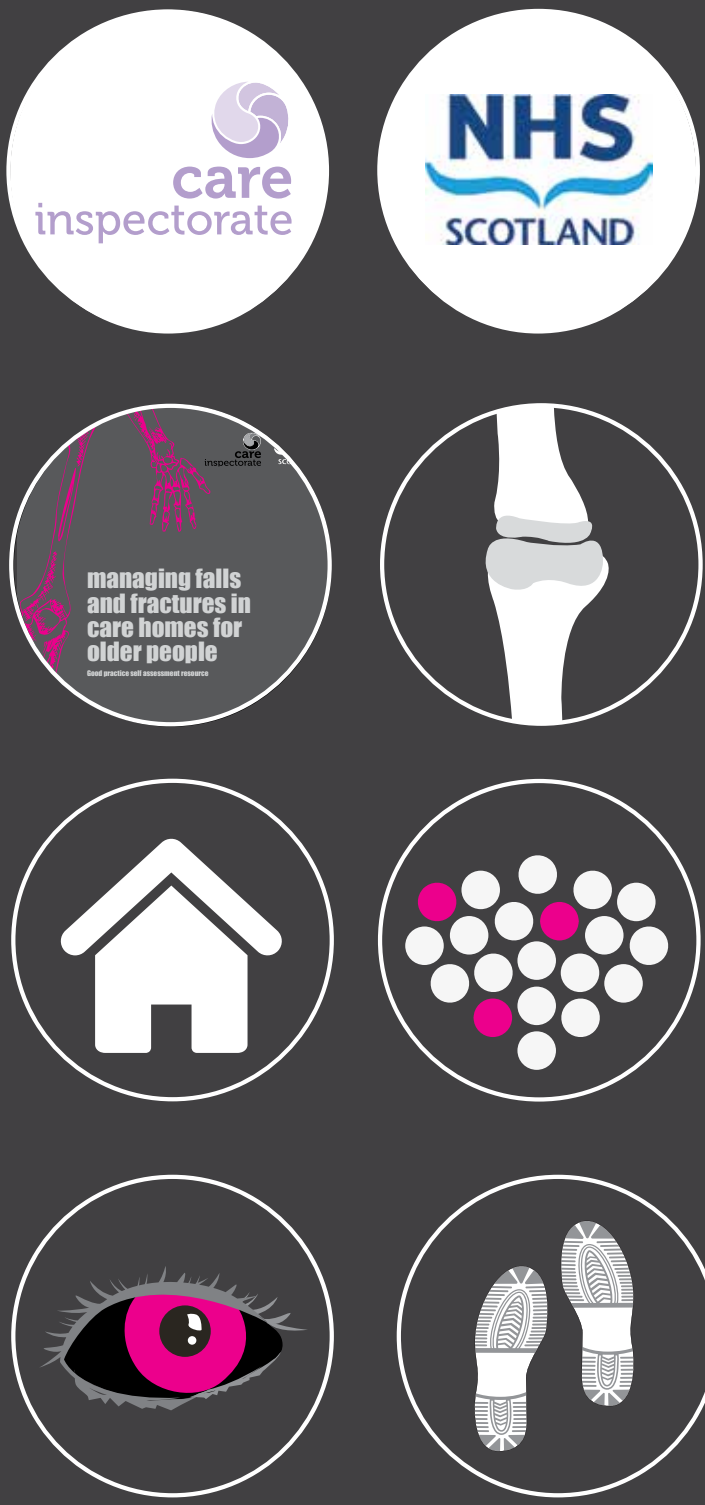


Managing Falls and **Fractures** in Care Homes for Older People – good practice resource

Revised edition

Contents

Foreword

Falls and the consequences of falls can significantly impact a person's wellbeing, mobility and confidence. In Scotland, falls are a major and growing concern for older people, their families and carers as well as health and social care providers.

Older people living in care homes are three times more likely to fall than older people living in their own homes, with the results of these falls often being more serious. Many factors can contribute to this heightened risk, such as physical frailty, the presence of long term conditions, physical inactivity, taking multiple medications and the unfamiliarity of new surroundings. However, in many cases taking the right steps at the right time can actively support an individual and reduce the risk of falls and harm from falls.

The 'Managing Falls and Fractures in Care Homes for Older People – good practice resource', published in 2011, has provided direction, advice and support to managers and staff in care homes for older people across Scotland. The resource has helped staff to understand the importance of taking a proactive approach to preventing falls and to support older people to have a physically active life.

The interaction of factors that contribute to an individual's risk of falling is unique to them. For this reason, it is important care homes for older people have a person centred approach to manage and prevent falls and fractures. This helps to improve the overall quality of care for an individual and has a huge impact on a person's level of independence, participation and enjoyment in life. Feedback from care home staff, the wider health and social care team and inspectors tells us that the resource pack is one of the things that has helped care homes to do this.

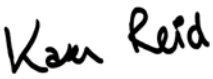
The Scottish Government's 'Up and About in Care Homes' project, during which the project team worked with a number of care homes across Scotland, helped to identify what is important for care home staff to know in order to manage and prevent falls and fractures, and how best they can be supported to use the resource pack. This revised edition takes this learning into consideration. It continues to offer care homes a self assessment to complete which, along with other information they may have on falls, can be used to develop an improvement plan that will measure the impact of changes on individuals as well as building staff knowledge, competency and confidence. The good practice guide has been updated, with more detail added where it was needed, along with some additional tools and resources.

A new section in this edition is, 'Guidance for improving the quality of care'. This has been added to support care homes to make improvements to how they manage falls, as well as prevent falls and fractures, using tried and tested approaches. It will help care homes to identify, plan, test and implement lasting improvements to successfully manage and prevent falls and fractures and support a person's wellbeing, independence, and participation in order to live as well as they possibly can. This

fits well with the Care Inspectorate's approach to scrutiny, which includes supporting care homes to make identified improvements in the quality of care, for example through specific pieces of work with services or signposting to good practice and helpful resources.

Over the last few years, there has been much work done, nationally and locally, to support care homes for older people to make improvements in this area of care. More people than ever understand and acknowledge that the risk of and harm from falls can be successfully managed. Key ingredients for success have been identified, such as strong leadership, working more closely with the local health and social care team, collecting and analysing falls data and having adequate resources.

We are delighted that significant improvements have been made in care homes since 2011 and as a result many falls have been prevented. The revised edition of this national resource pack is now available to support care homes to continue to identify and make improvements which are sustainable, and remind people 'falls prevention is everyone's business'. Ultimately this will improve the overall quality of care for older people in care homes in Scotland and support people to enjoy life and live well.



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Background

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

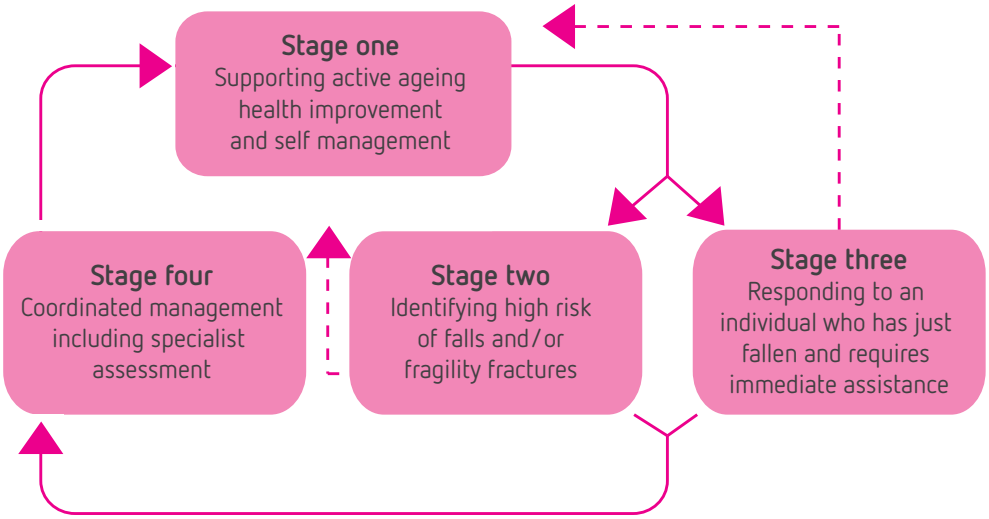
In 2011 the 'Managing Falls and Fractures in Care Homes for Older People – good practice resource' was published by the Care Inspectorate and NHS Scotland and issued to all care homes for older people in Scotland. The resource pack aimed to support care homes across Scotland to manage and prevent falls and prevent fractures with an emphasis on person-centred care and continuous improvement. An evaluation showed that where the resource was used by care home staff working in partnership with the wider health and social care team, there was improved person-centred falls prevention and management and a significant reduction in falls.

In 2014/15, the Scottish Government funded an 18 month improvement project called, 'Up and About in care homes'. This project supported 38 care homes in Scotland to use the resource pack together with improvement methods and tools. The project succeeded in developing and testing innovative ways of working to improve care. Participating care homes found that taking a proactive team approach to improvement, using the resource, reduced their residents' falls and injuries due to falls.

In 2014, the Scottish Government published 'The Prevention and Management of Falls in the Community. A Framework for Action for Scotland 2014-16'[1]. The Framework aims to support a more consistent approach to falls prevention and management and in doing so improve experiences and outcomes for older people, their families and carers. It recommends an integrated and co-ordinated approach focusing on the four stages of the Up and About Pathway (figure 1). This resource supports care home staff to adopt the approach set out in the Framework, for older people living in care homes.

[1] Scottish Government (2014) The prevention and management of falls in the community a framework for action for Scotland 2014/2015 http://www.gov.scot/Publications/2014/04/2038

Figure 1 Up and About Pathway



The Care Inspectorate has been reviewing its methodology and inspection processes. With an increased focus on supporting improvement, inspectors promote and reinforce good practice which is detailed in the resource pack.

The revised edition of the resource pack has been updated and improved using the learning from the 'Up and About in care homes' project along with input from subject matter experts, care home staff, inspectors, local falls leads and the wider health and social care team. The resource pack continues to provide a self assessment to identify areas for improvement. There are new sections on how to make improvements and keeping well, and a range of new links and tools.

Using the resource pack to improve care

What is the purpose of the resource pack?
This resource is for you if you are supporting older people in a care home, whether you are care home staff or part of the wider team. It will help you to take a proactive approach to preventing and managing falls and preventing fractures.

This resource pack will help you to:
- recognise quality care you are already giving
- identify and prioritise areas for improvement
- test out and put into practice (implement) new ways of working that both staff and residents will benefit from
- maintain the improvements you have implemented.

Sections of the resource pack can also be used during staff induction and training to raise awareness, increase knowledge and understanding, and involve everyone in your care home in falls prevention and management and fracture prevention.

