Managing Falls In Care Homes
This toolkit was produced by Derbyshire County Council and Derbyshire County PCT and updated in 2013 as part of a falls awareness training programme provided for workers in Care Homes and in the Community in Derby City.

Derby City Council would like to thank Southern Derbyshire Clinical Commissioning Group and Derbyshire County Council for agreeing to the inclusion of the toolkit as a training resource for the programme.

We also wish to acknowledge the contribution of Derby Hospitals Foundation Trust and Southern Derbyshire Clinical Commissioning Group to the delivery of the training programme.

The programme was funded by The Local Education and Training Board

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Managing Falls In Care Homes

Aims

This guidance booklet has been produced for the care home sector with the aims of:

- Reducing the number of falls which result in serious injury.
- Ensuring effective treatment and rehabilitation for those who have fallen.

The aims reflect those contained in:

- Standard six of the National Service Framework for Older People 2001 – Falls prevention.
- Prevention package for Older People DH 2009 – Falls and fractures, effective interventions in health and social care.
- Are supported by National Patient Safety Agency and Health and Safety Executive data on falls in this sector.

Objectives

The objectives of the booklet are to provide practical advice and signpost sources of further information for care home owners and managers in the following areas:

- General safety management.
- Developing and sustaining an effective falls management programme.
- Identifying and controlling significant risk factors.
- Utilising resources from other sectors.

To achieve these objectives the booklet has been produced with reference to relevant health, safety and regulatory bodies.

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Summary

Section One – Introduction and Background
This section summarises some of the key facts about falls, gives background to the extent of falls in the care home environment and introduces some of the concepts contained in this booklet.

Section Two – Risk and Risk Management
The concepts of risk, risk assessment and management are outlined in this section. This section briefly defines some terms commonly used when talking about risk.

Section Three – Legal Duties and Guidance
The main legal duties in health and safety law are set out, highlighting the important legal obligations in care planning and risk management.

Section Four – Person Specific Risk Factors
This section looks at the person specific risk factors that are related to falls. The risk factors examined are: drugs and alcohol use, age related physiological changes, psychological and mental health problems, medical conditions, balance/physical activity, footwear and mobility aids.

Section Five – Fractures and Osteoporosis
Many falls result in injury, with fractures being among the most serious consequences. This section looks at how fractures can be prevented through diagnosis and treatment for osteoporosis and the minimisation of trauma. The use of hip protector pads is discussed and advice given on their use.

Section Six – Environmental Risk Factors
This section outlines some of the environmental factors that can be implicated in a fall. Designing with safety in mind, floor surfaces, cleaning, lighting and colour schemes, and furniture, fittings and appliances are considered. Advice is also given on housekeeping and equipment maintenance.

Section Seven – Assessment and Management of Falls Risk Factors
Several tools are provided which can help a care provider in undertaking fall assessments. It is stressed that risk factors should not be assessed in isolation.

Section Eight – Training and Knowledge Updates
This section gives information on the different types of training available to care staff along with information on resources available within NHS Derbyshire County.

Section Nine – In the Event of a Fall/Post Fall Management
Not all falls can be prevented. This section outlines post fall action, reporting of incidents and the role of the East Midlands Ambulance Service.

Section Ten – Conclusion

Section Eleven - References, Section Twelve - further reading/information & Section Thirteen - sources and appendices
These provide additional information and resources for care providers.
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1. Introduction and Background

Slips, trips and falls are a major cause of injury in the older population. In care homes falls account for around 90% of reportable injuries to residents. Many of these falls are preventable. This booklet has been produced primarily for care home owners, operators and managers. It provides guidance on:

- How the likelihood of a fall can be reduced.
- How to limit the severity of injury if a fall should occur.
- What action can be taken after a fall to try to prevent a recurrence.

As falls risk management covers a wide range of factors, this booklet has been produced in consultation with relevant medical, safety and regulatory bodies.

Some facts about falls in the older population

- In care homes the rate of falls is almost three times that of older people living in the community.
- Injury rates are also considerably higher for people living in care homes, with 10-20% of institutional falls resulting in a hip fracture and 25% of people admitted to an acute hospital with a hip fracture coming directly from a care home.
- One in five orthopaedic beds are occupied by an older person with a fractured hip.
- In 2009/10 there were more than 130 people in Derbyshire admitted to hospital from care homes with a fractured hip. Strategies to reduce the risk of falling save more money than they cost.

The human consequences of older people falling

The quality of life of an older person can be significantly reduced following a fall. The effects include:

- Increased social isolation.
- Increased problems with activities of daily living.
- Increasing tendency to depression and mental health problems.
- Increasing physical and emotional dependence.

Many slips, trips and falls in residential care homes are preventable. Injuries arising from a fall can be reduced by prior intervention. Post fall assessment, review and remedial action can reduce the likelihood of further falls. It is important that those residents who have fallen and those who may be at risk from falling in the future have regular reviews of reversible risk factors. The risk factors rarely exist in isolation so effective falls management requires a preventive, holistic approach that considers all of the contributory risk factors.
2. Risk and Risk Management

Residents in care are a vulnerable group and the care provider is responsible for their well-being. 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 have to be trained and the environment and equipment has to be effectively designed and maintained. In other words, health and safety has to be managed as much as any other part of the business.

Managing Health and Safety

Effective management will help you to analyse problems, decide what to do, put decisions into practice and check that actions have been effective. This can be achieved by taking the following steps:

- **Plan:** Set standards and policies. Involve staff. Establish priorities and systems for carrying out risk assessments.
- **Organise:** Make it clear who does what to put the plans into practice. Carry out risk assessments and decide what measures need to be taken. Communicate and consult with staff.
- **Control:** Implement the standards and policies, control measures and training. Make sure that key staff carry out their responsibilities.
- **Monitor:** Check that your control measures are being applied by effective supervision, routine and spot checks, accident and incident investigations, staff feedback.
- **Review:** Ensure progressive improvement by reviewing your approach to risk management in the light of experience. Look at accident reports and investigations and consult employees. Are policies still working? Are standards still correct? Is more or different training needed?
- **Audit:** Periodically review the whole management system.

This 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*¹ and Health and Safety Executive guidance note HSG 65².

Risk Assessment

The management of risks involves identifying and controlling hazards before an incident arises. A typical risk assessment will follow a series of five logical steps;

1. Identifying hazards – a hazard being anything with the potential to cause harm (this could be a matter that relates to the individual, such as drug prescription, or to an environmental hazard such as a slippery floor).
2. Identifying who is likely to be affected and how.
3. Evaluating the risk from the identified hazards – a risk being the likelihood of a hazard causing harm. Decide whether existing precautions are adequate or if more needs to be done.
4. Record the findings.
5. Reviewing and revising the assessment at appropriate intervals.
The Health and Safety Executive advocate this ‘five step’ approach in the Approved Code of Practice that accompanies Regulation 3 of the Management of Health and Safety at Work Regulations 1999. Approved Codes of Practice have a special legal status which is explained in section 3.

Employers who control a number of homes containing similar activities may produce a ‘model’ risk assessment. Such ‘model’ assessments may be used at each workplace only if employers:

- Satisfy themselves that the model assessment is appropriate.
- Adapt the model to the detail of the actual situation.

The latter must include any extension necessary to cover hazards and risks not in the model. Risk assessments must be specific to the work environment. When carrying out a risk assessment, follow a logical procedure, document the findings and make sure that control measures are applied and maintained. Education and information for residents, staff and visitors will increase the effectiveness of the control measures. Risk factors relating to falls can be classified under two headings; Person specific risk factors and Environmental risk factors. These are explained in more detail later.

**It is important that residents who may be at risk from falling and those who have fallen have regular reviews.** The risk factors related to a fall rarely exist in isolation – risk assessments must therefore consider all relevant factors.

**Falls Audit tool**

To reduce falls in homes, managers need to take action in order to manage resources effectively, comply with the Health & Social Care Act essential standards of quality and safety and recommended policy frameworks, and follow good practice in order to improve life for residents. The maintenance of falls records and audits can identify patterns around the circumstances of falls, which can then inform appropriate actions to reduce the incidence of falls. The reporting procedure also raises and maintains staff awareness of the risks and the need for vigilance in this sensitive area of management. The ‘Provider Check List’ is a useful audit tool Appendix 1.

**Key points**

- Residents in care are a vulnerable group and the care provider is responsible for their well-being.
- Effective management will help you to analyse problems, decide what to do, put decisions into practice and check that actions have been effective.
- The management of risks involves identifying and controlling hazards before an incident arises by risk assessment.
- Risk assessment must address all relevant factors.
3. Legal Duties and Guidance

What Does the Law Require?

There are important legal obligations to provide effective care planning and falls management.

- There are general duties placed upon employers to safeguard the health and safety of employees and others (including residents, the public and contractors) by Sections 2 and 3 of the *Health and Safety at Work etc. Act 1974*.
- The *Management of Health and Safety at Work Regulations 1999*, Regulations 3 and 5 and the associated Approved Code of Practice, require employers to assess risks to the health and safety of both employees and residents and to put into effect appropriate arrangements for health and safety planning, organisation, control and review.
- The *Workplace (Health, Safety and Welfare) Regulations 1992*, Regulation 12, and the associated Approved Code of Practice establish an absolute duty for floors to be suitable for their purpose (this includes adequate slip resistance, evenness and slope). Floors must be kept free of obstructions and any article or substance that may cause any person to slip, trip or fall. Regulation 13 requires measures to be taken to prevent any person falling a distance likely to cause personal injury.
- Many Regulations have an associated Approved Code of Practice (ACOP). An ACOP has a special legal status in that if you do not follow the ACOP you must be able to show that you have complied with the law in some other way or a court will find you at fault.

Health and Safety in Care Homes - General Guidance

There is a Health and Safety Executive guidance document *Health and Safety in Care Homes*. The guidance advises on a wide range of relevant legal, managerial and technical matters relating to effective health and safety management. The guidance is intended for owners and managers of care homes, their staff and safety representatives. It describes the main risks found in care homes and how to safeguard workers and residents.

