for falls. For the individuals that you are caring for, this may be due to the ageing process, where decreased contrast sensitivity (making it harder to see the edge of steps and kerbs) alters depth perception and causes visual field disturbances.[15] It may also be caused by an eye condition such as glaucoma, diabetic retinopathy or cataracts.

To try and reduce the risk of falls associated with visual impairment staff should ensure that:

- individuals have their eyes tested once a year and receive appropriate treatment if staff have any concerns regarding their vision;

[15] CSP (unknown), Get up and go, P9

- individuals who are prescribed glasses are supported to keep them clean, in good working order and worn consistently;
- Varifocals and bifocals can increase the risk of falls, if staff have any concerns regarding the use of or prescription for these type of glasses with individuals who are at risk of falls, this needs to be discussed with the Optician.
- a clutter free environment is maintained with adequate lighting.

"*For people with a visual impairment or limited vision, the biggest risk to falls is objects on the floor that people have not been told of. This includes things left, or things moved without the person being told they were moved and where they have been moved too. Objects at head height can also be a problem. If your balance is not good and you hit something with your head or shoulder you could fall. Slippery falls are a significant issue, as is poor lighting. The tops and bottoms of stairs are a particular hazard. These need both tactile and good colour contrast.*" – Alun Davies, Thomas Pocklington Trust

Evidence shows that hearing loss increases the risk or impact of various other long-term conditions, and many health conditions are associated with ageing, so are likely to occur alongside hearing loss. Research has also shown that hearing aids can reduce the risk of developing or the impact of some of these conditions.

Research has shown that hearing loss:

- doubles the risk of depression
- increases the risk of anxiety and other mental health issues.
- can lead to dementia – there is strong evidence to support this in older people may lead to an increased risk in falls. [16]

To help reduce the risk of falls linked to a hearing impairment, staff should ensure:

- intervention if you have any concerns regarding their hearing between appointments;
- hearing aids are clean, in good working order, that batteries are checked regularly, and they are worn consistently;
- any concerns with an individual's hearing are reported to their GP as soon as possible.

For further advice and information on hearing loss, visit Support for health and social care professionals - RNID

[16] RNID (2022), Your patients with hearing loss, Your patients with hearing loss - RNID (accessed 16/04/23)

Environmental factors

Environmental hazards can be inside or outside of the care home and can contribute to the risk of falling. Falls often increase when there are new or unfamiliar care staff and/or new individuals and families. Falls also tend to increase during respite stays and the first three months of a new admission to the care home. Therefore, it is important to orientate individuals quickly to the care home.

Hazards in the surrounding environment could include:

- Poor lighting – 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 – high thresholds, poorly fitted and/or patterned carpets, changes in floor covering/colour, slippery floors, and rugs.
- Clutter and obstructions – furniture, clothing, medication/food trolleys, wheelchairs, manual handling, mobility aids and other equipment.
- Poorly maintained equipment – commodes, toilet seats, wheelchairs, walking aids, grab rails and shower seats.
- Access areas – poorly lit hallways, uneven paths, steep stairs, and thresholds at doorways.
- Outdoor areas – grass, stones, uneven and/or poorly maintained paths and poorly maintained gardens.

There are many reasons why an individual may be more at risk of falls because of their interaction with the environment.

- Some medical conditions make it more difficult to move from one place to another such as Parkinson's, dementia and for those who have suffered a stroke.
- Physical challenges such as poor balance and loss of muscle strength making it difficult to transfer or walk.
- Difficulty seeing the environment due to poor vision.
- Being disoriented in the surrounding environment.
- Being distracted by other people.

An environmental assessment should be completed for each individual upon admission and regularly updated. A general care home environmental risk assessment should also be completed monthly and any risks identified, and actions taken to reduce those risks recorded.

Dementia and cognitive impairment

Dementia is an umbrella term for a syndrome or group of related symptoms associated with a decline of brain function. It is the loss of cognitive functioning (thinking, remembering, language and problem solving) to such an extent that it interferes with a person's daily life and activities.

People living with dementia are known to be at higher risk of falls[17] and may have other conditions that further increase their risk. They are also more likely to sustain injury and require hospitalisation as a consequence of falling.