Read more about using the pack to educate care home staff about falls and fractures in the section 'Education and written guidance' on pages 93-94.

What does the resource pack include?
This table lists the sections in the resource pack and summarises information included in each section.

Section	Includes
Introduction to falls and fractures (page 10)	• Why falls prevention and management matters. • Why falls happen. • How falls and fractures can be prevented.
Guidance for improving the quality of care (page 18)	• How to identify areas for improvement. • How to use the self assessment. • How to plan, test, implement and evaluate the changes you make. • How to make improvement last.
Prevention of falls and fractures (page 27)	• How to use multifactorial falls risk screening to recognise and reduce individual resident's risk of falling. • How to take simple steps to reduce the risk of everyone in the care home falling.

Section	Includes
Keeping well: learning more about risk factors and how to prevent falls and fractures (page 34)	• How to identify and manage key risk factors for falls and fractures.
Management of falls and fractures (page 78)	• How to provide immediate care after a resident has fallen. • How to learn from falls to improve care, prevent further falls and reduce harm from falls.
Working together (page 90)	• How to build and strengthen links with the wider health and social care team, other care homes and the community to share learning and improve care.
Education and written guidance (page 93)	• How to improve the knowledge and skills of staff in your care home to improve care.
Falls prevention and management tools	• A range of tools that can be used to improve aspects of the management and prevention of falls and the prevention of fractures.

You can dip in and out of the resource pack and use what is helpful to you.

Falls prevention and management tools

There are a number of tools included in this resource. You can download the tools and use them freely to help you to improve the management and prevention of falls and the prevention of fractures in your care home. Completing the self assessment will direct you to the tools that may be appropriate and helpful.

Read more about the self assessment in Section 2.

A tool in the pack may be similar to one that you use in your care home already. It may be useful to compare the two. As a result you may continue to use your existing tool or change to the new tool. **We do not expect you to use all the tools unless you find it necessary.**

How do you know where to start?

Before you start your improvement journey, it is essential that everyone in your care home understands why falls prevention and management are important and that many falls are preventable. Reading the Introduction to falls and fractures (Section 1) will help you to understand why falls matter.

The next step is to identify areas of falls prevention and management and fracture prevention in your care home that need to be improved. This is covered in Section 2 'Guidance for improving quality of care' and Section 5 'Learning from falls'.

A well-planned, structured approach to improvement will give you a better chance of being successful. Figure 5 (page 20) summarises the structured approach to improvement recommended in this resource pack. Section 2 'Guidance for improving the quality of care' will guide you to use tried and tested quality improvement methods and tools, together with this resource, to make lasting improvements in your care home.

Section 1: Introduction to falls and fractures

Key things to remember

- **Falls can be a serious problem, resulting in suffering, disability, loss of independence and decline in quality of life.**
- **A common definition of falls should be used in your care home (see definition below).**
- **Aim to prevent falls while (a) preserving as much of the residents' independence as possible, (b) continuing to encourage safe physical activity, and (c) maximising quality of life.**
- **Do not accept falls as an inevitable part of getting older; many falls are preventable.**
- **A fall is nearly always due to one or more 'risk factors'. Recognising these and then removing or reducing an individual's risk factors can often prevent a fall.**
- **If a person has osteoporosis, they are more likely to break a bone if they fall. Falls and bone health need to be considered together.**

Preventing falls while maintaining quality of life

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

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

Definition of a fall (D5 in the self assessment)

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

Seeking a simple, comprehensive and inclusive definition of a fall to guide research programmes, the Prevention of Falls Network Europe (ProFaNE) and Outcomes Consensus Group[2] recommended a fall is defined as:

'an unexpected event in which the participant comes to rest on the ground, floor, or lower level'

(The World Health Organization definition of a fall uses nearly identical wording[3].)

[2] Lamb SE, Jorstad-Stein EC, Hauer K et al. (2005) Development of a common outcome data set for fall injury prevention trials: The Prevention of Falls Network Europe Consensus. Journal of the American Geriatrics Society 53: p.1618–22

[3] World Health Organization (2012) Falls Fact Sheet No 344. www.who.int/mediacentre/factsheets/fs344/en/ (accessed 3 April 2016).

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

It is useful to include unwitnessed falls in your reporting. Although in some cases the resident will have placed themselves intentionally on the floor, not including unwitnessed falls in your reporting may mean that you miss an opportunity to learn from the incident and prevent further falls.

Why falls matter

Each year around one third of people over 65 experience one or more falls. Almost half of people aged over 80 living in the community fall each year[4]. Falls rates among care home residents are much higher than among older people living in their own homes.

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

Most people experience a fall at some point in their life which often results in little more than embarrassment. However, as we get older falls can become more common and the consequences of a fall can become much more serious. Injury caused by falls is the leading cause of accidental death for people over 75.

As well as causing pain and distress, an injury caused by a fall can result in a person temporarily losing the ability to carry out their usual daily activities. For a frailer older person, this can quickly become a permanent loss.

Falls can result in psychological as well as physical harm. Whether or not there has been an injury, a fall can result in a person losing their confidence and becoming anxious and fearful of falling again.

Another cause of both physical and psychological harm following a fall is a long period of time spent on the floor waiting for assistance. Serious consequences include pressure sores, hypothermia and developing a deep fear of further falls.

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

Figures 2 and 3 (page 12) show some of the physical and psychological consequences of a fall and/or a prolonged length of time lying on the floor.

Falls also matter for a frail older person because they can be the first sign of a new or worsening health problem, such as an infection or a heart problem. A fall is a symptom not a diagnosis.

[4] Department of Health (2009) Falls and Fractures: Effective interventions in health and social care http://www.laterlifetraining.co.uk/wp-content/uploads/2011/12/FF_Effective-Interventions-in-health-and-social-care.pdf

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

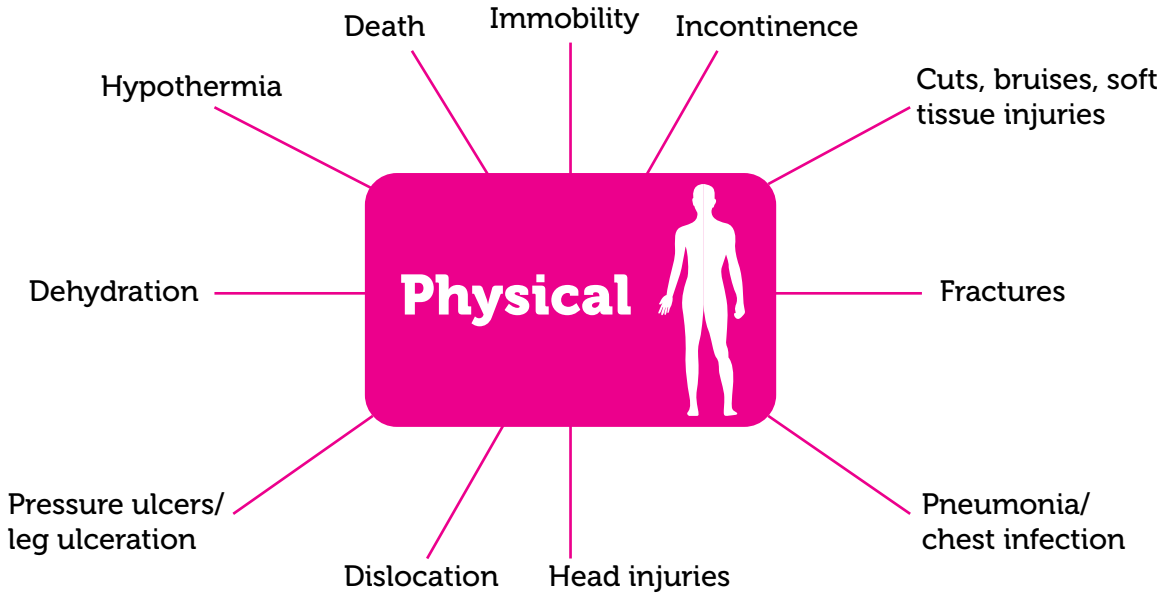
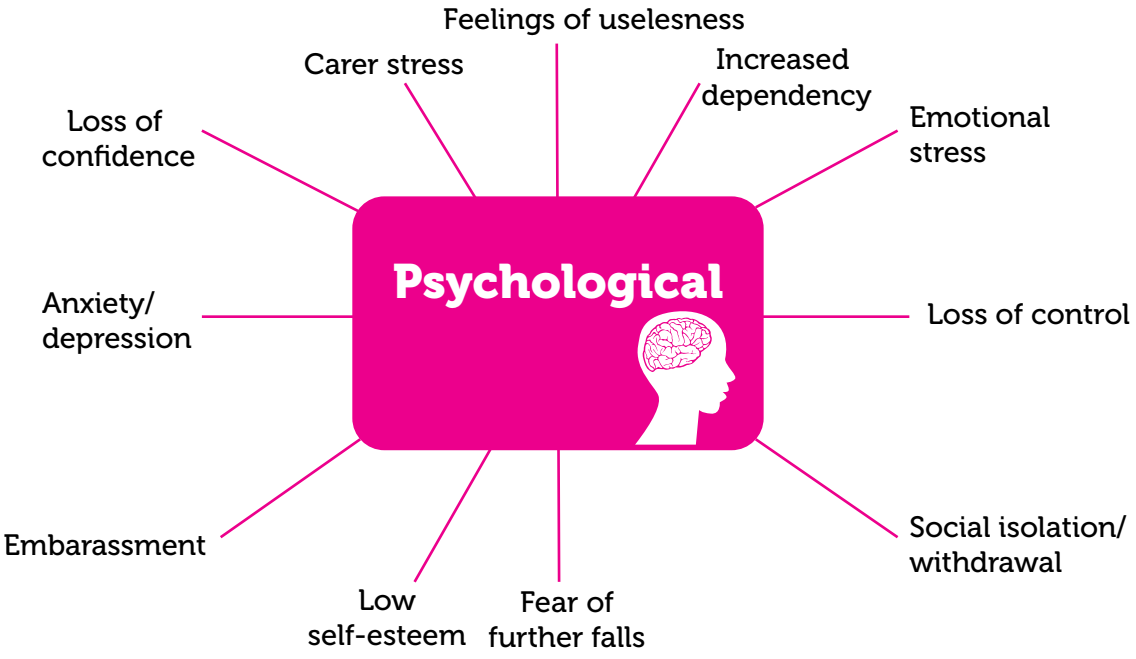