Roles and Responsibilities

**Director of Care or Designate:**

- To ensure that fall and falls prevention is a standard of care.
- Ensures that staff receive the appropriate training and education about falls prevention.

**Registered Nurse (Care Home with Nursing):**

- Completes a falls risk assessment on admission.
- Initiates a plan of care to address residents identified as high risk and implements the necessary safeguards.
- Provides education to family /resident about falls prevention strategies.
- Evaluates care and makes the referrals to the appropriate therapy services if required.

Manager /senior carer (Residential care home):

- Completes a falls risk assessment on admission.
- Initiates a plan of care to address residents identified as high risk and implements the necessary safeguards.
- Provides education to family /resident about falls prevention strategies.
- Evaluates care and makes the referrals to the appropriate therapy services if required.

Health Care Assistant:

- Follows procedure and care plan.
- Monitors resident.
- Recognisers, reports, and records any change in residents to the nurse in charge or manager in charge, depending on the care setting.

Key points

- There are legal obligations to provide 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).
4. Person Specific Risk Factors

The person specific risk factors are mainly related to:

- Drugs and alcohol use, including prescribed medication.
- Age related physiological changes e.g. vision.
- Medical conditions e.g. Stroke, Parkinson’s disease.
- Instability, balance and physical inactivity.
- Footwear or foot care issues.
- Lack of or incorrect use of mobility aids and postural care.
- Pain.
- Cognition, memory and mental health problems.

Studies show that assessing and modifying the person specific risk factors can reduce falls by between 50% and 60%.

Medication and Alcohol

Certain medications can increase the risk of falling. Taking a mixture of medicines adds to the risk. A resident on four or more different medications is at high risk of falling. Older people may have increased sensitivity to some medication - psychotropic drugs, sedatives, analgesics, beta-blockers, anti-depressants, diuretics and anti-hypertensive drugs can cause particular problems.

The consumption of alcohol can be a contributory factor in a fall. This may be compounded by the reaction of alcohol with a range of prescribed drugs, especially benzodiazepines. The medication chart (Appendix 2) gives a list of some of the most common prescribed drugs that can cause older people to fall.

Age Related Physiological Changes

As people age they experience changes such as deteriorating vision, impaired judgement and memory, altered mobility and increased frailty and dependence, all of which can increase the risk of falls.

A lack of exercise can contribute to weakening muscles, stiff joints and poor mobility and balance. There can be a decrease in physical functioning, such as difficulties with activities of daily living or poor night time sleep. Those in poor mental state are more at risk of falling and a fear of falling can cause anxiety, which in turn can itself lead to falls. Despite these changes, falls should not be viewed as being an inevitable consequence of growing older.

Sight impairment can increase the risk of falls. Four conditions commonly associated with falls are:

- Macular Degeneration (blank patches or dark spots in the centre of vision).
- Glaucoma (the optic nerve being damaged by raised pressure in the eye).
- Cataracts (a clouding of the lens making vision blurry or dim).
- Diabetic Retinopathy (loss of sight due to changes in the retina from diabetes).
The physical environment must cater for residents who have deteriorating vision (see the sections on environmental risk factors). Vision aids such as glasses should be kept clean and easily accessible. If a resident is prone to getting up during the night, glasses must be kept within easy reach of the bed. All residents should be seen by an optometrist on a regular basis.

**Psychological and Mental Health problems**

Anxiety and a fear of falling can lead to a reduction in activity and willingness to mobilise. Loss of confidence following a fall can also become disabling. Listen to the person's fears about falling, identify and manage the person’s falls risks then provide support and reassurance to reduce their anxiety about falling. People with learning difficulties or dementia may experience cognitive problems which make it difficult for them to explain physical symptoms to others e.g. pain or remember that there are limitations in their physical abilities e.g. mobility. Specialist physiotherapists and occupational therapists can provide assessments and advice.

**Cognitive impairment: Dementia**

Dementia is caused by different illnesses which affect the brain. The immediate cause is disease in the brain causing loss of nerve cells (neurons). As nerve cells cannot be replaced, the majority of affected people become worse over time. Falls can be a problem for people with dementia; this is due to several factors:

- The alteration in depth perception making judging distances to and between objects, stairs doorways etc very difficult.
- An alteration in the walking pattern can also increase falls risk.
- People can also suffer from prominent visual hallucinations or alternatively appear not to see everyday objects such as tables and walk into them.

These problems are particularly frequent in vascular dementia.

People in the early stages of dementia often respond well to balance and strength training and general exercise provision. In the later stages the aim is around reducing the risk of injury. Measures such as moving furniture, use of hip protectors and bone strengthening; through diet, exercise or medication may be considered.

**Particular attention needs to be paid to the effect of medications in people with dementia. (Alzheimer's disease Society)**

**Parkinson's disease**

Parkinson’s disease is a chronic, slowly progressive degeneration of the brain’s dopamine neuronal systems (Thompson et al, 1997). Loss of balance and falling can be common features in Parkinson’s. There are three main reasons for falling:

**Physical problems** - that increase risk of falling are: physiological changes to posture, ‘freezing’ or problems initiating movement.
Footwear - is also important as rubber soles, slippers and trainers have a tendency to stick on the floor. Leather soles tend to be better, but could be slippery on some floors. If in doubt, refer to an OT for assessment.

Hazards - both indoors and out.

Drugs used to treat Parkinson’s can cause lowering of blood pressure as a side effect. Due to the physical problems associated with Parkinson’s disease the risks associated with household hazards will increase. For example because of the shuffling gait of the Parkinson’s sufferer, rugs or carpets that are not properly fitted will increase in risk status. (Parkinson’s Disease Society, 2003)

Stroke or Cerebrovascular Accident.

In a study published by Forster and Young, (1995) 73% of stroke patient in the study fell in the six months after discharge from hospital.

Factors that will increase the risk of falling are:

- Hemiplegia – weakness or paralysis of one side of the body.
- Difficulties in perception.
- Cognitive problems.

If the deterioration is ‘new’ then referral to a physiotherapist should be made. However, if they have previously been seen and there is no change in their condition, then referral to GP or preventative advice would be more appropriate.

Medical Conditions

Some medical conditions can increase the risk of falling. Cardiovascular and neurological disorders can cause particular problems, see above. It is estimated that fainting or loss of consciousness is responsible for 5% of falls in older people. Some of the more common medical conditions which can be implicated in falls are:

- Stroke.
- Dementia.
- Fits, Faints and Blackouts.
- Postural Hypotension (low blood pressure).
- Urinary Tract Infections (UTIs).
- Urinary Frequency and Incontinence.
- Dehydration.

Residents who regularly wake during the night needing to urinate are at particular risk of falling. A commode placed next to the bed, ensuring that glasses and walking aids are within easy reach and adequate night-time lighting can reduce the risk of falls. Pressure pads placed under the carpet next to a resident’s bed, which are activated when a resident steps onto the pad, can alert staff that a resident may need assistance. Regular checks of residents who are known to get out of bed during the night are also important.
Increasing the amount of water care home residents drink has been shown to reduce the number of falls by up to 50%, other health improvements include better sleep patterns and reduced bladder problems (See further reading).

**Instability, Balance and Physical Activity**

Instability is a major cause of falls in older people. As people age, there are some natural changes in the way they walk. They tend to have:

- Slower gait / walking pattern.
- Decreased stride length and arm swing.
- Forward flexion at the head and torso.
- Increased flexion at the shoulders and knees.
- Increased sway away from the centre of the body.

An abnormal walking pattern may be caused by disease or a physical malfunction. Walking may be affected by many different factors, for example:

- Damage to the inner ear (which is responsible for maintaining balance).
- Central nervous system (causing muscular problems leading to gait abnormalities).
- Degenerative muscle diseases.
- Neurodegenerative illnesses (such as Parkinson’s disease).
- Skeletal abnormalities and disease.
- Arthritis.
- Skin Conditions and foot problems (bunions, ingrown toenails, etc).
- Toxic Reactions.
- Tight or uncomfortable shoes.
- Fear.
- Vision – bifocals / varifocals.
- Pain.

Residents who are suffering from gait instability or abnormal walking patterns should be assessed to rule out easily reversible causes such as foot problems or ill-fitting footwear. Those who continue to have difficulties may benefit from physiotherapy interventions or assessment at a falls clinic. An increase in physical activity may help prevent a fall.

**Exercise** - Physically active residents who remain as healthy, fit and active as possible, both mentally and physically, have fewer accidents and recover from them much more quickly than inactive older people.

Individually tailored strength and balance training exercises prescribed by a physiotherapist are effective in reducing falls by improving muscle strength, balance, reaction time, coordination, mobility and overall physical function. In general, to be effective, physical activity must be specific for the purpose.

- To improve health, and modify certain risk factors for falling (such as strength) moderate physical activity is sufficient.
- To reduce falls, exercise should focus on balance, strength, co-ordination and
reaction times.

- To reduce fractures, exercise should include weight bearing exercise in addition to the falls reduction exercises.

Weight bearing exercise can also help to prevent osteoporosis, and in turn reduce the likelihood of a person sustaining a fracture if they fall.

There is a network of locally trained facilitators who can support the provision of balance training including Otago and chair based exercises which have been shown to reduce the risk of falling. Contact your local falls team or falls activity co-ordinator for further exercise advice (Appendix 3).

**Footwear** - Slip resistance relies upon maintaining a suitable combination of footwear and flooring. Choice of footwear is therefore an important part in preventing falls. In a recent assessment of the causes of falls in residential homes in Bexley, 18% of residents who fell were found to be wearing incorrectly fitting footwear. It is vital that residents wear footwear that is both properly fitting and compatible with floor surfaces. Particular attention should be paid to those residents who have problems with their feet. Residents should be encouraged to wear footwear that provides a sole with good grip and an adjustable fastening (such as Velcro) to ensure good fit.