Each person experiences dementia in a different way, but their risk may be greater due to:

- difficulty finding their way around;
- problems with postural control, mobility, balance, and muscle weakness;
- problems processing what they see;
- a lack of awareness of risk behaviour;
- being unable to react to situations;
- taking medications that may cause dizziness, drowsiness, or reduced blood pressure.
- an inability to express their needs, feelings, or worries.
- depression or anxiety.

Osteoporosis

Strong bones are important for health and people with low bone mineral density are more likely to experience a fracture following a fall. Osteoporosis, which affects over 3 million people in the UK, is one of the reasons why people have low bone mineral density.

Fragility fractures are most common in bones of the spine, wrist, and hip. Fragility fractures are fractures that result from mechanical forces that would not ordinarily result in fracture, known as low-level or 'low energy' trauma. The World Health Organization (WHO) has quantified this as "forces equivalent to a fall from a standing height or less". Hip fractures alone account for 1.8 million hospital bed days and £1.1 billion in hospital costs every year, excluding the high cost of social care.[18]

[17] Peek, Kerry et al (2020), Reducing falls among people living with dementia: A systematic review. *Dementia*. Accessed online 31 March 2023.

[18] Office for Health Improvement and Disparities (2022) Falls: applying All Our Health https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health (Accessed 23.03.23)

Prevention of osteoporosis and fractures from osteoporosis is through nutrition, exercise, and osteoporosis medication. Important aspects of nutrition relate to having enough calcium and vitamin D.

Dizziness

Older people often experience dizziness or imbalance and this is a risk for falls. There are many potential causes of dizziness such as poor balance, cognitive changes, changes in blood pressure, medications and vertigo. Symptoms may not always be reported by the individual so should be specifically raised and reported to the individual's GP if required.

Hip protectors

Hip protectors are devices fitted with plastic shields or foam pads covering both sides of the hip. An individual or family may wish to purchase these to help reduce the risk of hip injury following a fall. For hip protectors to be of benefit, they must be worn consistently which can be can barrier as some people find them uncomfortable or difficult to put on/take off.

In older people living in nursing care facilities, providing a hip protector:

- probably decreases the chance of a hip fracture slightly
- may increase the small chance of a pelvic fracture slightly
- probably has little or no effect on other fractures or falls.[19]

NICE include Hip Protectors in the section 'Intervention that cannot be recommended because of insufficient evidence'. New guidance will be issued in 2024 however, the latest surveillance review (2019) did not find any new evidence relating to hip fractures that would alter this advice.[20]

2.5 Assistive technologies

All falls prevention equipment (including mats, sensors, and call bells) should be regularly checked to ensure they are working and in good condition. Staff should ensure that call bells are accessible for the individuals using them, whenever they need them.
The use of assistive technology requires careful consideration and risk assessment, particularly for those with cognitive impairment as they can increase the risk of falls in some

[19] Cochrane (2014), Hip protectors for preventing hip fractures in older people, https://www.cochrane.org/CD001255/MUSKINJ_hip-protectors-for-preventing-hip-fractures-in-older-people (accessed 01/04/23)
[20] NICE (2013), Falls in older people: assessing risk and prevention, https://www.nice.org.uk/guidance/cg161/chapter/1-recommendations (accessed 21/04/23)

circumstances. For example, a dark mat on the floor may be perceived by someone with a cognitive impairment as being a hole they need to step over or around. For those with visual impairments, Telecare may create a tripping hazard. In instances where Telecare equipment is deemed not to be appropriate, alternative solutions need to be put in place such as regular monitoring which should be incorporated in the risk assessment and Care Plan.

There are many types of equipment available, should you require further advice, the Gloucestershire Telecare Service can be contacted on telecare@gloucestershire.gov.uk and 01452 583 774 or 01452 583 784.

2.6 Safe and appropriate use of equipment

Individuals, care staff and prescribers need to follow the manufacturer's instructions whilst using equipment and any warnings about associated risks. Any moving and handling tasks undertaken by staff should be in accordance with the homes own policy and following the relevant moving and handling training.

Equipment prescribed by a Health Care Professional (HCP) such as an occupational therapist or physiotherapist should be issued with guidance and instructions on safe and appropriate use, which must always be followed by staff and any concerns discussed with the prescriber.

Equipment that is used by or with individuals should be maintained correctly and effectively and any damage or faulty equipment reported immediately. Staff should be monitoring equipment that is used with individuals for signs of wear or fault before each use.