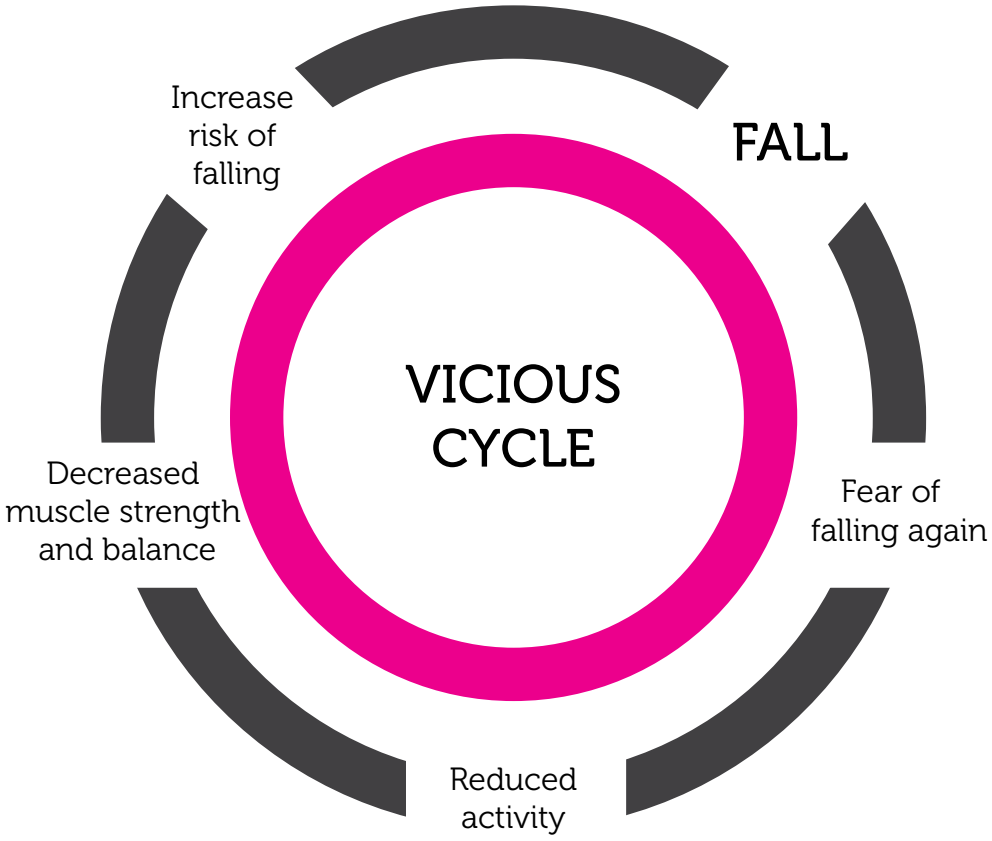
Figure 3: psychological consequences of a fall and/or a prolonged length of time lying on the floor



Fear of falling

It is common for an older person who has fallen to become fearful of falling again. A resident who has never fallen may also be frightened of falls. People who are fearful about falls often avoid physical activity, become weaker, and may fall more as a result. A vicious cycle can result - see figure 4. Take fear of falling seriously and when required, request advice from a health professional with knowledge of fear of falling.

Figure 4 The vicious cycle of falls



Rosemary's story about the consequences of falls

Rosemary was admitted to the care home from hospital where she had been recovering from injuries she sustained after a fall at home. She initially settled in well to the care home, however, she had a fall in the corridor which led to severe bruising of her face. She subsequently had another eight falls in eight weeks. Although she didn't sustain any broken bones, she suffered further cuts and bruises. Her family were very upset by this. The care home staff noticed that Rosemary stopped walking to the communal areas for her meals and social events. When they asked Rosemary about it she said she had "lost her confidence" and "felt useless". Staff were very concerned as she seemed to be sitting more and then had two urinary tract infections. They were concerned to see the deterioration of her physical and mental wellbeing.

Falls in care homes

In 2006, Help the Aged published a booklet called 'Preventing Falls. Managing risk and effect of falls among older people in care homes'.[5] It identified these reasons why falls in care homes are costly.

[5] Help the Aged (2006) Preventing Falls. Managing the risk and effect of falls among older people in care homes. http://www.educasante.org/img/helptheageduk.pdf

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

Falls can also have a negative impact on staff, with feelings of anxiety and guilt and low staff morale.

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

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

Although falls are common and the impact of falls can be very serious, the good news is that many falls are preventable.

Many falls are preventable

As we get older, we often accept that falls are unavoidable, however this is not the case. Most people over 65 do not fall each year. Falls are not an inevitable part of ageing. A fall is always due to the presence of one or more 'risk factors'.

Falls prevention is about recognising a person's falls risk factors then, where possible, removing or reducing them.

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

There will be cases when an individual remains at high risk of falling despite thorough screening, assessment and management. In these instances, you can try to reduce the risk of harm from falls by using suitable equipment and alarm systems (pages 62-67), ensuring residents take osteoporosis medications as prescribed (page 76), and following post fall protocols (page 78-81).

In your care home, the emphasis should be on anticipating and preventing falls rather than simply managing falls once they have occurred.

Risk factors for falling

Risk factors can be personal (relating to an individual) and/or related to the surrounding environment. The more risk factors present, the greater the risk of falling.

Personal risk factors can be present as a result of:

- changes in the body caused by the normal ageing process
- certain medical conditions
- the side-effects of some medications or a combination of many
- excessive alcohol
- being physically inactive.

Personal risk factors include:

- weak muscles, unsteadiness (poor balance) and/or difficulty walking and moving around
- slowed reactions
- foot problems
- numbness in the ankles and feet
- vision and hearing problems
- dizziness or blackouts
- seizures
- continence problems
- fear of falling
- pain
- cognitive problems, such as memory loss, lack of awareness of safety, a person not knowing their own limits and risk, impulsive behaviour, confusion (acute or chronic) and reduced understanding.

Environmental risk factors include:

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

Certain activities can be 'high risk' because of the specific interaction of risk factors involved, for example, getting up to use the toilet at night. Risk could relate to a person's strength, balance and walking, but also to their inability to use a call bell to get help, lack of lighting and lower staffing levels at night.

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

Specific conditions can increase risk of falling

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

Conditions include:

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

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

Dizziness, blackouts and heart palpitations

In some cases dizziness, blackouts or palpitations may occur before a fall. Always ask the resident if they had any of these symptoms before they fell. Sometimes a resident will not remember a blackout. If possible, speak to someone who witnessed the fall. Read more about this in the section on 'Dizziness, blackouts and heart palpitations' on pages 53–55.

Falls, broken bones and osteoporosis

If a person has a weakness in their bones, for example if they have osteoporosis, he or she is at greater risk of breaking a bone at the time of a fall. A hip fracture caused by a fall can lead to considerable suffering for an older person, loss of the ability to get about on their own and greater dependence on others to carry out day-to-day activities.

For this reason, you need to consider falls prevention, bone health and the diagnosis and management of osteoporosis together. Read more about this in the section on 'Keeping bones healthy' pages 71–77.

Frailty and falls

If a resident is falling, it may be an indication that they are becoming frail. Immobility, delirium, incontinence and an adverse reaction to medication can also indicate that a person is frail. Frailty is not always a permanent state. If you suspect a resident is becoming frail consider asking for a medical review – there may be interventions that can help.

People who are frail have less 'in reserve' so are less able to withstand illness without a loss of physical or cognitive function. Therefore, for a person with frailty, a relatively minor illness such as a cold, a urinary tract infection or even constipation can cause reduced mobility and confusion. This can lead to an increased risk of falling. It is important that staff are aware of this and decide how best to manage risk while the person is unwell.

Dementia and falls

Individuals with a level of cognitive impairment with or without a dementia diagnosis are an increasingly large group of people within care homes. Due to the loss of a person's cognitive abilities, there can be an increased risk of falls. Read more about this in the section on 'mild cognitive impairment, dementia and delirium' on page 39.

Section 2: Guidance for improving the quality of care

This section will help you to identify, plan, test and implement lasting improvements in your care home to successfully manage and prevent falls and prevent fractures.

Key things to remember

- The aim of improvement activity in care homes is to make the care you provide better.
- Improvement in the quality of care doesn't happen by accident; it needs to be planned and structured and takes time.
- Making improvements should benefit your residents, staff and the organisation.
- Essentials for achieving successful improvements include a belief that falls are a problem worth solving, strong leadership, clinical support, adequate resources, a dedicated improvement team and making falls and improvement everyone's business.
- A well-planned approach to improvement will give you a better chance of being successful and maintaining improvements.
- Using the self assessment in this resource and learning from any falls in your care home are two effective ways of identifying the areas of care in your care home that could be improved.
- The Model for Improvement is a tried and tested approach to achieving positive change.
- Consideration needs to be given to how improvements will last in the longer term.

'Quality does not happen by accident or because you want it to, wish it to, or hope and pray things will get better. Quality results from the deliberate and intentional actions of individuals within an organisation. It is not a program or a single project, not the responsibility of one individual (for example, the director of quality) or those assigned to the quality department. In short, quality is a way of thinking about work, approaching its improvement, and getting everyone involved.'

(Robert C. Lloyd, 2004)

Quality improvement is the term used to cover specific activities that can improve the quality of resident care. The aim of improvement activity in care homes is to make the care you provide better. That might be safer (less errors, infections, falls), more effective, more efficient (less waste) or more person-centred (caring, compassionate, fitting with resident/family wishes).

Quality improvement involves individuals, teams and organisations looking at how making changes to the way they work can improve care. Improving care is often about changing habits. Sometimes a small change can make a huge difference.

Making improvements should benefit your residents, your staff and the organisation.

Essentials for successful improvement

The table below outlines six essentials for successful improvement in falls prevention and management and fracture prevention.