**Footcare** - Foot problems cause pain and discomfort that affect people’s mobility and can increase their risk of falling. Footcare covers a set of tasks that a healthy adult, whatever their age, would normally do for themselves, this includes toenail cutting and skin care. Resident’s feet should be regularly monitored to ensure footcare needs are met and referred to a qualified podiatrist in order to assess and manage foot conditions.

**Use of mobility aids** - There is a range of equipment that can be provided to help mobility. Many pieces of equipment require individual adjustment to a resident’s personal needs. It is therefore essential to have in place a system to ensure that such equipment can be easily identified and used only by the designated user. Personal adjustments (for example, walking frame height) must only be made by a suitably qualified person. A system by which adjustments can be checked to confirm they are correct is advisable. Mobility aids must be readily available, particularly at times of most need and close to beds and seating. Remember that one person’s mobility aid can become a trip hazard to others.

**Key points**

- By addressing the person specific risk factors, between 50% and 60% of falls may be prevented.
- Most falls are multi-factorial in nature; risk factors should not be considered in isolation.
- Medication can increase the risk of falling.
- Residents who regularly wake during the night needing to urinate are at particular risk of falling.
- Gait instability is a major cause of falls in older people.
- Residents who are suffering from gait instability or abnormal gait patterns should be assessed to rule out easily reversible causes such as foot
problems or ill-fitting footwear.

- Residents who remain healthy, fit and active, both mentally and physically, have fewer accidents and recover much more quickly than inactive older people.
- Choice of footwear plays an important role in preventing slips and trips.
- Mobility aids must be properly adjusted and available.
- Vision – clean spectacles, the correct spectacles for the resident and varifocals.
5. Fractures and Osteoporosis

Not all falls can be prevented. Some residents will fall despite preventive steps taken to reduce the risk. It is therefore imperative that steps are taken to reduce the risk of an injury to a resident if a fall should occur. Fractures are among the most serious injuries caused by falls.

Risk of Fracture

The risk of fracture is highest in those with osteoporosis so approaches to injury prevention must address the force of the fall, the incidence of falling and bone fragility. In practice this means:

- Maximising and maintaining bone strength through the prevention, diagnosis and treatment of osteoporosis.
- Minimisation of trauma through the prevention of falls and the reduction of the force of impact as a result of falls.

Osteoporosis

Osteoporosis is a progressive disease of the skeleton characterised by low bone mass, which increases bone fragility and susceptibility to fracture. Although osteoporosis does not cause falls, those suffering with the disease are at higher risk of sustaining a fracture due to a fall than those with a healthy bone mass. Hip and wrist fractures are the most common fractures associated with osteoporosis. In the UK, one in two women and one in five men over the age of 50 will break a bone mainly because of poor bone health,(Osteoporosis Society 2013, http://www.nos.org.uk/page.aspx?pid=328).

Factors that can Increase the Risk of Osteoporosis - Women are more at risk of developing osteoporosis than men as women have smaller, less dense, bones. Women also experience the menopause, which greatly accelerates bone loss through a lack of oestrogen. Women who experience an early menopause (before the age of 45), an early hysterectomy (before the age of 45), particularly when both ovaries are removed, or who miss periods for six months or more (excluding pregnancy) as a result of over-exercising or over-dieting are particularly at risk. Low levels of the male hormone testosterone can cause osteoporosis in men. Genetic and environmental factors can contribute to the risk of osteoporosis in both men and women.

Diagnosis and Treatment of Osteoporosis - Osteoporosis can be diagnosed by measuring the density of bone, usually through a Dual-Energy X-ray Absorptiometry (DEXA) scan. Treatment for osteoporosis can include drugs such as Alendronate or Calcitonin and the prescribing of Calcium and Vitamin D supplements. If you suspect that a resident may be suffering with osteoporosis, they should be referred in the first instance to their GP.

Hip Protector Pads

Hip protectors consist of a specially designed pad made up of an outer shield of
polypropylene with an inner lining sewn or placed into special cotton Lycra underpants. The pad helps to absorb and spread the impact of a fall. Recent trials have found that hip fractures were prevented when residents wore the hip protectors. They are thought to be particularly useful for frail, thin older people who do not have substantial fat layers, which are known to protect bony areas during impact. The garment must be worn 24 hours a day to be totally effective and there have been some problems with acceptance by users. When used, the hip protectors are washable at up to 40 degrees, and can be worn with an incontinence pad. There are three types of protector currently available in the UK.

Hip protector pads are most suitable for residents who are at high risk of repeated falls and at risk of fracture – especially if they have osteoporosis. **They should only be used as part of a multi-factorial falls reduction management plan – they should not be considered in isolation.** If you feel that a resident is at high risk of fracture and would benefit from hip protectors, advice can be sought from the local falls team.

**Key points**

- Not all falls can be prevented. Steps should be taken to prevent a injury if a fall should occur.
- The risk of fracture is highest in those with osteoporosis who also have a high risk of falling.
- Osteoporosis affects 1 in 3 women and 1 in 10 men.
- Measures to reduce fractures may include treating for osteoporosis and/or the wearing of hip protector pads as part of a multi-factorial assessment.
6. Environmental Risk Factors

This section will look at environmental factors that may be implicated in a fall. Key areas are:

- Design of the physical environment.
- Housekeeping.
- Selection, use and maintenance of equipment.

In most cases slip, trip and fall accidents are unintentional, but risk-assessing falls from a height (particularly from upper floor windows) should take into account intended acts such as suicide. It is important to ensure that fire safety arrangements are not compromised when implementing physical control measures. Consult the fire authority where appropriate.

**Design of the physical environment**

Good design means getting environmental conditions right from the start. This is easier, more cost effective and causes less disruption than trying to apply control measures later. Remember the legal duty to ensure that floor surfaces are suitable for their purpose. Refurbishments, upgrades and redecoration are all good times to review design. Good design includes planning pedestrian and traffic routes to avoid overcrowding or mixing of conflicting activities. There are various sources of information to guide you. These include:

- The Centre for Accessible Environments (CAE)\(^5\), a registered charity.
- Organisations such as the Chartered Institution of Building Services Engineers (CIBSE)\(^6\) who produce specific design publications for residential buildings.
- Organisations such as the Royal National Institute for the Blind (RNIB)\(^7\) who produce guidance documents and an accreditation scheme for care homes.
- Dementia design checklist NHS Services Scotland.

If an architect or consultant is carrying out design work make sure that any known hazards are addressed during refurbishments. Good design also looks at issues such as ease of cleaning, lamp changing and routine maintenance.

**Floor Surfaces**

Floor surfaces are often chosen because they look good, are easy to clean or are inexpensive. There are other factors that must be considered to ensure that the floor surface is suitable for the purpose. When selecting a surface take the following into account:

- Location.
- Who will use it and how it will be used.
- Specific demands to be made on the surface (such as mobile furniture, lifting equipment, wheelchairs, deliveries, etc.).
- Likely sources of contamination.
- Exposure to extremes of temperature.
- Properties of the surface such as wear and slip resistance.
- How and how often it will be cleaned.

**Floor Care, Cleaning and Maintenance**

Correct floor care will:

- Reduce slip hazards.
- Increase the life of the floor.
- Save money in the long term.

Think about maintaining floor surfaces at the design stage; it may influence the choice of floor type. Most homes have many types of floor surface so a record of the manufacturer’s recommendations on care will help ensure that each surface is treated correctly. Cleaning staff must be adequately trained and/or contractors’ methods monitored. The cleaning method used must be relevant to the particular circumstances - it will depend upon the type of spill or dirt to be removed. Recent Health and Safety Executive research has shown that wetting a floor while cleaning up a small spill can result in a more widespread risk immediately after cleaning, even when the floor initially appears dry. Ensure that additional slip or trip hazards are not created (for example, from trailing leads) during cleaning and maintenance. Arrange for routine cleaning to take place at the safest time.

**Improving Slip Resistance**

Floors can sometimes be treated if slipping becomes a problem. The techniques used include:

- Abrading or chemical treatment to give a roughened finish.
- Resin coating with a product containing abrasive particles.
- Overlaying with a material containing abrasives or textured finish.
- Using adhesive backed flooring strips or squares.

There are a number of points to consider if treating an existing floor, these include:

- Compatibility with and suitability for existing surface.
- Cleanliness of existing surface.
- Manufacturer’s instructions for both existing floor and treatment.
- Competent application.

**Lighting, Colour and Pattern**

The main objective in selecting colour schemes in falls management is to enable residents to see and clearly recognise where they are. Lighting, both natural and
artificial, plays an important role. Colour coding may be used to help distinguish different communal, private and service units and areas of higher risk for falls such as stairwells. Older people take longer to adjust to changes in light intensity, which is particularly important when moving between adjoining spaces. This may need to be assessed at different times of the year as the effects of natural light change with the seasons. Glare, reflected light and shadows should be avoided.

Heavily patterned carpets can make changes in level and edges difficult to see and may be perceived as three-dimensional by those with poor sight. Ensure that changes in floor surfaces and levels are obvious. There is a range of advice available on lighting and general colour and pattern design in the documents listed in the references. Effective cleaning, particularly of light fittings, will help to ensure that the design levels are maintained. Light bulbs and tubes must be replaced with the same type and output.

**Furniture, Fittings and Appliances**

In a care environment it is likely that furniture and fittings will be used as a means of support, even though they have not been provided for this purpose. Take account of this in your risk assessment. The number and position of electrical outlets should be designed to minimise trailing leads to electrical appliances. When positioning furniture in a room, consider the location of electrical sockets, appliances and leads. Furniture such as beds and chairs must be at an appropriate height for effective transfers. This will vary between individual residents and should be assessed by a suitably qualified person. Any individual adjustments made must thereafter be maintained. The Health and Safety Executive guidance document *Handling Home Care* provides detailed advice on safe and efficient manual handling and transfers.