Mobility Aids

Care staff should ensure that mobility aids purchased or prescribed for an individual are readily available, in good working order and well maintained to promote safe mobility.

Wheelchairs – regular maintenance includes checking tyre pressure, treads, nuts and bolts, wheels, and brakes. Most wheelchair manufacturers recommend a full service once a year. Mobility aids – regular maintenance includes checking wheels and brakes, nuts, and bolts. Mobility equipment - Check ferrules regularly for wear and replace as necessary, these can be purchased online or in pharmacies.

Bed rails

Bed rails (also known as cot-sides, safety sides and bed guards) are intended to reduce the risk of a person falling out of bed and injuring themselves. They are not to be used to prevent people from leaving their beds or as a form of restraint.

Rigid bed rails can be classified into **two basic types:**

- **Integral** - incorporated into the bed design and supplied with it or are offered as an optional accessory by the bed manufacturer, to be fitted later.
- **Third party** - not specific to any particular model of bed. They may be intended to fit a wide range of domestic, divan or metal framed beds from different suppliers.[21]

When used incorrectly, bed rails have led to serious injury and death by asphyxiation because of entrapment of the head or chest. It is imperative that careful, thorough, and individual risk assessments are completed to avoid any serious incidents.

Bed levers (also known as bed sticks or grab handles) are also available to support people to get in and out of bed safely. They are not designed to prevent people from falling out of bed and they should also not be used as a form of restraint. Bed levers can present the same risks of injury as bed rails and require thorough risk assessment.

There should be a bed rail risk assessment completed for each individual considered to be at risk of falling from bed. This risk assessment should include whether the use of bed rails would be appropriate, the decision taken and the reasoning behind the decision. The assessment should be reviewed regularly and following a fall or change in care needs.

For further information regarding the appropriate use of bed rails, please refer to *appendix 4*.

Seating

It is important to have a selection of chairs which are different heights, depths, and widths to cater for individual's needs. Incorrect size seating can cause risk factors such as slipping forward, leaning, restlessness and reduced comfort. It will also affect how safely a person can sit into or stand from their seat.

[21] MHRA (2021), Safe use of bed rails, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/951734/Safe-Use-Bed-Rails_Jan2021.pdf (accessed 12/04/2023)

When adding pressure cushions or devices such as occupancy sensors to a seat, care must be taken to ensure that this does not affect the dimensions of the chair. For example, adding a pressure cushion may reduce the height of the arms of the chair which reduces the support the chair provides and will put an individual at risk of falling out. Likewise, adding a cushion such as a pressure cushion on top of a seat may make the seat unstable and put a person at risk of sliding or slipping from the chair. Riser Recliner chairs should be used with caution and must be risk assessed, they must also not be used as a means of restraint. Chairs should be supportive and comfortable. If you have any concerns regarding an individual's posture or ability to sit safely in a chair that is the correct size for them, they may require a specialist seating assessment which an occupational therapist can support with.

Further training on seating can be accessed through the Pressure Ulcer Prevention training offered by the Care Sector Support Team.

Moving and Handling Equipment

Moving and handling equipment must be used with caution and only following a thorough risk assessment, considering the individuals and carers needs.

Inappropriate and unsafe use of moving and handling equipment can result in falls and severe injury, so it is important that all staff are familiar with each individual and their care needs and follow the moving and handling guidance outlined in their care plan.

In cases where an HCP has prescribed moving and handling equipment, the advice and recommendations for use must always be followed. Any changes to the individual's needs must be reported back to them so that an updated assessment can be completed.

Guidance on the safe use of equipment can be found here - Moving and handling in health and social care: Moving and handling equipment (hse.gov.uk)

Information on the safe use of hoists and slings can be found here - Getting to grips with hoisting people Health Services Information Sheet No 3

Where lifting equipment, including hoists and slings, are used by people who are at work, the Lifting Operations and Lifting Equipment Regulations (LOLER) apply. More information can be found here - Equipment safety in health and social care services (hse.gov.uk)

Faulty equipment

Any mobility or lifting equipment should be maintained correctly and effectively and any damage or faults reported immediately. Staff should be monitoring equipment for signs of wear or fault before each use.

For equipment privately owned – Follow homes own policy.