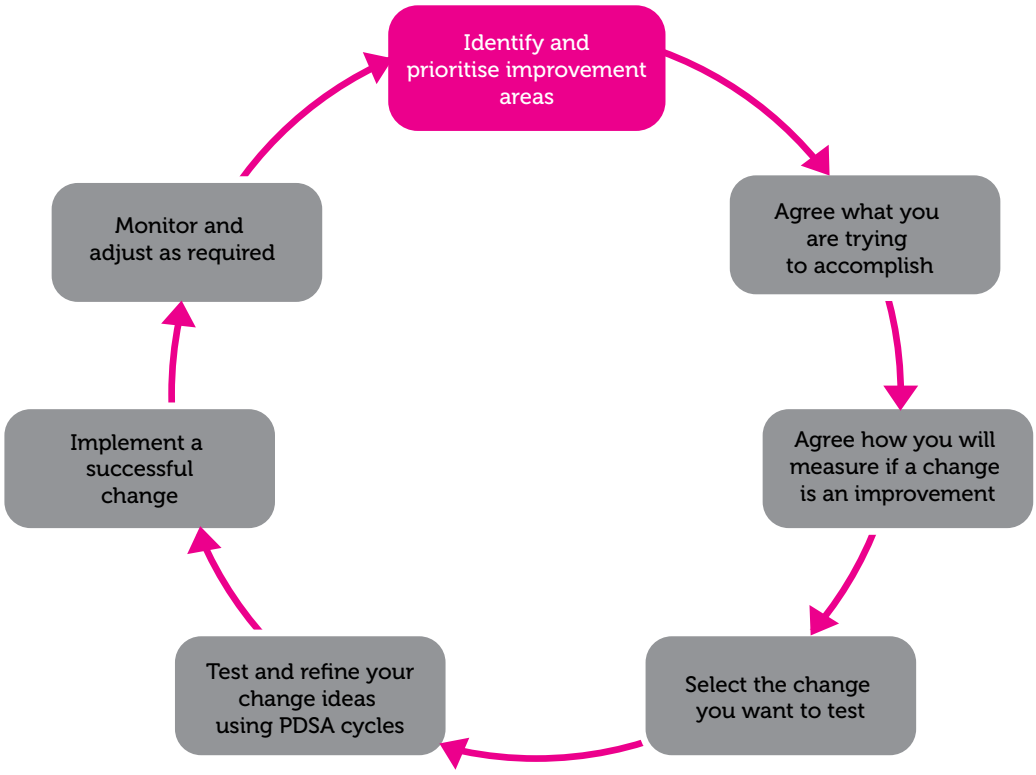
Six essentials for successful improvement	Things to consider
1. Everyone in the care home recognises that falls are a problem worth solving and believes that many falls are preventable.	• Consider induction and learning sessions with regular refreshers to improve staff knowledge and understanding.
2. Strong leadership to oversee improvement activities, give guidance and direction, and monitor and sustain the introduction of improvements.	• Leadership and support from the care home manager is vital, but remember there are other members of staff who can provide effective leadership too.
3. Support from the wider health and social care team.	• Consider a local falls lead or members of the wider multidisciplinary team.
4. Adequate resources to plan, test and implement improvements.	Consider the following resources. • Time to identify, test out and implement improvements. • Staff to support the improvement process including administrative support. • Equipment such as telecare. • Staff training requirements. • Any financial requirements. • Time to learn how to use improvement tools.
5. Having a named improvement team. This can include staff in your care home, members of the wider multidisciplinary team, residents, their families and friends, volunteers and other local community supports.	• Include a minimum of three staff members from your care home. This shares responsibility, allows for leave and provides some continuity.
6. Being clear about roles and responsibilities. This is important for your improvement team but also for everyone in the care home – improvement needs to be everyone's business.	• Identify an improvement team lead to provide leadership for the improvement work. • It may be helpful to identify team members as falls champions so staff are clear about their role.

A well-planned, structured approach to improvement will give you a better chance of being successful. Figure 5 summarises the structured approach to improvement recommended in this resource pack. The first step is to identify where changes can be made in your care home to improve care.

Improvement methods are very helpful for planning, testing and implementing changes and achieving the desired outcome. However, it is common to find unexpected challenges on your improvement journey and not every test of change will work – don't give up!

Making improvements can take time. However, if you reduce falls and the time spent dealing with the consequences of falls and improve quality of life for residents, the return on your investment will be significant.

Figure 5: a structured approach to improving quality of care



How do you identify where changes can be made in your care home to improve care?
You may already know where changes need to be made, for example from work you have already done, from complaints or from inspection reports. The data you gather about falls in your care home may also suggest where you need to focus your improvement work. Learning from falls is a very effective way to identify areas of care needing improvement.

Read more about learning from falls in Section 5 (page 78).

In the first instance, we recommend that you complete the **'self-assessment'** in this resource pack. It will help you to systematically identify gaps in good practice and highlight areas for improvement.

What is the self assessment? (There is a copy of the self assessment in the tool pack) (A1 in the self assessment)

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

Assessing the practice in your care home against good practice will help you to:

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

Who should complete the self assessment?

The manager of your care home or a senior member of staff should complete the self assessment. If possible, complete the self assessment with a colleague. You can then decide together whether working practices are fully in place or not.

How do you complete the self assessment?

Each statement in the self assessment describes a good working practice that you and your colleagues can introduce in your care home to help reduce the risk of falls and harm caused by falls. All of the practices listed in the self assessment are important and achievable.

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

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

It is important to complete the self assessment annually to monitor the care you are providing.

How do you prioritise improvement areas and create an action plan? (A3 in the self assessment)

We don't expect you to make all your improvements at once – prioritisation is key.

1. List all improvement areas you have identified on the improvement log (tool 2A). If you have completed the self assessment, these will be the working practices where a 'no' response is recorded. It may feel overwhelming but do not be discouraged if you find you have a lot of areas for improvement.

2. Discuss your areas for improvement with staff in your care home and with the wider multidisciplinary team.

3. Prioritise your improvements and agree a realistic timeframe for completion. Put this on the improvement log and note which good practice statement in the self assessment they relate to. Ensure all improvement areas have an approximate date when they will be addressed (even if this is a few months away). Small changes are often easier to make so look out for 'quick wins' to get you started and this will help motivate others to get on board.

4. A step-by-step action plan can help you to address all improvement areas you have identified. Starting with your immediate priorities, complete a separate action plan for each improvement area (tool 2b). For each action plan make sure you are very clear what you are trying to accomplish.

5. Check the resource pack for guidance, information, resources and points to consider to help decide on the actions you will take and the changes you will test. At the end of each statement in the self assessment you will see the relevant page of the resource that directs you to further information on the good practice area.

6. Record the date when you plan to have completed the action and who will be responsible.

7. Once you have completed the action, record the outcome and the completion date.

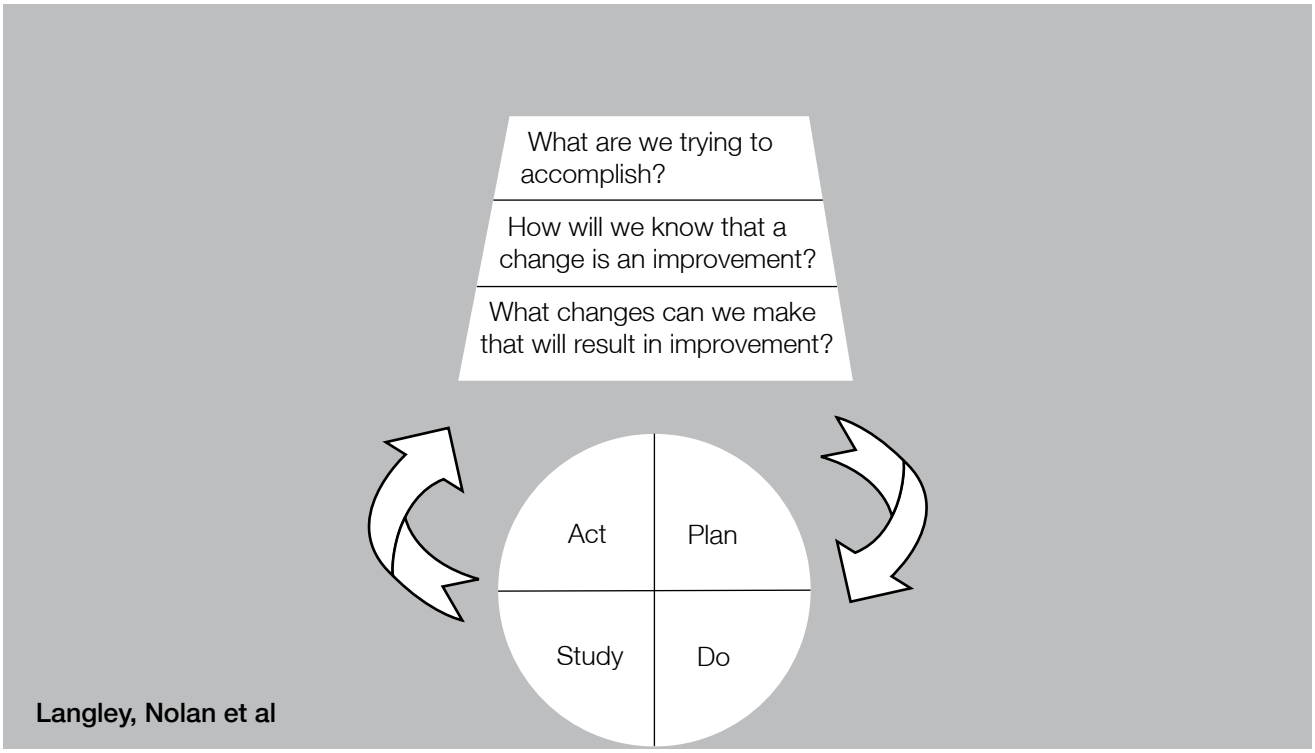
How do you use the resource to make lasting improvements in the quality of care?
Once you have identified areas for improvement and have the six essentials (page 19) in place, using this resource together with the 'Model for Improvement' can result in changes that will last.

Making changes to the way that you do things can be time consuming and can sometimes feel risky. The Model for Improvement is a tried and tested approach to achieving positive change.

This model offers the following benefits:
- It is a simple approach that anyone can apply.
- It reduces risk by starting small.
- It can be used to help plan, develop and implement change.
- It is highly effective.

What is the Model for Improvement?
The Model for Improvement (Figure 6) provides a framework for developing, testing and implementing changes to the way that things are done that will lead to improvement.

Figure 6: The Model for Improvement



The model consists of two parts that are of equal importance. The first, the 'thinking part', consists of three fundamental questions that are essential for guiding improvement work. The second part, the 'doing part', is made up of Plan, Do, Study, Act (PDSA) cycles that will help you make rapid change.

The three fundamental questions for achieving improvement

The three fundamental questions for achieving improvement provide a useful way to frame your work.

1. What are we trying to accomplish?

This question helps you to be clear about what you aim to achieve with your improvement activities. What will success look like in your care home? How will things be different? It is crucial for everyone involved to have a clear understanding of your aims.

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

While every improvement is a change, not every change results in improvement. Without measurement it is impossible to know whether things have improved. Agree what information you need to collect to measure whether or not the changes you make are improvements.

You can do this in terms of the way in which your results or outcomes might be different (for example, the number of falls in the care home), how the care that your residents receive will be better (for example, the number of residents receiving yearly eye health checks), or how your processes might change (for example, the number of residents receiving a multifactorial falls risk screen within 24 hours of admission).