**Housekeeping**

Good housekeeping, routine checks and staff awareness will help to control hazards. Floors need to be regularly checked for loose finishes, holes and cracks, worn rugs and mats, etc. Other building elements (e.g. handrails, stairs), portable equipment, fixtures and fittings that may be associated with a fall should all be checked on a routine basis. Daily checks by staff, weekly supervisory checks and an effective defect reporting and repair system will help to ensure that the home is kept in a safe condition. A typical resident's room and a general checklist are shown in appendix 4. Bedside clutter should be avoided as far as possible but essential personal items that may influence stability (such as glasses, walking frames, etc) must be readily available. Obstructions and objects left lying around can easily go unnoticed and cause a trip. Educate staff, residents and visitors to be aware of the risks of falling and encourage them to take positive action to address any perceived risks.

**Equipment Maintenance**

It is important to ensure that any equipment used in the home (particularly lifting, cleaning and mobility aids) is working properly. Maintenance should be a consideration when obtaining new or replacement equipment. All types of
equipment must be serviced and maintained by persons competent to do so. Most equipment requires routine maintenance, adjustment and breakdown repair at some time during its working life. The level of maintenance and inspection is normally linked to how complex the equipment is, how it is used and the risks associated with its use. The manufacturer of the equipment will be normally be able to advise on appropriate maintenance, inspection, testing, adjustment and servicing cycles. Refer to the joint Health and Social Care ‘Provision of Community Equipment for Care Homes in Derbyshire and Derby city’ for responsibilities for providing appropriate equipment including Telecare, medical and mobility equipment. (Publication due 2011).

There are specific regulations relating to lifting equipment that require personal lifting devices and ‘accessories for lifting’ (slings, ropes, etc.) to be examined either at least every six months or in accordance with a scheme drawn up by a ‘competent person’. A competent person in these circumstances is usually an insurance company surveyor or specialist lifting equipment engineer. It is important to keep records showing servicing, planned maintenance and breakdown repair. Individual pieces of equipment must be linked to their maintenance records so a way of identifying each piece of equipment (for example, by an asset or serial number) is essential. A typical equipment log sheet, which can be used for work and residents equipment, can be found at the back of this document.

**Key points**

- Assess the risks
- Don’t compromise fire safety arrangements
- Good design is cost effective
- There is a wide range of advice on good design available
- Regular routine checks will help you control slip and trip hazards
- Good defect reporting and repair arrangements will keep the environment safe
- Make sure that equipment is properly used and maintained
- Good documentation will help you manage equipment maintenance
7. Assessment and Management of Falls Risk Factors

Person specific risk factors need to be assessed for each individual resident and incorporated into their care plan. All risk factors need to be considered. There are various falls risk assessment tools that can be used. Examples of good practice include the 16 point falls risk assessment which leads into an action plan for managing falls risks, a copy can be found in the back of this document. (Appendices 6, 7 and 8) Once a falls assessment has been carried out for person specific risk factors, a care plan must be drawn up or evaluated. This care plan should include falls management interventions which meet the individual needs of the resident to reduce their risk of falling.

Environmental assessment tools

Assessment tools can be used to map ‘hot spots’ to identify where or when falls occur in a care home, simply draw a floor plan of the care home and over a period of time mark the places where falls occur.

Analysis tools can be used to investigate the causes of a serious fall or ‘near miss’ incident to prevent similar incidents occurring again.

Environmental checklists can be used to identify and eliminate hazards (Appendix 4)

Falls prevention checklists

Using a falls prevention checklist regularly has been found to be effective in reducing falls in hospital settings; this could also be used in a care home.

The Ipswich two hourly falls prevention observation tool (can be found in High Impact Actions 2010 – see further reading) includes:

- Hydration – making sure the person has something to drink.
- Checking toilet needs.
- Having the right footwear.
- De-cluttering the area and making sure things are in reach, like the call bell.
- Correctly fitted bedrail
- Appropriate walking aid, if applicable

Falls Risk Assessment Tool (FRAT)

This risk assessment tool indicates when a person is at high risk of future falls. The FRAT can be used to identify residents which might benefit from further falls assessment (e.g. 16 point type falls assessment – Appendix 6) and intervention from the GP or falls team to manage their falls risk. (Appendix 5)

Reducing / managing falls risk

Care plan strategies to resolve or reduce the individual risk factors identified for the resident.
The 16 point falls risk assessment guidance (Appendix 7) provides options for onward referral and management. Information in this guidance has provided some suggestions for falls management. There are a number of resources available through Age UK and other organisations, see reference list. The NHS Derbyshire County web site Falls prevention web page will have up to date information regarding falls management interventions. There are also links to local falls prevention information and resources; http://www southernderbyshireccg.nhs.uk/page1.aspx?p=10

Distraction techniques

Distraction techniques can be useful for people with dementia or cognitive impairment. The ‘Tiptree box and café style table’ (Staying safe - preventing falls, High impact actions for preventing falls, Institute for improvement and Innovation 2010) is a toolkit used to provide a distraction for patients with dementia. The toolkit consists of everyday items, which can have personal meaning to an individual, which the person can use and explore whilst sitting in a comfortable environment.

Bed rails, harnesses and lap straps

Bed rails, also known as safety sides, cot sides, and safety rails, can be used as a method of preventing residents falling or slipping from their beds. They can be either integral to the bed or can be attached and detached as required.

Caution must be used to ensure bed rails are not used as a method of restraint

Bed rails should only be used to reduce the risk of a patient accidentally slipping, sliding, falling, or rolling out of a bed. Bed rails used for this purpose are not a form of restraint. **Bed rails will not prevent a patient leaving their bed and falling elsewhere and should not be used for this purpose.** Bed rails are not intended as a moving and handling aid. The resident must always be assessed by the appropriate professional for bed rails or other restrictive equipment. The resident must also provide informed consent. If there is any doubt regarding the residents ability to provide informed consent refer to mental capacity and best interest policies.

When using bed rails, lap straps or harnesses a risk assessment must be completed and an individualised care plan written. This must outline why the safety equipment is required and how it should be used.

Key points

- Person specific risk factors need to be assessed for individual residents and incorporated into their care plan.
- Some people have different ways of expressing pain e.g. people with a learning disability or dementia. (see further reading section)
- There are various tools that can be used to assess risks, copies of which can be found in Appendices.
- Once a full falls assessment has been carried out for person specific factors, a care plan can be drawn up and residents referred to the appropriate service if necessary.
8. Training and knowledge updates

Programmes of staff education about falls have been shown to be effective in care homes. Education programmes should be on going and aim to give staff a thorough grounding in falls prevention. Training should be repeated at regular intervals, both as a reminder for existing staff and to ensure that new staff have up to date knowledge. There are various providers of training for care staff and many falls prevention courses, including modules of QCF qualifications.

Training available locally

Falls and the fear of falling are serious issues for older people. Slips, trips and falls are a major cause of injury in the older population. In care homes falls account for around 90% of reportable injuries to residents. Many of these falls are preventable. Programmes of training and staff development can help to reduce the numbers of people who fall, minimise the risks of people falling and empower staff to support people to be as independent as possible.

There are various providers of falls prevention training and further information about training providers can be found on the Skills for Care’s website www.skillsforcare.org.uk/eastmidlands look in qualifications and training, in the training provider directory search for ‘falls’.

The training may also link into qualifications on the Qualifications Credit Framework (QCF), and more information about the QCF can be found by contacting Skills for Care www.skillsforcare.org.uk/qualifications_and_training

North West Health Libraries produce an update bulletin on Falls prevention which collates together recent government guidance and clinical evidence and best practice: http://fallspreventionnwpctl.wordpress.com

Key points

- Programmes of staff education about falls have been shown to be effective in care homes.
- Any education programmes should be on-going and aim to give staff a thorough grounding in falls prevention.
9. In The Event of a Fall / Post Fall Management

Not all falls can be prevented. Some older people will fall, regardless of preventive measures. For these residents, it is imperative to:

- Minimise the risk of injury by ensuring the environment is as safe as possible.
- Implement measures to reduce the risk of a fracture.
- Investigate the underlying causes of the incident.
- Review care plans and risk assessments.

On witnessing a fall, or finding a resident who has fallen

1. An initial assessment to ascertain whether the resident is injured should be undertaken by a senior member of staff.
2. If emergency treatment is required follow individual care home policy.
3. If on initial assessment no serious injuries are found and the resident appears to be unaffected by the incident:
   - Complete a risk assessment to decide upon appropriate action, NHS 111 can be contacted for professional advice and guidance to inform the risk assessment and decision making process.
   - Decide action to be taken following the risk assessment this may include use of moving and handling techniques or equipment according to individual care home policy.
4. Ensure that the incident is fully documented and all actions carried out have a justifiable rationale.
5. Whenever possible, ascertain what caused the fall and take action to prevent further falls as necessary.
6. Record the fall in the appropriate accident book.
7. Notify the Incident Contact Centre if the relevant criteria under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) are met.

The Role of The Ambulance Service In Responding To Falls In Care Homes

The East Midlands Ambulance Service (EMAS) is often called to nursing and residential Care Homes across Derbyshire to assist care staff to lift residents after a fall. It is not the responsibility of EMAS to lift uninjured people up from the floor.

- The East Midlands Ambulance Service will continue to respond to all 999 calls to Care Homes in a manner appropriate to identified clinical need.
- If a resident is assessed as being injured or medically unwell the ambulance service will assess, treat and convey the resident to the appropriate hospital.
- However, if assessed by the attending ambulance personnel as being uninjured, the responsibility for lifting the resident will rest with the staff of the Care Home. In these situations EMAS will document their clinical findings and will recommend that the resident is referred to the Falls team or GP for further investigation as to the cause of the fall as recommended in the National Service Framework for Older People – Standard 6 (2001)
A reporting system has been established for ambulance personnel to identify incidents where they have been called upon to lift obviously uninjured residents. These will be investigated to determine if the ambulance service was used to lift the resident when staff trained in manual handling should have been available at the care home.

EMAS will be monitoring the number and type of calls to care homes.