For equipment prescribed by a Health Care Professional and issued by GIS –
Repairs/Breakdowns of Hoists, Mattresses or Beds -
Mon – Fri 9am to 5pm, call MEDIQUIP - 0117 957 9140
Mon - Fri 5pm to 9am, Saturday, Sunday and Bank holidays, call CYGNET - 0208 573 2871
Any other equipment which is worn/ defective/ broken/ unsafe or if an individual's needs have changed, please get in touch with the Adult Helpdesk (01452) 426 868 or the appropriate ICT as a reassessment may be needed before a replacement can be issued.

2.7 Activity (and why it matters)

Regardless of age, physical activity and exercise is beneficial for health and wellbeing. This is no different for those living in care homes. Studies have shown a lot of inactivity amongst care home individuals with many activities of daily living being taken over unnecessarily by care staff. Many of these activities could be performed by the individuals themselves with support or supervision.

The Care Act (2014) urges care providers to provide services to those in their care that promote independence and prevent deterioration (regardless of any pre-existing condition).[22]

The Chief Medical Officers' guidelines for physical activity in older adults indicate that activities that improve strength, balance and flexibility are important to maintain function and confidence, as well as reduce the risk of falls.[23]

[22] Care Act 2014 UK Government – updated version March 2023 Care Act 2014 (legislation.gov.uk) Accessed online 15 March 2023.

[23] UK Chief Medical Officers' Physical Activity Guidelines (2019). Department of Health. Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK (www.gov.uk). Accessed 13 March 2023

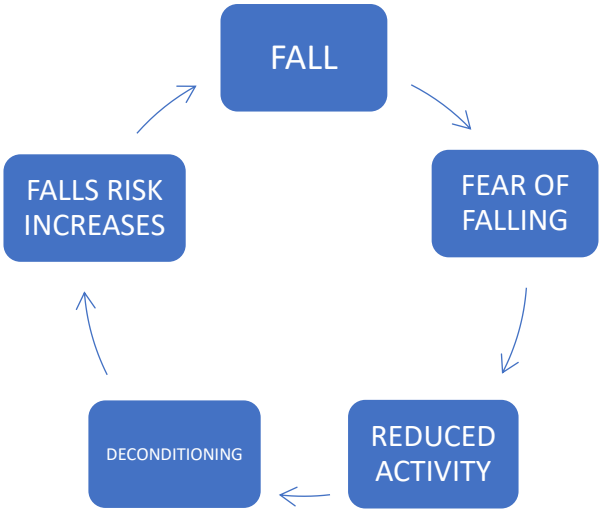
Too much time lying down or sitting, and not enough movement can make health deteriorate. This can lead to issues such as frailty and loss of bone health, leaving an individual vulnerable to slips, trips, and falls. It can also result in loneliness, depression, and a poorer quality of life.

What can happen because of inactivity?

- Loss of muscle mass and power.
- Muscles can tighten and shorten (adaptive shortening, contractures) so joints can become stiff and less flexible.
- Bones lose mineral content and get weaker.
- Development of respiratory problems, aspiration, chest infections, pneumonia.
- Slowing down of the digestive system, constipation, faecal impaction.
- Neurological problems including desensitisation or developing hypersensitivity.
- Malnutrition, anorexia, dehydration.
- Slower metabolism or weight gain.
- Kidney dysfunction, urinary tract infections, urinary retention, incontinence
- Circulation compromise.
- Pressure ulcers.
- Blood clot.
- Loss of confidence.
- Feeling more isolated.
- Becoming depressed.

All of these can increase the risk of falling. Once someone has experienced a fall, their risk of having another fall increases. This is known as the Falls Cycle

THE FALLS CYCLE



Falling once doubles the person's chances of falling again.
For individuals, the opportunity to participate in some sort of physical activity needs to be a priority, as this is a risk factor that is modifiable. The least active individuals stand to gain the most from small increases in physical activity. Exercise seems to benefit the oldest of old most, as well as those in long-term care facilities.

What are the benefits?

The benefits mean that an individual is less likely to experience the negative impacts of immobility/inactivity:

- Improved balance and posture.
- Remaining as independent as possible.
- Improved cardiovascular fitness.
- Improved strength and flexibility.
- Less dependence on staff.
- Reduction in agitation or apathy for those with dementia.
- Confidence to be more active.
- Reduction of pain.
- Preserving physical function and mobility.
- Maintaining abilities for activities of daily living.
- Having some fun and enjoyment with others.
- Having a sense of purpose.
- Reducing feelings of loneliness and isolation.
- Improved mood and self-esteem.
- Improved sleep quality.
- Maintaining cognitive function.