3. What changes can we make that can lead to an improvement?

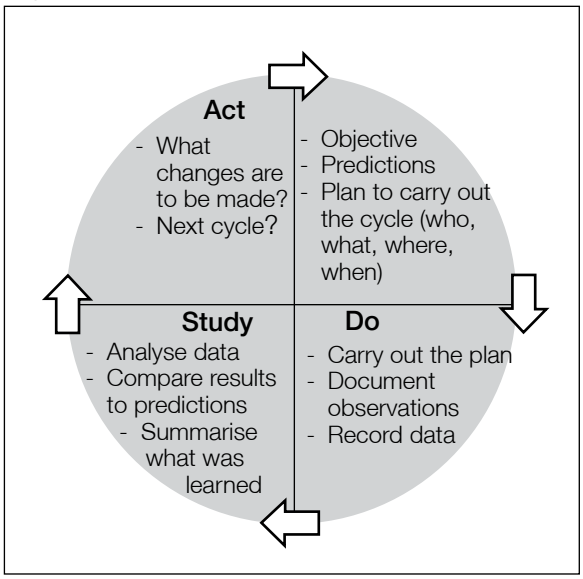
Finally, you need to decide what changes you will test to achieve the results you are looking for.

Consider:

- Ideas and tools available in this resource that can improve care.
- Evidence you have from elsewhere about what is most likely to work.
- What you and your team think is a good idea.
- What other people have done that you could try.

This is where you can adapt ideas or be completely creative. Remember that you know your own care home best, so use your knowledge and experience to guide you. Gather together as many ideas as you can. These will form the basis for the next step – your tests of change, otherwise known as PDSA cycles.

Figure 7



PDSA Cycles

PDSA stands for 'Plan, Do, Study, Act'. A PDSA cycle is sometimes referred to as a test of change. Once you have decided exactly what you want to achieve, you can use PDSA cycles to test out your ideas developed from the third question, 'What changes can we make that will lead to an improvement?'

Figure 7 summarises important considerations at each of the four stages of your PDSA cycle.

First 'Plan' your PDSA cycle - what, where, when and who. Think what information (data) you need to collect to learn whether or not your test is successful. Predict what you think will happen - reflecting on this later will help your learning.

The key is to try out your change on a small scale to begin with. You might, for example, like to run your cycle over one day, with one staff member or one resident. You can carry out a number of cycles to build up information about how effective your change is.

Taking this approach makes it easier to get started, gives results rapidly and reduces the risk of something going wrong and having a major impact. If what you try doesn't work as well as you hoped, you can always go back to the way you did things before. When you have built up enough information to feel confident about your change, you can then implement it as part of the routine in your care home.

After you've carried out your Plan ('Do'), the 'Study' part of the cycle gives you the opportunity to reflect on what happened, think about what you have learnt and build your knowledge.

Finally, you can move on to your next step – the 'Act' part of the cycle. Do you need to run the same cycle again, gathering more evidence or making some changes based on what you learnt? Or do you need to carry out further cycles to move your work forwards?

Always remember:

- PDSAs cannot be too small
- One PDSA will almost always lead to one or more others
- You can achieve rapid results
- PDSA cycles will help you to be thorough and systematic
- PDSA cycles will help you learn from your work
- Anyone can use them in any area.

To read more about how to use the Model for Improvement go to tools 1a,1b,1c in the toolkit.

How do you move from testing to implementation?

If the data gathered from the tests of change is showing consistent improvement, set a date for implementation. Inform staff about the change, when it will happen, how it will happen and where it will happen. Involve staff in your care home throughout the process.

Update written guidance and policies to include the new way of working.

Further tweaks may be needed during the implementation phase using PDSAs. Regularly review any data and processes to ensure improvements continue.

Effort will be required to ensure improvements are maintained over time.

Things to consider

- Provide ongoing, supportive leadership.
- Always include falls prevention and management in the induction process.
- Keep everyone informed and involved and identify the best way to do this.
- Embed continuous improvement into the culture of the care home.
- Include falls prevention and management as part of your quality improvement and health and safety monitoring.
- Celebrate successes.
- Establish a local network of interested people to share knowledge, learning and ideas.

Resources

Tool 1a – The Model for Improvement
Tool 1b – The Model for Improvement and PDSA cycle planning and progress proforma
Tool 1c – The Model for Improvement example
Tool 2a – Improvement log
Tool 2b – Action plan

NHS Scotland's Quality Improvement Hub provides a wide range of resources to support learning about improvement, including e-learning modules and a library of tools.

Visit the QI Hub at http://www.qihub.scot.nhs.uk/home.aspx

Pillars for success

The 10 'Pillars for success' are the lessons learnt from the 'Up and About in Care Homes' project. They show that improvement is successful as a result of a combination of factors.

1. Take a holistic approach to the prevention and management of falls and the prevention of fractures focusing on enabling individuals to age well and participate in life as they would choose.
2. Integrate falls prevention into every day practice and make falls prevention a priority.
3. Take a person-centred, outcomes focused, systematic approach to falls risk screening.
4. Gather, analyse and report information about falls on a regular basis, identify trends and highlight areas for improvement.
5. Have access to computers and technology with staff trained in its use.
6. Know who can help in your local health and social care team and the local community, and how to access that support. Work in partnership.
7. Establish and maintain both leadership and commitment from care home staff and the wider team to make continuous improvements – it's everyone's business.
8. Learn from testing and implementing innovate practices and share examples of good practice.
9. Recognise and celebrate achievements regularly.
10. Identify adequate resources on an ongoing basis, including staff time, to carry out the improvements.

To read more about the 'Up and About in Care Homes' project go to http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme/up-and-about-in-care-homes.aspx

Section 3: Prevention of Falls and Fractures

This section focuses on the prevention of falls and outlines good practice relating to falls and fracture risk assessment and falls care planning. By carrying out a Multifactorial Falls Risk Screen (MFRS) risk factors can be identified and action taken to remove or reduce risk where possible.

Key things to remember

- The emphasis should always be on anticipating and preventing falls rather than simply managing falls once they have occurred.
- A fall is nearly always due to the presence of one or more risk factors.
- All individuals admitted to the care home should have a Preadmission Falls Questionnaire completed (tool 3).
- All residents must have a MFRS completed within 24 hours of admission to the care home, including people being admitted for respite.
- The MFRS must be reviewed and updated at monthly reviews or if a resident falls, or there is any change in the resident's health and wellbeing.
- When you identify a risk using the MFRS, the actions to reduce risk should be documented in the falls care plan within the resident's general care plan.
- A person-centred approach should be taken to MFRS and falls care planning.

The emphasis should always be on anticipating and preventing falls rather than simply managing falls once they have occurred. Evidence shows that falls can be reduced when an individual's risk of falls is assessed and actions are taken to reduce risk.

What can you do to reduce the risk of falls at preadmission? (F14 in the self assessment)
All individuals who are being admitted to the care home should have a Preadmission Falls Questionnaire completed (tool 3). This may be completed by the individual themselves, a relative, carer or friend. Once it is completed a member of the care staff should review the information, discuss it with the individual or the most appropriate person. This information will contribute to the MFRS and falls care plan.

What can you do to reduce the risk of falls in your care home?
There are general measures you can put in place to reduce the risk of falls and harm from falls for all residents in your care home. Read more about general measures on page 33.

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

Care home stories: reviewing staffing levels to reduce falls

1. Southside Care Home in Inverness carried out an analysis of the information they had on falls in their care home. A large percentage of falls occurred at meal times. In response to this the care home manager decided to adjust the staffing levels at meal times and catering staff were employed to serve meals to enable care staff to support the individual needs of residents. This resulted in a reduction in falls at these times of day.

2. Peacock Care Home in Livingston increased the staffing in the care home in the evening because their falls information told them that there were more falls taking place at that time of day. This ensured a member of staff was in the day room at all times in the evening. As a result the number of falls reduced.

General measures and staffing are important, but it is essential that you also consider and manage each individual resident's risk.

How do you assess a resident's risk of falling?
A fall is nearly always due to the presence of one or more risk factors. Recognising then removing or reducing an individual's risk can often prevent a fall. A person will often be exposed to a combination of risk factors for falling; the more risk factors present, the greater their risk of falling. Risk factors can relate to the individual and/or their surrounding environment. Read more about falls risk factors on pages 15.

As well as considering risk factors for falls, bone health should also be considered. If a person has a weakness in their bones, such as osteoporosis, he or she is more likely to break a bone if they fall. For this reason, you need to consider falls and bone health together. Read more about risk factors for breaking bones (fractures) on pages 71–72.

The risk of falling and/or breaking a bone can never be completely removed, however by carrying out a MFRS on every resident, risk factors can be identified and a personalised falls care plan created and actioned to remove or reduce the risk of falls and fractures where possible.

An introduction to the MFRS and the falls care planning process (B1, B3, F4 in the self assessment)
A comprehensive MFRS aims to systematically identify the falls risk factors a resident may be exposed to. Once completed, the information from the screen is then used to complete a personalised falls care plan which is part of a resident's general care plan. The falls care plan should state clearly the measures your care home staff and the wider team need to take.

There is evidence that residents are particularly at risk from falls and fractures in the first few months after admission to a care home[7]. This is likely to be due to the change of environment and/or a period of ill health prior to admission. It is therefore essential that you screen residents for their risk of falling and put a falls care plan into practice to manage risk as soon as possible.

Aim to carry out a MFRS for all new residents to the care home within 24 hours of admission. This includes respite residents and those returning to the care home following a hospital admission. In addition, new residents should be orientated fully to their new environment.

It is good practice for all members of the care home team to be involved in and aware of the MFRS, falls care planning and review of an individual's risk of falls. Where required, involve the wider team. The resident and resident's family should also be involved in the falls care planning process. A guardian or welfare attorney should be involved if the person is unable to communicate or understand the process. Read more on person-centred falls care planning on page 31.

What do you do when you identify a risk?
When you identify a risk, it should be translated into an action in the falls care plan. For example, if you identify the resident has poor mobility, the action plan could look like table 1 below.

Table 1

Risk factors identified	Identification date and signature	Action required	Action date and signature	Outcome	Completion date and signature
Poor mobility	06/04/2014 L.F.	Refer to Physiotherapy	07/04/2014 R.T.	Physio has supplied a walking aid	04/05/2015 T.S.
Poor mobility	06/04/2014 L.F.	Supervision Plan	07/04/2014 L.F.	Supervised when going to the toilet	Ongoing – reviewed monthly
Poor mobility	06/04/2014 L.F.	Encourage physical activity	07/04/2014 L.F.	Participating in chair-based exercises	Ongoing

Risks factors are often interrelated. For example, poor mobility may affect a resident's continence because he or she is unable to walk to the toilet in time. Therefore, risk factors should not be considered in isolation.

[7] Rapp et al (2009) Fractures After Nursing Home Admission: Incidence and Potential Consequences, Osteoporosis International, 20:p.1775-1783

The falls care plan will focus on enabling and empowering the resident to keep active while minimising the risk of falling. It should take into account the importance of choice, rights, independence and personal outcomes for an individual at all times. Any support required should be clearly recorded.