Further information is available from the East Midlands Ambulance Service.

**Post Fall Guidance Flowcharts**

These have been designed as a point of reference in the event of a fall and may be a useful checklist. Individual care home policy and patient care plans must always be adhered to.

- Post Fall Injury Assessment and Management – Residential Homes. (Appendix 9)
- Post Fall Injury Assessment and Management – Nursing Homes. (Appendix 10)
- Post Fall Moving and Handling Assessment and Management. (appendix 11)

**Record Keeping**

Good record keeping and using the information that you gather will help with falls management. Records will:

- Show that the control measures identified in the risk assessments are being put in place.
- Show that maintenance and repairs are being carried out.
- Help to identify trends.
- Help to anticipate and plan additional control measures.

The proper recording of individual and environmental assessments is a key element in effective falls management. This can take various forms (for example, records relating to medication review; environmental check sheets; supervisory audits of cleaning contractors and training records). These records all show that appropriate action is being taken and help to maintain management control.

All accidents, including falls, suffered by a resident should be recorded in the appropriate accident book. It is also good practice to keep a ‘falls register’ or ‘falls diary’ for each resident so that multiple falls and patterns can be identified. Periodic review will help to identify trends. For example, a resident may demonstrate unsteadiness at particular times of the day that may be associated with medication, meal times or particular activities.

Long-term review may identify that there are environmental factors that need attention but which only arise at certain times of the year (for example, high contrasting light levels during the summer, low sun causing glare on a floor surface during winter).

There are certain circumstances where the information that must be recorded is set out in law or is a requirement of the Registration and Inspection body. Keeping
details beyond these minimum requirements will provide you with information that will help in planning a falls management programme.

As well as recording incidents that occur it is good practice to have a procedure to identify and record ‘near misses’. A near miss is an incident that could have resulted in a fall or injury. Near miss analysis will help you to plan and review your falls management arrangements. Near miss recording may trigger risk assessment review for an individual or an environmental factor, or identify a training need.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require employers to report certain types of injury, occupational ill health and dangerous occurrences that arise ‘out of or in connection with work’. There is detailed guidance available in the HSE Document Health and Safety in Care Homes and also in information leaflets HSE 31 and MISC310 (both available from your health and safety enforcing authority or the HSE website www.hse.gov.uk).

In general, the following are reportable if they arise ‘out of or in connection with work’:

- Accidents that result in an employee or a self employed person dying, suffering a major injury, or being absent from work or unable to do their normal duties for more than three days.
- Accidents that result in a person not at work (including a resident) suffering an injury and being taken to a hospital.
- An employee or a self employed person suffering one of the specified work related diseases.
- One of the specified ‘dangerous occurrences’. These do not necessarily result in injury but have the potential to cause harm.

To show you are meeting legal duties it is necessary to keep records of training that is provided to employees working directly with residents and to those that may be indirectly associated with fall risks (such as cleaners). Details should include what the training content was, when it was held and an acknowledgement from the employee that they attended. Training evaluation, by seeking feedback from all those involved in the training, will help to assess whether it has been beneficial, how it can be improved and when and how it can be further developed.

**Key points**

- Not all falls can be prevented. Some older people will fall, regardless of preventive measures.
- By ensuring that residents who fall are monitored and appropriately referred, further falls may be avoided.
- It is important to investigate incidents thoroughly. Effective accident investigation should look beyond the immediate cause of the incident.
- All accidents, including falls, should be recorded in the appropriate accident book and reported if RIDDOR criteria are met.
10. Conclusion

Falls in the older population have wide ranging effects on the individual, their families, care providers and the wider health services. Many slips, trips and falls in residential care homes are preventable. Injuries arising from a fall can be reduced by prior intervention. Post fall assessment, review and remedial action can reduce the likelihood of further falls. It is important that those residents who have fallen and those who may be at risk from falling in the future have regular reviews of reversible risk factors. The most effective way to manage falls in care homes is to take a preventive approach looking at the wide range of contributory risk factors that relate to the individual and the environment in which they live.

11. Acknowledgements

The ‘Managing Falls in Care Homes’ guidance document version one, 2011 was compiled by NHS Derbyshire County. Version two, 2013 is a refresh of the document to include Derby City details. We wish to acknowledge and thank the following people for their valuable contributions;

**Version One**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avril Robinson</td>
<td>Derbyshire County Council</td>
<td>PSDO Derbyshire Adult Care,</td>
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<tr>
<td></td>
<td></td>
<td>Staff Education &amp; Training Centre</td>
</tr>
<tr>
<td>John Boadle</td>
<td>Derbyshire County Council</td>
<td>Planning and Project Manager</td>
</tr>
<tr>
<td>Trevor Thacker</td>
<td>Derbyshire County Council</td>
<td>Principal H&amp;S Officer Derbyshire Adult Care</td>
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<tr>
<td>Aileen Knowles</td>
<td>Derbyshire Mental Health Trust</td>
<td>Falls Co-ordinator</td>
</tr>
<tr>
<td>Sam Pessoll</td>
<td>Derbyshire Community Health Services Amber Valley</td>
<td>Care Homes Support Team</td>
</tr>
<tr>
<td>Jayne Williams</td>
<td>Derbyshire Community Health Services Amber Valley</td>
<td>Care Homes Support Team</td>
</tr>
<tr>
<td>Diane Smith</td>
<td>NHS Derbyshire County</td>
<td>Head of Commissioning for Learning Disabilities</td>
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</table>

Public Health Dept, NHS Derbyshire County

The Care Home Managers who reviewed the document

Members of the Derbyshire County Falls Advisory Group

**Version Two**

<table>
<thead>
<tr>
<th>Name</th>
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<th>Role</th>
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<tbody>
<tr>
<td>Dr Ian Lawrence</td>
<td>Southern Derbyshire CCG</td>
<td>Clinical Lead</td>
</tr>
</tbody>
</table>

Integrated Commissioning Team Derby City Council
12. References


10. Managing falls in Care Homes NHS Bexley PCT

13. Further reading/information sources

1. The Health and Safety Executive provide a wide range of free advice, including access to many information sheets: [www.hse.gov.uk](http://www.hse.gov.uk)

2. Age Concern provide a wide range of information and reference sources: [http://www.ageuk.org.uk/health-wellbeing/preventing-falls/](http://www.ageuk.org.uk/health-wellbeing/preventing-falls/)

3. For accident reporting and information: [www.riddor.gov.uk](http://www.riddor.gov.uk)

4. Prevention package for Older People – Falls and fractures effective interventions in health and social care Department of Health 2009

5. Health on tap is a programme to increase water intake in older people in residential care and thus to reduce falls. The Good Hydration Charter, a voluntary code of practise, supports: Staff training on the importance of good hydration, fresh tap water to be constantly available and easily accessible and establishing a drinking water routine. [http://www.anglianwater.co.uk/community/education/water-for-health/care-homes/](http://www.anglianwater.co.uk/community/education/water-for-health/care-homes/)


8. Dementia design checklist – NHS Services Scotland. This document provides practical tips for designing a dementia friendly environment.


PROVIDER CHECK LIST

As a provider of care in either nursing or residential care homes the Registered Care Home Manager is responsible for managing the risks and effects of falls in their home. By implementing the following actions the risks and effects of falls can be significantly reduced and the outcomes improve the life of residents.

Tick those actions that the home currently practices

1. MANAGEMENT OF POLICIES & PRACTICES

| ASSESSMENT – all new and existing residents regularly assessed for their risk of falling | □ |
| TRAINING & AWARENESS – awareness training for staff to embed the reduction of falls into holistic care | □ |
| FALLS RECORDS & AUDITS – maintain falls records & audits | □ |

2. SUPPORT FOR RESIDENTS

| EXERCISE & ACTIVITY – promotion of appropriate exercise | □ |
| INCREASING BONE DENSITY - nutritional assessment of diet and compliance with GP prescriptions | □ |
| REDUCE THE IMPACT OF FALLS - appropriate provision of hip protectors | □ |
| VISION – assistance with spectacle usage and maintenance | □ |
| FOOTCARE & FOOTWEAR - advice on footwear & walking aids & facilitate chiropody & podiatry visits | □ |
| CLOTHING & DRESSING - assistance with dressing safely and raise awareness of risks with ill fitting clothing | □ |
| INFORMATION - advice on the risk of falling and how those risks can be reduced | □ |

3. IMPROVING THE ENVIRONMENT

| NATIONAL MINIMUM REQUIREMENTS FOR A SAFE ENVIRONMENT - compliance | □ |
| ENVIRONMENTAL ASSESSMENT – specifically assess environmental risks to reduce falls | □ |
Some drugs are more likely to be associated with falls. This chart will help you identify those drugs that may cause problems in the elderly. Relevant drugs have been graded using a traffic light system according to their potential to cause a fall.

**Derbyshire Falls Service**

**Medication & the Risk of Falls in the Older Person**

Patients on four or more medications are at greater risk of having a fall. Medication review can plan an important part in falls prevent. The Derbyshire Falls Service recommends the following guidelines on medication review for fall patients:-

Patients with a newly recognised falls risk who are taking four or more medications, of which at least one is graded as moderate or high risk (Amber and Red sections below) should be referred for medication review as soon as possible. That medication review should give consideration to falls risk alongside the patient’s other medical history.

Patients with a newly recognised falls risk taking four or more medications, where none of those medications have been graded as moderate or high risk (Amber and Red sections below), should continue to have their medication reviewed as normal.