These factors can reduce the risk of falling and harm from falls.

Abilities and needs

Those who are least active have the most to gain from being active, even with small increases of regular activity. If individuals gradually increase the amount and intensity of their activities, they are unlikely to experience undue risk.

'Function focused care'[24] has been proven to be significantly more beneficial to the health and wellbeing of those in individual care. It helps optimise physical activity rather than

[24] Galik t al. (2013) Optimising Functional and Physical activity among nursing home individuals with dementia: Testing the impact of Function-Focused Care. Optimizing Function and Physical Activity Among Nursing Home

simply completing nursing or care tasks and is based around the individual. Essentially it is "doing with rather than doing for" and reduces the risk of the individual becoming de-skilled and deconditioned. The activity needs to be meaningful and enjoyable for it to be sustained, and any movement is preferable to no movement.

Function focussed care activities might include:

- setting the dining table
- folding laundry
- Gardening
- serving 'tea' in the dining room as opposed to a trolley.

How to encourage activity

Whilst there is limited evidence concerning understanding and knowledge of the best ways to optimise support for individuals' physical activity, mobility, and functional independence, the first thing is to get to know what people want. Being prescriptive (telling people what to do) is only going to work if someone is really engaged in getting more active.

Daily activity is important to encourage and enable individuals to move more often. Using an enablement approach, where people are encouraged to be as independent as possible, rather than a more task orientated way of working can work well. Care staff play a key role in successful uptake of programmes designed to increase physical activity and functional independence among individuals in care homes.[25]

Developing community links can be beneficial as many individuals and organisations are willing to visit or bring resources into a care setting. If a positive attitude towards physical activity is developed, not only can it help to reduce falls, but it can also help support positive behaviours and contribute to the health and wellbeing of the home community.

For further information and guidance on activity provision in Care Homes please see the Royal College of Occupational Therapists resources - Living well in care homes - RCOT

Individuals With Dementia: Testing the Impact of Function-Focused Care | The Gerontologist | Oxford Academic (oup.com). Accessed 1 February 2023

[25] Care… About physical activity (2020), Final Report from the Care About Physical Activity Improvement Programme, The Scottish Care Inspectorate. final-report-care-about-physical-activity.pdf (careinspectorate.com). Accessed 1 February 2023

SECTION 3

3.1 How to immediately respond to someone who has fallen

What you do at the time of a fall is really important. Safe moving and handling and prompt, appropriate care and attention can greatly improve an individual's chance of making a full recovery. The immediate care of an individual, following a fall, should include safety at the scene and addressing any injuries sustained, where appropriate. An untimely response can delay the diagnosis and treatment of serious injuries. The responses made should be in keeping with an individual's ReSPECT form or Advance Care Plan (ACP), including any DNACPR (Do Not Attempt Cardiopulmonary Resuscitation).

Steps to take:

- ensure safety at the scene;
- assess for and attend to obvious injury, where appropriate;
- ask for additional help as required;
- where directed, safely move the individual from the floor;
- report and comprehensively record the fall and the consequences of the fall.[26]

The following guidance has been agreed locally with South Western Ambulance Service NHS Trust and NHS Gloucestershire ICB:
Provided the individual is conscious and not at risk of choking, fluids should not be withheld. Regular, small sips of water are important to maintain hydration levels.
Medications should also be administered at the correct intervals, especially those relating to conditions such as Parkinson's, epilepsy, and diabetes. This may be different to the advice you receive from the 999 call handler who cannot see or speak to the individual so routinely must give this advice for safety purposes.

Assessment

In Gloucestershire, we recommend the use of the following post falls assessment tools to help you decide whether is it safe of appropriate to move the person who has fallen –
Post Falls Decision Making Poster
Post Falls Decision Making Tool

The above can be found in a*ppendix 5*. These have been produced by and in conjunction with SWASFT with other healthcare partners.

[26] Scottish Care Inspectorate (2016) Managing Falls and Fractures in Care Homes for Older People – good practice resource, p78

Dignity

Each person should be treated as an individual and included in any discussions and decision making regarding their care.