A falls care plan is a working document, which you review and update regularly following the initial MFRS, continually identifying and responding to any falls, change in the resident's condition or care needs.

Screening and creating an action plan alone does not prevent falls; it is following the falls care plan that will make the difference.

There are MFRS tools available that help you to identify risk systemically and include suggested steps to take to address identified risks. Two examples are included in the tools section of this resource pack (tools 4a, 4b). Regardless of which tool you use you must always consider what is appropriate for each individual resident according to their needs and choices. No tool will have all the answers.

Resources:

MFRS tool options:
Tool 4a: MFRS and falls care plan
Tool 4b: Care home resident falls and fracture risk/intervention tool

Find out if there is documentation and/or tools that you are encouraged to use by your organisation or your local health and social care team.

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

- Falls risk scores, also called risk prediction tools, do not consider all the important risk factors.
- There is no tool to predict risk of falling accurately or consistently; it may under or over predict falls risk.
- Having a total score does not itself lead to interventions. For example, a resident can have a 'low risk' score because he or she has only one or two risk factors present. As the score was low, the tool indicates no action is required. However, in reality, taking action to address any risk identified could still contribute to a reduction in risk for that individual.
- Some organisations use falls risk scores to identify which residents should go on to receive comprehensive MFRS. You can argue that in the care home setting, where the majority of residents

will be at risk of falling, every resident should receive a comprehensive MFRS, therefore a falls risk score is not necessary.

- If a risk score is used, a further MFRS that identifies risk factors that you can modify is still required. This MFRS will help to identify all actions you need to take to reduce risk of falls and harm from falls.
- There are some benefits to using a falls risk score, for example, it may raise awareness of the problem of falls, but you must also consider the limitations of these tools.

When should you update and review the MFRS and falls care plan? (B4, B5, B6 in the self assessment)

The MFRS and falls care plan will need to be updated and reviewed as required.

It is good practice to:

- update a resident's MFRS and falls care plan
  - every month
  - after a change in medication
  - after every fall
  - when there is a significant change in a person's condition, for example during or following illness
  - on re-admission to the care home following discharge from another setting, for example, on discharge from hospital.
- formally review a resident's MFRS and falls care plan on a regular basis, for example, every six months or according to local policy.

Resident transfers between the care home, the hospital and other settings. (B7, B8, B9 in the self assessment)

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

On discharge from hospital, advice for ongoing rehabilitation, re-ablement and recovery (for example, following a broken hip), should be requested if not provided. It would be useful to find out whether a resident has had any falls risk assessments previously, what services have been involved, and what steps have been taken to reduce risks.

Person-centred falls care planning (B10, F15 in the self assessment)

It is essential that a person-centred care approach is taken to falls prevention and management and fracture prevention, where the resident and their families are seen as equal partners in planning of their care. It involves putting residents and their families at the heart of all decisions. The individual's values, preferences, wishes, routines, likes and dislikes should be central.

Whenever appropriate, it is important to involve the welfare attorney or guardian and/or resident's family principal carer in deciding on their care. It is very useful to hear a family member or carer's view on the person's previous falls and their falls risk.

This approach can raise a number of issues around risk. Risk can often be a complex issue where care home staff struggle to balance choice and empowerment with keeping an individual safe. This can be particularly difficult when an individual appears not to have insight into the risks they face. It should be assumed that an individual has the capacity to make their own decisions unless proved otherwise. Where capacity is impaired, residents should be supported to make decisions about their care.

Good risk enablement should be person-centred. It should involve a discussion with the individual and others as appropriate. It should be based on a balance between benefits, managing risk, avoiding harm and respecting rights, choice and freedom.

Resources:

Tool 5 – Falls information for Friends and Family

Care home story: using 'active resident care' to deliver care

Fleet Valley Care Home use 'Active Resident Care' - a person-centred approach to the delivery of care for residents within a care home. It originated from a model called 'Intentional Rounding' that was used in hospital settings.

With active resident care you give residents an individual care timetable depending on their needs. A whole care home approach is preferred but it can be used on an individual resident basis.

Active resident care involves regular checks on residents. The frequency of the check can be from hourly up to every 6 hours. These checks may be dependent on the time of day (may be less frequent at night or more frequent if a person becomes agitated).

The care plan for a resident is reviewed and discussed as a team to look at what the resident's daily patterns are. It is decided when these checks will take place and this should be discussed with the resident. It may change over time if the resident becomes unwell or there are other changes to their needs. When used in combination with a falls diary, staff are able to analyse times when a resident falls and put in checks when a resident may be more at risk.

During the checks agreed questions are asked by staff who respond appropriately to the resident's needs. These include questions about toileting, hydration, physical activity and pain control.

If used within the care home, this individual approach can reduce falls, pressure ulcers, urinary tract infections and call bell use. Residents have reported that they are put at ease as they know when a staff member will be back to see them. They also feel that staff are taking time to care for them. Staff have reported that they have more quality time to spend with residents and feel more satisfied at their work.

What general falls prevention measures should be taken in your care home for all residents?
MFRS and falls care planning will identify an individual's risks and the actions that can reduce risk. However, some basic safety precautions are appropriate for all residents.

For each resident please make sure that:

- there is a call bell to hand, the resident can use it and the importance of getting assistance is explained
- their chair is suitable
- safe walking is discussed
- their walking aid (if used) is within reach and in good condition
- their bed is the right height
- the area around them is free of hazards
- their regularly used items are within easy reach
- their footwear and clothing fits well
- they are not left unaided on commodes, toilets, in baths or showers if they have a cognitive impairment or poor mobility and you know that they tend not to ask for assistance.

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

The Falls management checklist (tool 6) can be used to check if falls prevention actions are being carried out. It can be used to check one area of the care home or on a random selection of residents.

Staffing and skill mix
Staffing levels, work patterns and staff knowledge and skills can affect the risk of falls in a care home.

A care home manager should make sure that the care home has the appropriate staffing levels and skill mix to manage the risk of falls.

Resources

Tool 6 – Falls management checklist

Section 4: Keeping well

Learning more about risk factors and how to prevent falls and fractures

Keeping well provides information about 10 common risk areas and some things you can do to reduce the risk of falls and harm from falls. It provides guidance, points to consider, tools and links to some useful websites.

Keeping physically active and mobile (C1 in the self assessment)

This section outlines why keeping mobile, doing regular exercise and being physically active is important. It provides some key things to consider along with care home stories which are examples of good practice.

Key things to remember

- Enabling people to contribute to the day to day life of a care home will increase physical activity.
- Reduced mobility should be investigated, especially if it happens suddenly.
- Physical activity has been found to protect against the loss of mobility, strength and balance.
- Individualised strength and balance exercises can help reduce the risk of falls in some cases.

Why is it important to keep mobile, do regular exercise and be physically active?

When older people keep mobile, exercise regularly and stay physically active it can play an important role in:

- slowing the ageing process
- reducing the risk of developing some long term conditions, such as diabetes, heart disease, obesity, lung disease and osteoarthritis
- managing the above conditions when present
- improving or maintaining mobility
- keeping socially active
- managing depression
- enabling older people to maintain their ability to carry out daily activities and contribute to care home and community living.

What do we mean by being mobile?

Being mobile means to have the ability to walk or move about aided or unaided. Some people will walk independently; some may be mobile with the support of a walking stick, other equipment, or another person. Read more about supporting mobility in the walking aids section on page 38.

What do we mean by being physically active?

You can define physical activity as 'any bodily movement produced by skeletal muscles that results in energy expenditure'[8]. It is a broad term covering all types of movement and includes basic activities, such as getting in and out of a chair, on and off a bed, washing, dressing and walking (with or without a walking aid).

Being physically active is as valuable to care home residents as it is to people living elsewhere. It is important that physical activities are suitable and safe for the person and that staff or the resident's family and friends provide adequate support and/or supervision. For example, walking to the dining room or toilet, with a walking aid, supervision or assistance as required, is beneficial, even if the distance is short.

What do we mean by exercise?

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

Strength and balance exercise programme

Research has shown that exercise which improves a person's muscle strength and standing balance can reduce the risk of falling[9]. However, the exercise must be 'tailored' to the person to ensure it is safe and at the right level for them. Knowledge of exercise and falls prevention, usually gained from training and experience, is necessary to teach this type of exercise, whether it is on a one-to-one or group basis. Strength and balance exercise programmes are usually prescribed and/or delivered by trained physiotherapists and exercise instructors. However, anyone can encourage and support people to carry out their exercises

Care home story: Let's Motivate

Dumfries and Galloway care home staff took part in Let's Motivate training organised by local NHS and Sport and Leisure colleagues. This was designed to teach care home staff skills to enhance the strength, balance and co-ordination of residents and facilitate an increase in their physical activity levels. The training enabled staff to provide fun, friendly sessions using Boccia and indoor curling, as well as chair based and standing exercises. It taught staff to adapt the exercises for different abilities. In Fleet Valley Care Home, a group of activity champions who have attended the training are motivating and encouraging residents to be as mobile as possible. They have a daily exercise class, support residents with individual activity plans and encourage them to move about daily.

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[8] World Health Organization (2010) Global Recommendations for Physical Activity and Health. Geneva. ISBN: 97892415999793

[9] Sherrington C, Whitney J, Lord S, Herbert R, Cumming R, Close J (2008) Effective exercise for the prevention of falls: a systematic review and meta-analysis. Journal of the American Geriatrics Society 2008;56 (12):2234-43

Care home story: Boccia

The Reshaping Care for Older People programme has provided the opportunity for introducing the sport of Boccia into care homes across NHS Highland. The activity co-ordinator said "Boccia is ideal because of the inclusivity of the sport. It is played from a seated position and players of any level of physical ability can compete equally. It's also great fun!"

Things to consider

Residents with poor or reduced mobility, balance and/or muscle strength in their legs are more at risk of falls.

In this situation, the actions you should consider are:

- **A medical review** to establish if there is a medical cause.
- **Physiotherapy referral** for assessment of mobility, balance and muscle strength, assessment for mobility aids and/or prescription of an exercise programme.
- **Occupational Therapy referral** for assessment and advice on equipment, adaptations, enablement and engaging residents in day to day activity.
- **Creating an enabling environment** for example chairs and beds at the correct height for individuals, rest opportunities along corridors, appropriate equipment and adaptations.
- **Including a section in the care plan noting supervision required to enable safe mobility** for a person who is unsteady. Caution is required when encouraging a resident who is unsteady to increase their level of activity, as their falls risk could increase. However, it is important for them to remain as active as possible safely. Some residents may need a high level of supervision; others may require supervision at certain times of the day or when carrying out certain activities. At all times you should consider the resident's rights, they must be treated with dignity and respect and agree the plan of care.