### Drug Class

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Antidepressants</th>
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<tbody>
<tr>
<td>Tricyclic (TCAs) &amp; related antidepressants: amitriptyline, clomipramine, dosulepin, lofepramine, imipramine and nortriptyline</td>
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</tr>
<tr>
<td>SSRIs: fluoxetine, paroxetine, citalopram, sertraline, fluvoxamine</td>
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</tr>
<tr>
<td>Others: duloxetine, mirzapine, trazodone, venlafaxine</td>
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<tr>
<td>TCAs may cause drowsiness &amp; blurred vision. SSRI's slightly less sedating. May also cause blurred vision.</td>
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### Antipsychotics including atypicals

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Antipsychotics including atypicals</th>
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<tbody>
<tr>
<td>“Typicals”: chlorpromazine, haloperidol, promazine, trifluoperazine, sulpiride</td>
<td></td>
</tr>
<tr>
<td>Atypicals: amisulpride, aripiprazole, clozapine, olanzapine, risperidone, quetiapine, Prochlorperazine is frequently prescribed for dizziness due to postural instability and the most frequently implicated drug in causing drug induced Parkinson’s disease.</td>
<td></td>
</tr>
<tr>
<td>Antipsychotics can cause postural hypotension, particularly in the elderly, causing dangerous falls. Dizziness and drowsiness can also contribute to falls. Even if drugs cannot be stopped completely attempts to reduce the dose to the minimum effective dose should be made.</td>
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### Anti-muscarinic drugs (anti-cholinergics)

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Anti-muscarinic drugs (anti-cholinergics)</th>
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<tbody>
<tr>
<td>Oxybutynin, tolterodine, orphenadrine, procyclidine, trihexyphenidyl, duloxetine, solifenacin</td>
<td></td>
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<tr>
<td>Oxybutynin may cause acute confusion in the elderly, especially those with pre-existing cognitive impairment. Antimuscarinics in general can cause blurred vision, dry eyes, drowsiness and dizziness which can contribute to falls.</td>
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### Benzodiazepines & hypnotics (anxiety or sleeping tablets)

<table>
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<tr>
<th>Drugs</th>
<th>Benzodiazepines &amp; hypnotics (anxiety or sleeping tablets)</th>
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</thead>
<tbody>
<tr>
<td>Benzodiazepines: Diazepam, lorazepam, nitrazepam, temazepam, chloridiazepoxide</td>
<td></td>
</tr>
<tr>
<td>Others: zolpidem, zopiclone</td>
<td></td>
</tr>
<tr>
<td>May cause hangover effects next morning. May cause unsteadiness if getting up in the night. Reduction in dose and frequency and use of medication as necessary rather than regularly should be made even if the medication cannot be stopped entirely.</td>
<td></td>
</tr>
</tbody>
</table>

### Dopaminergic drugs

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Dopaminergic drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dopamine-boosting drugs: Amantadine, bromocriptine, levodopa (co-beneldopla, Madopar, co-careldopa, Sinemet), pergolide, selegilin, rasagiline, apomorphine, cabergoline, pramipexole, ropinirole, rotigotine Sudden excessive daytime sleepiness can occur with levodopa and other dopamine boosting drugs.</td>
<td></td>
</tr>
</tbody>
</table>

### Anticoagulants

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Anticoagulants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warfarin, acenocoumarol, phenindione</td>
<td></td>
</tr>
<tr>
<td>Anticoagulants do not contribute to falls but they must be reviewed following a fall as the patient of major is at risk of major bleeding if falling continues.</td>
<td></td>
</tr>
</tbody>
</table>
Aspirin may be a suitable alternative.

### Drugs

#### ACE Inhibitors /angiotensin II antagonists
Used to treat hypertension, heart failure and following a heart attack.

- captopril, enalapril, lisinopril, ramipril, perindopril, quinapril, fosinopril, trandolapril losartan, valsartan, irbesartan, candesartan, eprosartan, telmisartan

Greater risk of hypotension if taking a diuretic, incidence of dizziness varies

#### Alpha-blockers
Used in men to treat enlarged prostate gland, may be used to treat hypertension.

- doxazosin, indoramin, prazosin, terazosin

Doses used for treatment prostate problems are less likely to cause hypotension and dizziness than those required to treat hypertension.

#### Anti-arrhythmics
Drugs used to control how the heart beats and to help keep its rhythm.

- digoxin, amiodarone, flecainide,

Dizziness and drowsiness are possible signs of digoxin toxicity

Flecainide has a high risk for drug interactions and can also cause dizziness

#### Beta-blockers
Used to treat hypertension, angina, heart irregularities and after heart attack.

- atenolol, bisoprolol, metoprolol, nebivolol, acebutolol,

Reports of dizziness may be due to postural hypotension

#### Diuretics
Used to treat hypertension, heart failure and fluid retention.

- bendroflumethiazide, chlorothalidone, cyclopenthiazide, indapamide, metolazone, furosemide, bumetanide, amiloride, triamterene, spironolactone.

Can cause dehydration, dizziness, confusion and postural hypotension

#### Anti-epileptics (anti-convulsants)
These drugs help people with epilepsy to lead a normal life by reducing fit frequency and reduce the possibility of brain damage. Also used to treat nerve pain.

- carbamazepine, clonazepam, gabapentin, lamotrigine, levetiracetam, phenobarbital, phenytoin, sodium valproate, topiramate, vigabatrin.

Phenytoin side effects such as dizziness, drowsiness or blurred vision etc. may be signs of drug related toxicity.

Carbamazepine incidence of dizziness, drowsiness and blurred vision are dose related side effects.

Anti-epileptics can all cause drowsiness & dizziness so should be used at the minimum effective dose and reviewed frequently, especially when used for nerve pain.

#### Anti-histamines
Used in hay-fever, itching and to control nausea, vomiting, and vertigo.

- chlorphenamine, diphenhydramine & promethazine,

Others include: loratadine, desloratadine, cetirizine, cinnarizine

Risk of hypotension with cinnarizine is dose related, short term use where possible.

#### Calcium channel blockers
Used in hypertension & angina.

- diltiazem, verapamil, amlodipine, felodipine, lacidipine, nifedipine,

May cause dizziness or fatigue

#### Nitrates
Used to ease angina.

- glyceryl trinitrate, isosorbide mononitrate & dinitrate.

Dizziness may be due to postural hypotension.

#### Opiate analgesics
Used to relieve moderate to severe pain.

- morphine, buprenorphine, codeine, co-codamol, co-dydramol, diamorphine, dihydrocodeine, morphine, tramadol.

Drowsiness and sedation common when starting treatment.

Confusion reported with tramadol.

### Using this Medication Chart in Conjunction with Falls Risk Assessment

For the purposes of carrying out a falls risk assessment:-

- Where a patient is taking four or more medications, but none of those medications is graded as moderate or high risk (Amber and Red sections above) the patient should be given a negative rating for the risk factor.

- Where a patient is taking four or more medications and one or more of the patient’s medications is graded as moderate or high risk (Amber and Red sections above) the patient should be given a positive rating for the risk factor.

**NB:** If you have any doubt as to whether or not any medications being taken by a patient belong to any of the drug families graded as moderate or high risk (Amber and Red sections above), and that patient is taking four or more medications you should give that patient a positive rating.

Prepared by Hazel Baxter, Intermediate Care Pharmacist, Derbyshire Community Health Services Mar 2013
Contact details for specialist falls prevention advice and assessment, however, please complete a falls risk assessment and discuss with GP before referring onto these services.

<table>
<thead>
<tr>
<th>Area</th>
<th>Address</th>
<th>Telephone No</th>
<th>Fax No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chesterfield</td>
<td>Walton Assessment and Rehabilitation Centre, Walton Hospital, Chesterfield Community Rehab Team</td>
<td>01246 515 556</td>
<td>01246 515 979</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01246 515 989</td>
<td></td>
</tr>
<tr>
<td>Bolsover</td>
<td>Bolsover Therapy Unit</td>
<td>01246 562 101</td>
<td>01246 562 109</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01246 562 160</td>
<td></td>
</tr>
<tr>
<td>Clay Cross</td>
<td>Clay Cross Therapy Unit, Clay Cross Community Hospital. S45 9DZ</td>
<td>01246 252 927</td>
<td></td>
</tr>
<tr>
<td>Derbyshire Dales North</td>
<td>Stanton Day Hospital, Newholme Hospital, Bakewell, DE45 1AD</td>
<td>01629 817 852</td>
<td>01629 817 893</td>
</tr>
<tr>
<td>Derbyshire Dales South</td>
<td>St Oswald’s, Ashbourne DE6 1AU</td>
<td>01335 230034</td>
<td>01335 343 967</td>
</tr>
<tr>
<td>South Derbyshire</td>
<td>Repton Health Centre Ashbourne</td>
<td>01283 702 932</td>
<td>01283 704 187</td>
</tr>
<tr>
<td></td>
<td></td>
<td>01335 230 056</td>
<td></td>
</tr>
<tr>
<td>High Peak</td>
<td>High Peak Therapy Team Cavendish Hospital, Buxton SK17 6TE</td>
<td>01298 212 865</td>
<td>01298 212 861</td>
</tr>
<tr>
<td>Amber Valley</td>
<td>Babington Hospital Belper DE56 1WH</td>
<td>01773 828 700</td>
<td>01773 828 702</td>
</tr>
<tr>
<td>Erewash</td>
<td>Erewash Intermediate Care Team, Long Eaton Health Centre</td>
<td>0115 855 4126</td>
<td>0115 8554 170</td>
</tr>
<tr>
<td>Ash Green Learning</td>
<td>LD referrals only</td>
<td>01246 565 000 ext.</td>
<td>01246 565 014</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Ash Green, Ashgate Road, Chesterfield. S42 7JE</td>
<td>10314 Kirstin or 188 Nancy</td>
<td></td>
</tr>
<tr>
<td>Team (North Derbyshire)</td>
<td>Kirstin Twelves / Nancy Abbotts Community Falls Team Co-ordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>01246 565 014</td>
<td></td>
</tr>
<tr>
<td>Amber Valley</td>
<td>Babington Hospital Belper DE56 1WH</td>
<td>01773 828 700</td>
<td>01773 828 702</td>
</tr>
<tr>
<td>Erewash</td>
<td>Erewash Intermediate Care Team, Long Eaton Health Centre</td>
<td>0115 855 4126</td>
<td>0115 8554 170</td>
</tr>
</tbody>
</table>

