Cumberland Council

F1 Falls Prevention

Extra Care Housing Servce	Support at Home Service	OA Day Services	Residential Services	DMH Day Services	DMH Supported Living Services	Community Equipment Services	Shared Lives Service
✓	X	✓	✓	✓	✓	X	X

Policy

To ensure the health and welfare of the people who use our services are protected and that staff are fully aware of their roles in the prevention of falls.

Procedure

People in a care environment are three times more likely to fall than other people, however falls can be reduced by 50% when an individual's risk of falling is assessed and action taken to reduce them. The NICE Guidelines identify the priorities that an organisation must adhere to. This has been simplified in the following diagram:

N.B – any actions/areas of concern or medium/high scores (Appendix 2) on any appendices must be followed through with relevant risk assessments for individual service users. The term "Risk Assessment" is used as the title of appendices 1 & 2, but these do require further risk assessing.

Where a person who we support is at risk or has a history of falls, the admission protocol must be followed and on initial assessment, an environment risk assessment Appendix 1 completed. Any identified risk on a falls risk assessment **must** be logged. Individuals reporting a fall or considered at risk of falling should be observed undertaking a simple "get up and go test" for balance and gait deficits. Complete the Falls Risk Assessment Scale (FRAS) Appendix 2 and if required individual risk assessment.

Where a fall occurs

No intervention required. Older Adults Residential, DMH Supported Living must be recorded on the person-centred care plan (PCCP)

- Check for any apparent injury; seek treatment as appropriate.
- Support the person as appropriate; following DIAG manual handling assessment, refer to the DIAG Code of Practice.
- Complete an accident form, make sure the manager signs this off and put it on E-Safety. (Consider if it is a RIDDOR)
- Review appendices 1 & 2 and complete appendices 3 and 4 for a fall. If recurrent, ascertain if there is a pattern emerging. **If the person has scored medium or high risk, specialist intervention MUST be sought.** (In Day Services, if the person who we support scores medium or high risk, the primary carer should be informed, and this must be recorded on the daily notes. If requested by the primary carer, day services should initiate contact with the appropriate specialist health professional).
- For individuals who require medical intervention due to a fall; report recurrent falls in the past year or demonstrate abnormalities of gait and/or balance, consider assistive technology. This **must** be recorded in the PCCP / Support Plan and any action followed up.
- Inform the family/carer/NOK immediately if appropriate.
- Update and or review the PCCP / Support Plan, DIAG, individual risk assessment for falls, daily diary/communication records and record on the body map if required.
- Where appropriate, fill in a CQC notification form and/or report to safeguarding team.
- Check for issues such as poorly fitting footwear, vision, and environment etc. Ensure equipment is in good working order and free from defects. Any defects **must** be reported immediately.
- Equipment checks **must** be done following a fall and recorded on the PCCP.
- Review FRAS annually, immediately after fall or more frequently if required or as the needs change with the person who we support.

Following the review, if the individual scores "low risk," the person we support **must** be monitored, and the annual review date recorded in the PCCP / support plan.	Following a review if they score "medium or high risk" a specialist healthcare professional **must** be sought, and an individual risk assessment

1. Staff **must** have appropriate awareness and knowledge of falls prevention.

2. Posters and leaflets should be available in each establishment for relatives and the person we support.

3. For the person we support falls prevention **must** become part of the admission process by ascertaining if the person is at risk of falls or has a history of falls.

What constitutes a fall?

A fall is when the person we support is found on the floor regardless of circumstances, witnessed or unwitnessed.

Pre-Admission / Admission

1. It is important to establish the following as part of the pre-admission assessment: history of falls, history of fractures, osteoporosis, current medication, any mobility aids that are required, specialist equipment for example raised chair seats, profiling beds and environment.

2. Falls can be caused by environmental issues. It is essential a proactive approach is adopted to prevent and identify issues through good housekeeping e.g., well-lit environment, corridors free from clutter, trip hazards and obstacles.

3. The person we support **must** be properly orientated with the environment by completing Appendix 1 on admission and adjustments made / risk assessments completed when / where required.

   Use Appendix 1 to help consider what may be required. **Family members should be involved in this process.** Any identified risks **must** be added to the person-centred care plan/support plan and an individual risk assessment for falling put in place. For services using the Electronic Care Planning system (IAS), the Falls and Environment risk assessment (Appendix 1) is included as part of the care plan.

   Things that should be considered:

   - we often support people who can choose not to follow the advice or not use equipment that has been specifically provided for them. They may

make a decision that appears unwise or raise concerns about their capacity. If there are concerns, follow the MCA procedure regarding best interest and unwise decisions.

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review
- footwear
- environment, slip trip and fall hazards.

Use the F1 Environment Tool and the F1 Environment and orientation Tool to help you prevent falls.

4. All walking aids **must** be checked for wear and tear on admission and any issues reported and recorded immediately. Checks on walking aids and wheelchairs **must** be completed following the M7 Managers monthly safety checks monthly or more frequently as required. Any identified defects **must** be dealt with immediately. For services using the Electronic Care Planning (IAS), Equipment is used as an approved heading in the daily diaries and will be checked daily. Bedrail/mattress checks must be completed as per B3 (Bedrail) Policy and Procedure.

5. An assessment of the footwear that the person we are supporting is using should be completed regularly and where there are any issues, this **must** be dealt with immediately. Consult with a Podiatrist if required.