Encouraging daily physical activity and exercise

- **Individualised exercise programmes**

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

- **General exercise programmes**

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

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

Not all residents will choose to or be able to participate in a formal exercise programme.

Care... about swimming

Many care homes are recognising the benefit of swimming to residents. Six residents in a North Lanarkshire care home participated in a swimming pilot in conjunction with the NHS Lanarkshire Care Home Liaison team and North Lanarkshire Leisure. A 92 year old resident who took part said "you are never too old to learn a new skill" having never tried swimming before. Other residents described how their aches and pains vanished as soon as they got into the water. Some residents were able to mobilise independently, rather than with assistance and others had more energy, slept better and had a better appetite.

- **Enabling residents to be physically active every day**

Daily activities are important to enable residents to be active and move more often. This can be done by using an enablement approach where people are encouraged to be as independent as possible as opposed to a more traditional task orientated way of working. For example, enable a resident to stand and wash at their sink instead of sitting at the edge of their bed with a basin or walk part or all of the way to the toilet. Also, some residents may have interests and hobbies, which will enable them to be active.

It is important to consider:

- what motivates a person to be more active and bring purpose and meaning to their day
- their needs and abilities
- their potential to be more active.

Links with the local community and knowing what local parks and other facilities can be accessed easily can provide opportunities for residents to be more active.

Resources

Care... about physical activity
This resource supports care homes to promote physically activity.
http://www.careinspectorate.com/index.php?option=com_content&view=article&id=8429&Item-id=100214

College of Occupational Therapy, Living Well in Care Homes toolkit
Provides guidance on promoting meaningful activity
https://www.cot.co.uk/living-well-care-homes

Make Every Moment Count
Provides a guide to every day living.
http://www.careinspectorate.com/index.php?option=com_content&view=article&id=8196:-make-every-moment-count-v15-8196&catid=320:Professional-General&Itemid=766

Walking aids, wheelchairs and other equipment (C9 in the self assessment)

Walking aids

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

Care and maintenance

Staff should regularly maintain walking aids by:

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

Wheelchairs and other equipment (C10 in the self assessment)

Wheelchairs should be checked for wear and tear on a regular basis, for example, monthly, or according to local policy, and this should be documented. (tools 7a and 7b.)

Good practice should include regularly checking other equipment such as:

- moving and handling equipment
- commodes and toileting equipment.

Safe moving and handling

Falls can happen when a resident is moving or being assisted to move around the care home. It is good practice that all staff are trained in moving and handling techniques, which should include falls prevention and management, and be aware of any risks relating to specific residents. A resident's ability to move around can change. Communication systems should be in place to ensure all staff are aware of this.

Tips for enabling safe mobility

1. Getting up from a chair - a resident should move their bottom to the edge of the chair, make sure their feet are in a good position to stand up, bend forward as they start to rise from the chair, use their hands to push up from the arms of the chair and once they have their balance, they should reach for their walking aid.

2. Sitting down on a chair – a resident should ensure that they have moved as close to the chair as possible with their walking aid so that they can feel the back of their legs against the chair, reach down to the arms of the chair with their hands and sit down slowly.

Resources

Tool 7a – Wheelchair safety inspection guide
Tool 7b – Wheelchair safety inspection record
Tool 8 – Falls Prevention Monitoring form (walking aids/footwear/wheelchairs/commodes/chairs)

Mild cognitive impairment, dementia and delirium (C2 in the self assessment)

This section outlines important points to consider relating to preventing falls when someone has a cognitive impairment, has a diagnosis of dementia or has delirium.

Key things to remember

- People with a mild cognitive impairment may be more at risk of falls.
- Falls are not inevitable for people with a diagnosis of dementia.
- People with dementia can have the same risk factors as people without dementia and therefore need to have a MFRS completed.
- Delirium is an acute confusional state and should be looked on as a serious medical emergency and managed appropriately.
- You should consider delirium if a) a resident suddenly becomes confused or their confusion gets worse, b) a resident suddenly has a change in their cognitive ability.
- The 4AT tool is useful for helping you to identify delirium.

There are many people living in care homes with a level of cognitive impairment, with or without the diagnosis of dementia and episodes of delirium. It is important to apply the same good practice in falls prevention and management and fracture prevention as for older people in general. It is also essential that family and friends are involved in this process to help reinforce the principles.

What is mild cognitive impairment (MCI)?

MCI is a slight but noticeable and measurable decline in an individual's cognitive function. It may include memory loss and a decline in thinking and judgement skills. If someone has lost some of their cognitive ability it can affect how the person copes with day to day activities and recognition of risk. This can result in an increased risk of falls. A person with MCI is at an increased risk of developing a dementia.

The Abbreviated Mental Test (AMT) (tool 9) is a screening tool to identify cognitive impairment in older people.

What about dementia and falls?

People with dementia experience changes to their physical, mental and emotional functioning that affects how they cope with day to day activities, relate to others and how they communicate. Confusion, disorientation, memory loss, restlessness, agitation, behaviour that challenges us and lack of judgement and insight can contribute to their falls risk. People with a diagnosis of dementia are eight times more likely to fall than those without a diagnosis of dementia[10].

People who have dementia are at greater risk of falls due to the following:

- physical weakness, changes in mobility and poor balance
- memory impairment and disorientation
- visual problems
- impaired judgment, insight and safety awareness
- side effects of medication
- symptomatic orthostatic hypotension (a drop in blood pressure usually when a person gets up from a lying or sitting position that causes dizziness, feeling faint, unsteadiness or confusion)
- depression
- symptoms of stress and distress (pain, physical, psychological).

What is delirium?

Delirium is known as an 'acute confusional state' and should be looked on as a serious medical emergency. It is sometimes overlooked or misdiagnosed as other conditions. Dementia, illness, surgery and medication can cause delirium which often starts suddenly and changes frequently. Symptoms include an altered level of alertness, changes in behaviour and mood, sleep disturbance, hallucinations and delusions. Delirium usually ends once the condition or situation causing it has been removed. It can be a very frightening experience not only for the person who is unwell but for those near the person.

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[10] World Health Organization (2010) Global Recommendations for Physical Activity and Health. Geneva. ISBN: 97892415999793

The 4AT is an assessment tool which has been developed to help identify delirium and cognitive impairment. To find out more go to www.the4at.com

Things to consider

- **A MFRS** should be completed for all residents no matter what their diagnosis is, paying particular attention to the risk issues on page 40.
- **Create a dementia friendly environment** which will help individuals in your care home to be more orientated and reduce the risk of falls. For example, good signage, lighting and colour contrast between furniture and flooring. See the examples in figure 8.

Figure 8

- **Encourage people to be more physically active**, which can prevent the deterioration of mobility, strength and balance.
- Rehabilitation approaches such as physiotherapy and occupational therapy can be helpful. People with dementia can benefit from rehabilitation.
- Engage people in daily life enabling them to have purpose and meaning to their day. The guide to everyday living 'Make Every Moment Count' may help you - see resources section.

Resources

Make Every Moment Count
Provides a guide to everyday living.
http://www.careinspectorate.com/index.php?option=com_content&view=article&id=8196:-make-every-moment-count-v15-8196&catid=320:Professional-General&Itemid=766

Dementia and Sight Loss Leaflet on RNIB Website
http://www.rnib.org.uk/services-we-offer-advice-professionals-social-care-professionals/working-older-people

Thomas Pocklington Trust – Dementia and Sight Loss publications and design guides
http://www.pocklington-trust.org.uk/researchandknowledge/publications/ RF42DesignForDementiaAndSightLoss.htm

Stirling Dementia Services Development Centre – dementia design
http://dementia.stir.ac.uk/

4AT is an assessment tool
http://www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/delirium_toolkit.aspx

'Nothing Ventured, Nothing Gained' Department of Health 2010 – risk guidance for people with dementia
https://www.gov.uk/government/publications/nothing-ventured-nothing-gained-risk-guidance-for-people-with-dementia

Managing medication

This section outlines why managing medication is important and provides some things for you to consider that can improve care.

Key things to remember

- Residents should receive regular medication reviews.
- Your care home should have written guidance on medication reviews.
- Look out for medication side effects. If a resident is unable to communicate that they have side effects, look out for changes in behaviour/mood or unsteadiness when transferring or walking.
- As part of the post-fall protocol you should consider the increased risk of fracture or bleeding due to medication. For example, if a resident is on warfarin and has a head injury, you must seek medical advice.

Managing medications is important because certain medications can contribute to the risk of falls and harm caused by falls. It is important that staff in your care home are aware of this.

What do you need to know about medication and risk of falling?

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

- drowsiness
- dizziness
- hypotension (low blood pressure) or slowed heart rate
- Parkinsonian or extra-pyramidal side effects (such as slowness of bodily movement, difficulty starting movement, tremor, shuffling walking pattern)
- walking disorders
- vision disturbance
- dehydration
- confusion
- memory impairment
- delirium
- constipation.

Types of drugs that most commonly increase the risk of falling include:

- sedatives
- anti-depressants
- drugs for psychosis and agitation
- anti-hypertensives (tablets to lower the blood pressure)
- anti-Parkinsonian medications

- anti-histamines
- opioid analgesics
- anticonvulsants (medications for epilepsy).

(Note: These are some examples. Many other medications can cause unwanted side effects.)

Side effects from medications can be caused by a number of factors including the type of medication, the number of medications a person is taking and the dose. However, low doses of some medications can still cause side effects.

Falls may be the consequence of recent medication changes, but are usually caused by medicines that residents have been taking for some time. As a person becomes older and frailer he or she may become more sensitive to unwanted effects from medicines because of changes in the way the body absorbs and processes the medication.

What type of medication can increase the risk of harm from falls?
Theoretically, any drug that causes the following effects can increase the risk of serious harm if the resident falls.

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

Things to consider (C3, F11 in the self assessment)

A regular **medication review by a GP or pharmacist** provides an opportunity to check that all the medications a resident is taking are necessary and the correct dose. The medication review should take into consideration the resident's falls history. Skilful medication management by a GP and/or pharmacist may help reduce risk. It may be useful to establish how often local GPs and/or pharmacists carry out routine medication reviews.

At all times, if you see any symptoms that could be a side effect such as those listed above, it is useful to **check the 'Patient information leaflet'**, supplied with the medication, to find out whether or not the effect is likely to occur. You should especially consider side effects if a new medicine has been started or if the dose of a medicine has been increased. Further advice is available from your local GP or pharmacist. If a resident is unable to communicate that they have side effects, look out for changes in behaviour/mood or unsteadiness when transferring or walking.