**Other Falls Prevention Contacts**

<table>
<thead>
<tr>
<th></th>
<th>Address</th>
<th>Telephone No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning Manager SDCCG</td>
<td>Helen O’Higgins SDCCG, 1st Floor, North Point Cardinal Square, 10 Nottingham Road Derby DE1 3QT</td>
<td>01332 888 175</td>
</tr>
<tr>
<td>Catherine Anguish Marie Clarke</td>
<td>Derby Falls Prevention Team Community Services Business Unit DHFT Office Suite 3 level 3</td>
<td>01332 258 258 01332 380328</td>
</tr>
</tbody>
</table>
| Derby City | London Road Community Hospital  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>London Road, Derby. DE1 2QY</td>
<td></td>
</tr>
</tbody>
</table>
| Aileen Knowles | Falls Coordinator  
| DMHT | Advice on falls management for  
| people with Mental Health problems |
| 01332 623 700 |
| Aileen.knowles@derbysmhservices.nhs.net |
| Diane Ball | Falls Prevention Service Advisor  
| High Peak, Chesterfield, Bolsover, Amber Valley & North East Derbyshire |
| Walton Day Hospital  
| Whitecoats Lane  
| Chesterfield  
| S40 3HW |
| 01246 515657 |
| Diane.Ball@dchs.nhs.uk |
| Jo Briggs | Falls Prevention Service Advisor  
| Age UK Derby & Derbyshire  
| Erewash, Derbyshire Dales & South Derbyshire |
| 07837 277 252 |
| fallsprevention@ageukderbyandderbyshire.org.uk |
| Susan Sallis | Falls Prevention Service Advisor  
| Age UK Derby & Derbyshire  
| 15 The Morledge |
| Derby DE1 2AW |
| 01332 343 232  
| 07851 731 772 |
| SueSallis@ageukderby.org.uk |
Environmental Factors – Falls Checklist (General)  *(Appendix 4)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Condition</th>
<th>Comments and Action Required</th>
<th>Complete Sign and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor surface/covering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Windows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating/ventilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage/obstructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stairs/steps</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Environmental Factors – Falls Checklist (General)  
*(Appendix 4 cont)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Condition</th>
<th>Comments and Action Required</th>
<th>Complete Sign and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanitary services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear circulation routes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Environmental Factors – Falls Checklist for Residents Room

*(Appendix 5)*

<table>
<thead>
<tr>
<th>Item</th>
<th>Condition</th>
<th>Comments and Action Required</th>
<th>Complete Sign and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor surface/covering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Windows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating/ventilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Storage/obstructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand/grab rails</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Area checked: ………………………………………………………………………………………………………

Checked by: ………………………………………………………………………………………………………

Date: ………………………………………………………………………………………………………

Complete Sign and Date
Environmental Factors – Falls Checklist for Residents Room
(Appendix 5 cont)

<table>
<thead>
<tr>
<th>Item</th>
<th>Condition</th>
<th>Comments and Action Required</th>
<th>Complete Sign and Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanitary services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to corrective aids (glasses etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual mobility aids (list)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer arrangements (lifts, bed/chair heights etc) (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>1</td>
<td>Have you had any falls in the last 12 months?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Do you regularly take 4 or more prescribed medications each day?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>Have you had a diagnosis of stroke or Parkinson’s disease?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Do you have any problems with your balance?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Are you unable to get up from a chair of knee height (dining chair) without using your arms to assist. Yes (unable) No (able)</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

If the score is 3 or more the person is at high risk of future falls, consider;

1. Completing a more detailed falls risk assessment
2. Referral to a GP
3. Referral to a specialist falls team

<table>
<thead>
<tr>
<th>Total Score</th>
</tr>
</thead>
</table>

1. If a resident is at a high risk of falls, the care home should implement advice given in this guidance document.

2. A more detailed falls risk assessment should be completed to identify specific manageable risks.

3. The resident’s GP should be contacted to ensure medical causes of falls are well managed.

4. The County or City Falls Teams can then be contacted for advice, further assessment and management interventions.
### Sample

<table>
<thead>
<tr>
<th>SURNAME</th>
<th>NHS No</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FORNAME</td>
<td>MALE / FEMALE</td>
<td>WARD</td>
</tr>
<tr>
<td>ADDRESS</td>
<td>D.O.B.</td>
<td>GP / Consultant</td>
</tr>
</tbody>
</table>

#### FALLS RISK ASSESSMENT FOR OLDER PEOPLE / COMMUNITY TOOL

<table>
<thead>
<tr>
<th>SCREENING TOOL</th>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. History of Falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has history of 1 or more falls in past year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Number of Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Takes more than 4 medications per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Central Nervous System Suppressants (e.g., sleeping tablets, anti-depressants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses 1 or more for more than 2 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Alcohol Intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 1 unit of alcohol per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Postural Hypotension</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dizziness on standing or sitting up</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recent loss of weight, poor fluid intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty reading a book or newspaper, cannot recognise an object across room, recently started wearing bifocals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Has difficulty in hearing conversational speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Footwear / Foot Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty with foot care affecting mobility, inappropriate footwear</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Balance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Needs to hold onto furniture, requires walking aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Transfers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of control when moving between surfaces, e.g., bed to chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Walking</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unsteady on feet, shuffles or takes uneven steps, housebound</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Environmental Hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cluttered, slip or trip hazards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Reduced Confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fear of further falls, change in lifestyle due to falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Coping Strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to get up from floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to summon help</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Memory/Comprehension (understanding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Short-term memory or comprehension difficulties which may affect ability to follow advice given</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If ‘YES’ for any factor, refer to intervention / referral guide, complete action plan.
GUIDELINES FOR FALLS RISK ASSESSMENT FOR OLDER PEOPLE / COMMUNITY TOOL
INTERVENTION AND REFERRAL GUIDE

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Interventions</th>
<th>Referral Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of Falls</td>
<td>▪ Review incident(s), identifying causes of falls</td>
<td>▪ GP / falls team if unresolved</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss emergency call alarms</td>
<td></td>
</tr>
<tr>
<td>2. Number of medications</td>
<td>▪ Identify medication being taken (including non-prescribed and over-the counter medicines/drugs)</td>
<td>▪ GP / Pharmacist</td>
</tr>
<tr>
<td></td>
<td>▪ Identify type of medication (see laminated drug guide)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Ask About symptoms of dizziness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Discuss referral for review of medication</td>
<td></td>
</tr>
<tr>
<td>3. CNS Suppressants</td>
<td>▪ Identify type of medication (see laminated drug guide)</td>
<td>▪ GP / Pharmacist</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss for review of medication</td>
<td></td>
</tr>
<tr>
<td>4. Alcohol Intake</td>
<td>▪ Discuss immediate and long term consequences of alcohol, including dulling of neurological capacity</td>
<td>▪ Nurse / GP</td>
</tr>
<tr>
<td>5. Postural Hypertension</td>
<td>▪ Check lying and standing blood pressure</td>
<td>▪ Nurse / Occupational Therapist / Physiotherapist / Intermediate Care Service</td>
</tr>
<tr>
<td></td>
<td>▪ Discuss referral for review of medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Teach how to stabilise self after changing position and before walking</td>
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<td></td>
<td>▪ Consider raising head of bed if severe</td>
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<td>6. Nutrition</td>
<td>▪ Explain importance of well-balanced diet for good health and well-being</td>
<td>▪ Nurse/Dietician</td>
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<td></td>
<td>▪ Explain importance of calcium and vitamin D for bone health</td>
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<td></td>
<td>▪ Explain importance of good hydration</td>
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<td></td>
<td>▪ Nutritional assessment</td>
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<tr>
<td>7. Vision</td>
<td>▪ Explain risk of falls from blurring and misjudging distances</td>
<td>▪ Family</td>
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<td></td>
<td>▪ Recommend caution in new situations and on uneven surfaces</td>
<td>▪ Optician</td>
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<td></td>
<td>▪ Advise caution with bi/varifocal glasses if not used to them</td>
<td>▪ SS Sensory Team/DAB</td>
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<td></td>
<td>▪ Check correct glasses are being worn and are clean</td>
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<td></td>
<td>▪ Advise annual eyesight tests</td>
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<tr>
<td></td>
<td>▪ If registered blind or partially-sighted, discuss referral to Sensory Tam / DAM</td>
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</tbody>
</table>
| 8. Hearing                  | - Check ear canal for wax  
|                           | - Check that hearing has been tested and correct as far as possible  
|                           | - Check that hearing aid, if worn, is being used and is working correctly  
|                           | Nurse  
|                           | GP  
|                           | CAMTAD/Hearing Clinic  
| 9. Footwear/Footcare      | - Advise on suitable footwear  
|                           | - Ensure maintain good foot care, toe nails cut etc  
|                           | - Check condition of foot  
|                           | Nurse/Chiropodist/GP  
| 10. Balance               | - Assessment of balance-rated problems  
|                           | - Consider changes to home environment to maximise safety  
|                           | - Ensure mobility aids available and appropriate  
|                           | - Exercise programmes including chair based exercise groups  
|                           | PT/ICS  
|                           | PT/OT/ICS  
|                           | Falls teams  
| 11. Transfers             | - Assessment and advice re safe transfers  
|                           | - Consider changes to home environment to maximise safety  
|                           | PT/ICS  
|                           | PT/OT/ICS  
| 12. Walking               | - Mobility assessment, including walking aids if appropriate  
|                           | - Exercise programmes including chair based exercise  
|                           | PT/OT/ICS/Nurse  
| 13. Environmental Hazards | - Advise re safety in home  
|                           | - Check if minor repairs are needed  
|                           | - Check if equipment is faulty  
|                           | - Refer to environmental assessment / checklist  
|                           | OT  
|                           | SS OT  
|                           | Falls teams  
| 14. Reduced Confidence    | - Discuss emergency call alarms  
|                           | - Discuss fear of falling with patient and try to address their concerns  
|                           | - Discuss referral for further assessment  
|                           | ICS/PT/OT  
|                           | Falls teams  
| 15. Coping Strategies     | - Discuss emergency call alarms  
|                           | - Teach how to get up from floor  
|                           | - Advise on coping strategies  
|                           | PT/OT/ICS  
|                           | PT/OT/ICS/Nurse  
| 16. Memory / Comprehension| - Advised / discuss action plan with carer  
|                           | - Discuss referral for further assessment  
|                           | CMHT/OT  