6. If the person we support has a history of or are at risk of falling **must** be assessed for balance and gait deficits (known as the “get up and go test”) by using Appendix 2 Falls Risk Assessment Scale (FRAS) as soon as possible on admission. For services using the Electronic Care Planning system (IAS), the falls risk assessment scale is included as part of the care plan.

Gait – Hesitant – means difficulty in starting to walk/move.
Poor transfer – means the service user requires help and cannot safely do the following:

- get in/out of bed.
- on/off chair/wheelchair

- move from chair/bed to standing.

Sensory deficit – sight deficit means unable to see well even with glasses on or registered as blind or partially sighted. Hearing deficit means hearing problems with or without aid (whether worn or not). Balance deficit means being unable to stand without the support of one or more carers and/or an aid.

Medication – some medication can affect the risk of falls. Sleeping tablets e.g., Diazepam, Sedatives e.g., Risperidone. Blood pressure medication including water tablets e.g., Furosemide. Check the patient information leaflet.

Mobility – restricted mobility means the person requires supervision or help to walk and is not safe to walk alone even with the help of an aid.

Using the form – fill in the service username, D.O.B and circle each applicable score accordingly. At the bottom of the form add up the scores and initial when the assessment score has been completed. For services using the Electronic Care Planning (IAS), the falls risk assessment scale will calculate the assessment score and identify the level of risk.

The scoring is as follows:

Scoring

Identified Risk	Actual Score
Low Risk	3-8
Medium Risk	9-12
High Risk	13+

Consult specialist health care professional or inform the primary carer and record all intervention detail in the care plan / support plan and action plan. Ensure relevant risk assessments are in place.

For Residential and Supported Living Services, if the person we support is at medium or high risk, specialist healthcare advice **must** be sought immediately, and risk assessment completed. If appropriate the use of assistive technology should be considered (least restrictive).

In Day Services, if the person we support scores medium or high risk, the primary carer should be informed, and this **must** be recorded on the support plan and daily notes. A risk assessment must also be completed and held in support plan. If requested by the primary carer, day services should initiate contact with the appropriate specialist health professional.

Details of all interventions **must** be recorded on the person-centred care plan/support plan and the Appendix 4 **must** be filled in and followed up. For services using the Electronic Care Planning (IAS), the Falls Action Plan/log must be completed.

7. In Older Adults Residential services, as a preventative measure, these assessments **must** be reviewed annually. For services using the Electronic Care Planning (IAS), the falls and environment risk assessment and the falls risk assessment scale will be reviewed as part of the care plan.

   For all services appendices 1 and 2 **must** be reviewed after a fall or if there is any significant change in the person's condition / environment. The person-centred care plan/support plan **must** be updated. For services using the Electronic Care Planning (IAS) this must recorded on the review section of care plan and or falls log/action plan.

8. These are some of the ways we can help prevent the risk of falling:

   - Make sure the person we support wears their glasses or hearing aid.
   - Encourage the person we support to use their walking aid(s) if they require them.
   - Encourage the person we support to use the call bell if they need support.
   - Ensure any specific equipment is put in place and is in good working order.
   - Ensure the person we support is wearing suitable footwear.
   - Ensure all care staff are made aware if the person we support becomes unwell or unsteady on their feet.
   - Keep the person's fluid levels up.
   - Ensure good housekeeping and the environment is clear from anything lying around that could be a trip hazard.
   - Check the person's medication.

9. All staff involved in the care of the person we support **must** be made aware of mobility issues and the risk of falls, as well as any prevention strategy developed which **must** be recorded on the person-centred care plan / support plan.

Post Fall

1. If a fall occurs, it is imperative that you look after the person's welfare. Where there are concerns such as the person complaining of pain, the emergency services **must** be contacted immediately. Where there is a suspected head injury follow the head injury procedure.

2. If a fall occurs, it is essential to take a proactive approach in identifying any cause. Evidence shows if an older person falls, they are likely to fall again.

3. The Appendix 3 Falls log and appendix 4 Falls Action plan **must** be completed and used to monitor **every** fall. They can identify a pattern of falls, e.g., falling at the same time of day could indicate a medication or staffing issue or falling at a particular place may indicate an issue with the environment. The computerised version of the form is automated therefore you can use the drop-down boxes to select. For services using the Electronic Care Planning (IAS), the Falls and Environment Risk Assessment and the Falls Risk Assessment Scale are held within the care / support plan and **must** be completed or identified as reviewed on the review section and or falls log after every fall.

4. Where the incident has caused any injury including bruising, the B2 body map **must** be completed.

5. An Incident/Accident form **must** be completed and uploaded to E-safety. Consider if this is a RIDDOR referral. The manager/supervisor **must** see the form and be notified of the incident.

6. Contact the family/carer immediately if appropriate and write this on the communication records/daily diaries (either electronic or paper system).

7. Where appropriate, CQC **must** be informed by completing a notification form. Where a notification is sent to CQC, a copy of the notification **must** be emailed to the quality and performance team. At this point consider if this needs to be referred to the Safeguarding team.

8. Complete the daily record/communication records. Ensure exact, factual details are recorded and dated.

9. A review of the fall's prevention **must** be undertaken if there are recurring falls. Specialist falls professionals **must** be contacted and the use of the least restrictive assistive technology considered. All changes **must** be written up on the person-centred care plan / support plan and communicated to staff.

10. If in any doubt, contact the falls specialists.