Comfort

Following a fall, if the individual cannot be safely assisted from the floor in a timely manner, and unless contraindicated, the following practices could be considered to reduce the risk for development of a pressure ulcer or worsening a present one:

- Use the 30° tilted side-lying position or the prone position, if the individual can tolerate this, using appropriate manual handling techniques.
- Avoid lying postures that increase pressure, such as the 90° side-lying position, or the semi-recumbent position.
- Consider using blankets or pillows under the lower leg to offload pressure on heels.

Observations

Observations should be done as soon as possible after the fall. For those individuals who are assessed as being safe to lift and do not require emergency services, they should continue to be observed at the following intervals:

- Every 15 minutes for one hour;
- Once half an hour later;
- Once one hour later;
- Once two hours later;
- Every four hours until a minimum of 24 hours post-fall. Wake the individual up to do the checks (do not assume the individual is simply asleep);[27]
- Continue observations for a further 24 hours if there are ongoing concerns (contact GP/111 for advice where needed).

Should the individual remain on the floor, a member of staff should remain with the individual where possible, and observations should be taken every 15 minutes whilst awaiting for advice, assistance or for the emergency services to arrive.

An example of a post fall observation log can be found in *appendix 6*.

[27] Hampshire County Council Adult Services (2021); Post Falls Protocol; https://documents.hants.gov.uk/adultservices/Procedures/FallsProtocol.docx (accessed 15/05/2023)

Observations should be taken by a competent member of staff. In Gloucestershire, the use of RESTORE2 to calculate a NEWS2 score is recommended.

Free RESTORE2 training is available through the West of England Academic Health Science Network (https://www.weahsn.net/our-work/transforming-services-and-systems/keeping-people-safe-during-and-after-covid-19/training-resources-for-care-homes/book-restore2-training/).

Assisting an individual off the floor

There must be a documented plan in place for getting someone up after a fall.

If the individual is assessed as being safe to move from the floor (see *Post Falls Decision Making Tool* in *appendix 5*), the following actions should be taken:

Independent person
Where appropriate, verbally coach the individual through rising from the floor. A helpful guide can be found in *appendix 7*.

Dependent person
An appropriate hoist or lifting equipment (cushion/chair) must be used to lift the individual from the floor. Please refer to the care home's moving and handling policy and individual risk assessment and Care Plans.

3.2 How to prepare for emergency services attending

The following outlines the 999 and 111 call process

Identification of the critical individual
Before further details are taken, call handlers will establish if the individual is conscious and breathing. This is so that critical calls can be immediately prioritised, and first aid or CPR instructions can be provided.

What is the reason for the call?
This enables the call handlers to follow the most appropriate triage route for the presenting complaint. This determines the clinical assessment undertaken and subsequent questions that you will be asked.

Location

What is the full address - including the postcode? The call handlers will ask you to repeat the address to confirm that they have the correct location.

Age

How old is the individual? It would be helpful to have the individuals' date of birth.

Clinical assessment

The call handler will ask a series of questions to determine the clinical priority of the incident. Instructions may be given throughout the triage.

Depending on the nature of the incident, the triage may include questions about the individuals' medical history and current medications. All questions throughout the telephone triage are asked to identify potentially time critical or serious underlying conditions. It may feel as though some of these questions are not relevant to the call but it is important that the call handlers gather as much information as possible in order to arrange the most appropriate response. These questions will not delay the help that is being provided. Wherever possible, the call handler will ask to speak directly with the individual to better understand their clinical need.

Access and safety

The call handlers will need to know if there are any difficulties in accessing the individual or the property. For example, are door codes required? Where within the property is the individual located? Is the address particularly difficult to find? The call handlers will also request that pets are put into a separate room. You may feel that the animal is no risk to the attending crew, but animals can be unpredictable in emergency events or interrupt the timely provision of care.

Outcome

After your call has been triaged, you will be informed of what the next step is. This could include an emergency or non-emergency ambulance, referral to a GP, other specialist service or advice to make own way to a treatment centre or hospital. Some calls may be passed to a Clinician for further remote triage or for telephone advice in order to ensure that the most appropriate response is arranged.

Dispatch

If an ambulance is arranged and the incident is immediately life threatening (or if continued pre-arrival instructions are required) the call handler will remain on the line until help arrives.