Adapted version for Care Homes booklet

SS - Social Services  
ICS - Intermediate Care Service  
OT - Occupational Therapist  
PT - Physiotherapist  
CAMTAD - Campaign for Tackling Acquired Deafness  
CMHT - Community Mental Health Team  
DAB - Derbyshire Association for the Blind  
GP - General Practitioner
**SAMPLE**

| SURNAME .................................................. | NHS No _ _ / _ _ / _ _ | HOSPITAL |
| FORNAME .................................................. | MALE / FEMALE | WARD |
| ADDRESS .................................................. | D.O.B. ......................... | GP / Consultant |

**FALLS RISK ASSESSMENT FOR OLDER PEOPLE / COMMUNITY TOOL**

**ACTION PLAN**

(Including onward referrals if appropriate)

<table>
<thead>
<tr>
<th>Risk Identified</th>
<th>Action</th>
<th>Date/Time</th>
<th>Print Name and Sign</th>
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</table>

Issue 1 March 2011 revised issue 2 February 2013
### Post Fall Injury Assessment and Management

#### Residential Homes

#### Resident Falls - Assess for Injuries

<table>
<thead>
<tr>
<th>Fell and hit head</th>
<th>Fell and did not hit head</th>
<th>Unwitnessed fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not move initially</td>
<td>Check ABC, airway, breathing, circulation</td>
<td>Call for assistance</td>
</tr>
<tr>
<td>Check for signs of injury</td>
<td>If head and neck pain is reported immobilise head and neck</td>
<td>Check for fractures – bruising, pain, swelling, behaviour</td>
</tr>
<tr>
<td>Consider the reason for the fall, e.g. slip or trip, faint, known medical condition (e.g. hypertension, diabetes) or medication i.e. sedatives</td>
<td>If there are signs of physical injury that may be serious or any other doubt about the person’s condition</td>
<td>Refer to care plan / Personal Handling Plan</td>
</tr>
</tbody>
</table>

**Special Considerations** – Residents on anticoagulant and/or anti-platelet therapy are at increased risk of **internal bleeding**. Anticoagulants include: Warfarin, Heparin, Enoxaparin (Clexane), Dalteparin (Fragmin). Anti-platelet drugs include Aspirin, Clopidogrel, Aspirin+Dipyridamole (Asasantin). Alcohol dependent persons are considered coagulopathic (impaired ability of the blood to clot).

If there are signs of physical injury that may be serious or any other doubt about the person’s condition, **DO NOT MOVE THE PERSON**. Dial 999 and ask for the ambulance service.

**Non urgent medical concerns**
Nurse review or contact GP/Out of Hours service

If no serious injury, assess for safe moving and handling up from the floor
(Post Fall Moving and Handling assessment)
If no suspected head injury consider need for analgesia

Follow advice from GP or clinician regarding observations and monitoring

Notify NOK/family

Complete incident report and Falls diary,
If not already involved notify GP if appropriate
If not already flagged as high risk of fall injury, flag as per care home protocol

**Post fall review**
Document in care record strategies implemented as above
Care Management and CQC should be informed of serious falls and recurrent falls

Reassess falls risk status – Review circumstances of fall, refer to relevant staff to review, update care plan and implement falls prevention strategies

**Communication** - All staff involved in care of the resident to be informed of incident outcome and revised care plan
### Post Fall Injury Assessment and Management

#### Nursing Homes

**Resident Falls - Assess for injuries**

**Special Considerations** – Residents on anticoagulant and/or anti-platelet therapy are at increased risk of intracranial haemorrhage. Anticoagulants include: Warfarin, Heparin, Enoxaparin (Clexane), Dalteparin (Fragmin). Anti-platelet drugs include Aspirin, Clopidogrel, Aspirin+Dipyridamole (Asasantin). Alcohol dependent persons are considered coagulopathic. (Impaired ability of the blood to clot)

- Do not move initially
- Check ABC, airway, breathing, circulation
- Call for assistance
- Check for signs of injury (fracture or potential spinal injury)
- If head and neck pain is reported immobilise head and neck
- Check for fractures – bruising, pain, behaviour
- Consider the reason for the fall, e.g. slip or trip, faint, known medical condition (e.g. hypertension, diabetes) or medication i.e. sedatives
- Refer to care plan / Personal Handling Plan

If there are signs of physical injury that may be serious or any other doubt about the person’s condition **DO NOT MOVE THE PERSON.** Dial 999 and ask for the ambulance service.

**Non urgent medical concerns**

- Nurse review or contact GP/ Out of Hours service

If no serious injury, assess for safe moving and handling up from the floor

*(Post fall Moving and Handling Assessment)*

If no suspected head injury consider need for analgesia

<table>
<thead>
<tr>
<th>Fell and hit head</th>
<th>Fell and did not hit head</th>
<th>Unwitnessed fall</th>
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</thead>
<tbody>
<tr>
<td><strong>Observations</strong> (follow clinical guidance)</td>
<td><strong>Observations</strong> (follow clinical guidance)</td>
<td><strong>Observations</strong> (follow clinical guidance)</td>
</tr>
<tr>
<td>- Monitor and record observations e.g. Vital signs, bruising, swelling, pain, breathing, circulation, level of consciousness, verbal responses, motor responses</td>
<td>- Record observations for 24 hours and monitor&lt;br&gt;  - bruising, swelling, pain, breathing, circulation, level of consciousness, verbal responses, motor responses</td>
<td>- Monitor and record observations e.g. Vital signs, bruising, swelling, pain, breathing, circulation, level of consciousness, verbal responses, motor responses</td>
</tr>
<tr>
<td>- ½ hourly for 2 hours, then 1 hourly for 4 hours then review (NICE 52: Head Injury)</td>
<td>- Continue observing at least 2 hourly for 24 hours then review</td>
<td>- ½ hourly for 2 hours, then 1 hourly for 4 hours, then review (NICE 52: Head Injury)</td>
</tr>
<tr>
<td>- Notify GP if any change in observations</td>
<td></td>
<td>- Continue observing at least 2 hourly for 24 hours then review</td>
</tr>
<tr>
<td></td>
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<td>- Notify GP if any change in observations</td>
</tr>
</tbody>
</table>

**Notify NOK / family**

Complete incident report and Falls diary, if not already involved notify GP if appropriate

If not already flagged as high risk of fall injury, flag as per care home protocol

**Post fall review**

Document in care record above strategies implemented as above

Care management and CQC to be informed of serious or recurrent falls

**Reassess falls risk status** – Review circumstances of fall, refer to relevant staff to review, update care plan and implement falls prevention strategies

**Communication** - All staff involved in care of the resident to be informed of incident outcome and revised care plan
Post Fall Moving and Handling Assessment and Management

Resident falls.
Complete ‘Post fall Injury assessment’ if no contraindications due to injury then safely assist resident up from the floor

Where there are no signs of physical injury it may be possible to encourage the person to get themselves up from the floor

**CARERS SHOULD NOT ATTEMPT TO MANUALLY ASSIST THE PERSON FROM THE FLOOR.**

**Person able to get up independently with supervision and guidance**
A person who has just fallen may be disorientated but after a rest may be capable of getting up from the floor independently. Do not rush the situation. Make the person comfortable and allow them to stand in their own time. It should be noted that a person who has just fallen, standing immediately may increase the risk of falling again, e.g. low blood pressure

The person should be encouraged to undergo the following routine (refer to pictures on the ‘Had a fall’ poster).
It may be safe to give minimal physical assistance to help with this routine at certain key stages, e.g. rolling.

- Side lying
- Push up on to hands into side sitting (or half sitting)
- Bend knees up and bring pelvis round to roll on all fours
- Rest hands on a chair or stool and move in to upright kneeling
- Pull on leg through in to half kneeling position
- Lift self up on to chair/seat

An inability to proceed may occur at any stage. If so, the person should be guided back to a safe position until appropriate equipment can be obtained.

**Equipment required to assist person up from the floor**

When a person is unable to assist themselves to stand then the use of a suitable piece of equipment may be necessary.

- Hoist and suitable sling – to safely transfer the person from the floor to the nearest chair/bed.
- Lifting Cushion – to safely raise the person from the floor in a seated position. They can then be transferred to a chair with the aid of a standing hoist or by using a safe sit to stand technique.
Head Injury Pathway for Residential Homes

Resident falls and suffers a bang to the head

Is the resident conscious?

Yes

Is it within normal working hours (9-5)?

Yes – Do you have a Specialist Nurse linked to the home?

No – call your local out of hours service for advice

Yes - Call Specialist Nurse, for urgent advice/visit

No – Is it within normal GP working hours (8-6)?

Yes – Call GP for urgent advice/visit

No – call your local out of hours service for advice

No – Call 999 and accompany resident to hospital with details and record incident
I have had a fall

I can get up

Ease your self up onto your elbows
Move onto your hands and knees
Facing the chair ease yourself to a standing position
Turn yourself gently and sit on a firm surface

I can’t get up

Can I attract attention?
• Shout and bang something
• Press your pendant alarm
• Use the telephone if you can

Can I get comfortable?
Find a near by • Pillow • Cushion • Rolled up item of clothing to put under your head

Can I keep warm?
Cover yourself with clothing, • Tablecloth • Rug

Can I keep moving?
• Move position to avoid getting pressure sores
• Move joints to avoid stiffness and help circulation
• Roll away from a damp area if your bladder “Lets go”

Tell your G.P. or Health Professional about your fall