Unfortunately, the call handlers are unable to provide an estimated arrival time. Allocated ambulances can be diverted to individuals where there is a more urgent clinical need or risk to life. This is a dynamic process as 999 calls are continually received. Regular contact from the Emergency Operations Centre will be made to ensure that the clinical priority of your call is still appropriate to the individuals' needs so please try to keep the telephone line open so that the call handler can call you back.

Please be assured that the ambulance service will provide assistance as soon as possible. If there is a change in the individual's condition, please call 999 for re-assessment.

A *post falls assessment and conveyance form* which has been produced in conjunction with both SWASFT and GHFT can be found in *appendix 8*. We recommend that this form is completed as soon as possible to ensure that the right information for both the call handlers and the emergency services is available. A copy of the form can also be scanned into the individual's care records.

3.3 How to prepare for a conveyance to hospital

If the individual is conveyed, SWASFT will need to take medications and up to date Medication Administration Records (MARs chart), relevant care plans and end of life documentation such as Treatment Escalation Plans (TEPs) and DNACPR. They will also need the original copy of the ReSPECT form.

Following a clinical assessment of the individual, the attending ambulance may decide that the individual can safely remain at their current location or may refer the individual for onward care and support within the community. Certain conditions also require treatment at a specialist centre which may mean bypassing a local hospital to reach the most appropriate definitive care for the individual.[28]

3.4 Rapid Response Service – Nursing Homes

Nursing Home clinicians who have completed the Rapid Response training modules are able to refer any individuals into the service who are unwell (with a NEWS2 score of 3 or above),

[28] SWAST (unknown date) https://www.swast.nhs.uk/welcome/hcps/what-to-expect-when-you-call-999 (accessed 03/04/2023)

but not for a fall alone. Homes should continue to contact the appropriate clinical service where necessary following a fall to ensure people are triaged appropriately.
It is possible that the emergency services may refer the person who has fallen into Rapid Response however this referral must come from the emergency services, not directly from the home.

If an individual experiences a non-injurious fall and has been safely lifted but then becomes clinically unwell, Nursing Homes can contact Rapid Response through the usual method.

Section 4

4.1 Post falls documentation

Details of any fall or near miss should be recorded in the history sheet/falls diary/accident form in line with the Care Home's own policy.

"It is important to comprehensively document the fall, the events surrounding the incident and the ongoing care plan in the individuals' care notes to ensure that any subsequent visiting family, carers, or other HCPs are aware of the fall and can help to support the individual safely. Recording when, where and how an individual has fallen is vital for identifying patterns and regularity of falls and helps to provide an accurate history for future clinical assessments. Near misses should also be documented". – South Western Ambulance Service NHS Foundation Trust

Examples of what could be documented:

- Date, time, and location of the fall.
- Description of the fall - what the individual was doing at the time of the fall or whether it was an unwitnessed fall.
- How the individual was found – what position they were in e.g., lying on back or kneeling.
- If they use a walking aid, where was it at the time of the accident.
- Potential causes of the fall.
- Any injuries sustained and/or change in cognition.
- What happened after the fall – did the individual get up themselves, require support or did they have to remain on the floor to await emergency services.
- Whether a GP was called, 111 contacted or an ambulance requested.

- If the individual was taken to hospital (and the outcome of this).
- If the next of kin was informed.
- What has been learned from the incident.
- What actions have happened following the fall i.e., changes to the environment, Care Plan or wider changes.

4.2 The importance of post falls analysis

Gathering and analysing information (data) on falls helps to anticipate and prevent falls rather than just manage problems once they have occurred. Learning from a fall can help you prevent the same resident from falling again but can also prevent others from falling. This can be the case if things like staffing levels, the environment or routines in your care home have contributed to the fall. – Scottish Care Inspectorate

It is important to always investigate the underlying cause of a fall.

Falls Safety Cross

The Falls Safety Cross is a tool recommended by many health and care organisations. It documents falls for each day of a month with the aim of using the data to raise awareness within the team regarding how many falls there have been and promote good practice. It is important to link the data to an improvement aim rather than it being purely for reporting purposes e.g., reducing the number of falls by 20% over a 6-month period.

A falls safety cross, can be found in *appendix 9.*

Reporting a fall

Staff should follow the Care Homes policy and guidance for falls requiring a report.

Further guidance can be found here: Regulation 18: Notification of other incidents - Care Quality Commission (cqc.org.uk)