As part of the post-fall protocol you need to consider any **increased risk of harm**, such as fracture or bleeding, due to the medications the resident is taking. For example, if a resident is on warfarin and has a head injury, you must seek medical advice.

It is useful to have **written guidance on medication reviews**. The outcome of a medication review should always be recorded in the resident's care plan.

Continence (C4 in the self assessment)

This section outlines the importance of supporting residents in your care home to remain continent and provides some useful things for you to consider.

Key things to remember

- Incontinence is a symptom and not a diagnosis.
- Sensitive assistance when a resident needs to use the toilet promotes continence, respects dignity and can reduce the risk of falls.
- Often when a resident feels they need to go to the toilet they try to get up and walk and it may not be safe to do so. If the person is able to walk ensure any walking aid or a call bell is kept within reach of the resident.
- Having an urgent desire to pass urine during the day and/or overnight can increase the risk of falls as the resident may rush to reach the toilet in time.
- There are simple things you can try to promote continence such as, responding quickly to a request from a resident to use the toilet, promoting a good fluid intake and a good night's sleep.
- Incontinence is a private matter and should always be discussed sensitively BUT to manage bladder and bowel problems effectively we need to talk about it.
- Many continence issues are treatable and older people can improve with the right support and care – incontinence does not have to be for life. The aim should always be cure and treatment and not containment.
- Where products are required the right product for the person must be used and reviewed regularly.
- Family can get involved in promoting continence, for example, prompting relatives to go to the toilet and encouraging a good fluid intake. Promoting continence is everybody's business.

Some bladder and bowel symptoms can increase the risk of falls and fractures for residents in your care home. Just feeling the need to use the toilet is known to increase the risk of falls as residents may try to get up and walk when it may not be safe for them to do so. Many people living in a care home have urinary or bowel incontinence and it is thought a number of falls in a care home may be related to visits to the toilet, especially at night. It is important to remember that incontinence is a symptom, not a diagnosis and there are many things that can be done to help. Everyone can support people to be continent in some way; promoting continence is everyone's business.

For an older person with frailty in a care home, relatively minor conditions such as a urinary tract infection or constipation can result in reduced mobility, cognitive function and an increased risk of falls.

What urinary problems can increase the risk of falls?

Urgency urinary incontinence

Urgency urinary incontinence is the most common type of incontinence experienced by older people. Urgency means 'a sudden overwhelming desire to pass urine that is difficult to put off'. When older people have urgency they tend to pass urine more often than usual (frequency) and may also need to get up at night to pass urine (nocturia). All three bladder problems can increase the risk of falls in older people. [11]

Urinary Tract Infection (UTI) and Catheter Associated Urinary Tract Infection (CAUTI)

UTI and/or CAUTI can be a risk factor for falls. UTI is the most common infection in care homes accounting for more than half of all infections[12]. A UTI is common in frail older people, both male and female, and often has more severe consequences than for younger people. These can include sepsis (a common potentially life threatening condition triggered by an infection), the need for antibiotic treatment and even death[13]. UTIs are also a major source of distress and discomfort and have a negative impact on the older person's quality of life[14].

What bowel disorders can increase the risk of falls?

Bowel disorders such as constipation and bowel incontinence are common in frail older people and may increase the risk of falls. There are several reasons why these disorders occur including medication, diet, reduced physical activity, muscle weakness and/or an underlying medical cause.

Constipation

Constipation is a common condition and can affect people of all ages. It is most common in older people and affects twice as many women as men. When someone is constipated it means they may not be able to open their bowels regularly or completely empty their bowels. The severity of constipation varies, it can be short or long term, causing a lot of discomfort and pain and affecting quality of life.

Bowel incontinence

This is an inability to control bowel movements, resulting in involuntary soiling. It is also sometimes known as faecal incontinence. People have different experiences of bowel incontinence; some feel they need to go to the toilet but are unable to reach it on time, this is known as urge bowel incontinence. Others experience no sensation before soiling themselves; this is known as passive incontinence.

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[11] Chiarelli, P.E., L.A. Mackenzie, and P.G. Osmotherly (2009) Urinary incontinence is associated with an increase in falls: a systematic review. Aust J Physiother, 55(2): p. 89-95

[12] Health Protection Scotland (2011) Healthcare associated infections in European long term care facilities (HALT). Prevalence study 2010 in Scotland.

[13] Koch AM, Eriksen HM, Elstrom P, Aavitsland P, Harthug S. (2009) Severe consequences of Healthcare-associated infections among residents of nursing homes: a cohort study. Journal of Hospital Infection 2009, 71, p.269-274

[14] Bermingham S, Ashe J. (2012) Systematic review of the impact of urinary tract infections on health related quality of life. BJU Int doi :10.1111/j.1464-410X.2012.11337.x

People can experience bowel incontinence on a daily basis or it may only happen from time to time. It tends to be more common in women than in men.

How do you assess for bowel disorders?

If a person has symptoms which indicate a bowel disorder it is important to carry out a holistic assessment of their bowel function and your aim should be to identify the most likely cause. The assessment should be based on the person's lifestyle and normal bowel habit and must consider all factors that can impact on a person's bowel health including medication, physical activity and nutritional intake. In order to do this a seven day bowel diary should be kept that records frequency and type of stool. The information gathered in the diary should be reviewed along with information on the normal bowel habit for the person. If constipation or bowel incontinence is identified, you should consider if there is an underlying medical condition. You may need to discuss this with a nurse or your local GP.

Things to consider when promoting healthy bowel and bladder function

Successful toilet use

Getting to and using the toilet is a complex activity. As shown below there are many steps for a person to take in order to safely and successfully get to and use the toilet. The person also needs to, while taking the steps, negotiate the environment and keep control of their bladder and/or bowel. All these factors should be considered in order to prevent falls and fractures. It is particularly important to identify any specific challenges for individual residents. Raise awareness with your staff about how complex this activity is. Encourage staff to consider the steps required for a resident to safely and successfully use the toilet. This will help them understand and identify the falls risks and take action.

Steps required for successful toilet use

- Recognise the need for the toilet.
- Find the toilet.
- Stand up.
- Walk to the toilet.
- Undress.
- Sit down.
- Empty bowels and/or bladder.
- Wipe with toilet paper.
- Stand up.
- Dress.
- Wash hands.

- Walk back.
- Sit down.

Maintaining a healthy bowel

B Bowels benefit from routine. The most usual time for a bowel action is about half an hour after meals. Eating regularly can help your bowel develop a predictable pattern. Don't miss breakfast.

O Only take as long as you need. Don't sit for ages on the toilet. You should be able to empty your bowel with minimal effort. Try not to strain: relax and allow yourself enough time and privacy to empty the bowel properly.

W When you feel the need to empty the bowel – respond! Constipation can happen if you frequently ignore the need to move your bowels, for example because you are busy or there are too many people around.

E Eat properly. Fibre can improve your bowel habit. Try to eat five portions of fruit and/or vegetables a day. However, if you have trouble controlling your bowel or suffer severe constipation, too much fibre can make matters worse. Fibre can also cause excessive wind. Drink plenty liquids – seven to eight cups of fluid a day unless you have been otherwise advised by your doctor.

L Limber up! Regular exercise can stimulate the bowel to work regularly.

Adapted from 'Advice for a healthy bowel', NHS Lothian

Other things should you consider for successful toilet use

- Give the person time on the toilet.
- Make sure clothing is manageable.
- Check if a hoist or mobility aid is required and make sure that is available.
- Check if hip protectors are being worn and the resident can manage them safely.
- Check if you need to be in the cubicle with the person or not and protect dignity and privacy at all times.
- If any continence products are being used check this will not interfere with the person's balance.
- If the person has passed urine encourage them to pass it for a second time to help empty their bladder and prevent leakage.
- Check if the resident needs support with their personal hygiene.
- Make sure the resident can reach the toilet roll.

Negotiating the environment

There are many things you can do to help a person to negotiate the environment safely and to successfully use the toilet.

Signage – obvious and easy to read signage directing people to the toilet, a sign on the toilet door.

Lighting – adequate lighting in the toilet area, the light switch should be easy to reach.

Distance – if the distance to the toilet is too far for some residents, put strategies in place to address this. For example, ask them to make their way to the toilet a bit sooner, sit nearer the toilet or put a chair in the hallway for residents to rest on.

Doorway – the door access must be wide enough to allow for walking aids and wheelchairs. Check it can be opened and closed easily by the resident. Make sure there is a working lock on the toilet door. This is essential for privacy and dignity, however it should be one that can be opened in an emergency.

Toilet – the resident should be balanced, secure and comfortable while sitting on the toilet. The person may need assistance to get on/off the toilet. Make sure the toilet is the right height for the resident; they may need equipment such as a raised toilet seat.

Adequate space – make sure there is enough room for the resident and any assistant to move around comfortably in the toilet area.

Calling for assistance – make sure a call bell is within easy reach and the resident can use it. Ensure the toilet area is warm, clean, well equipped and private.

Promoting continence

There are many things that can be done to promote continence and make a big difference to quality of life.

- Know how often a person normally goes to the toilet in a day and how they achieve that successfully.
- There may be particular behaviours which indicate a person would like to go to the toilet so pay attention to body language, facial expression and any behaviour change such as agitation or discomfort. This could include pulling at their clothes or looking for somewhere to go to the toilet.
- Know what word the person uses for toilet.
- Avoid delay once the need to use the toilet is recognised – any delay increases the sense of urgency and likelihood of incontinence. It also affects the resident's trust in care staff.
- Use call bells and other alert systems, especially at night, when required.
- Know what specific equipment a resident may require and how to use it.
- Promoting continence programmes may be required if a resident does not recognise the need to use the toilet. These programmes should be designed around the person's normal bowel and bladder function and will involve undertaking a holistic assessment that takes account of the person's lifestyle. This may include the use of a three day bladder diary to determine the type of incontinence they have.

Promoting continence programmes must be balanced with the wishes of individual resident's throughout the day. For example, promote toilet use before/after meals, know the individuals triggers and understand what works for each resident. This approach can greatly reduce the incidence of incontinence while at the same time promoting activity and reducing the likelihood of falls.

- Prevent UTIs by, for example, stressing the importance of consistently good fluid intake and minimising the use of absorbent products.
- Know how to refer to the local continence advisory service, physiotherapy and/or occupational therapy for assessment and support when required.

Resources:

Care Inspectorate resource: Promoting continence for people living with dementia and long term conditions.

http://www.careinspectorate.com/index.php?option=com_content&view=article&id=8681&Item-id=100230

Keeping feet healthy (C5 in the self assessment)

This section outlines the importance of regular good foot care and sensible footwear choices. It includes a description of a good foot care regime and guidance on selecting good footwear.

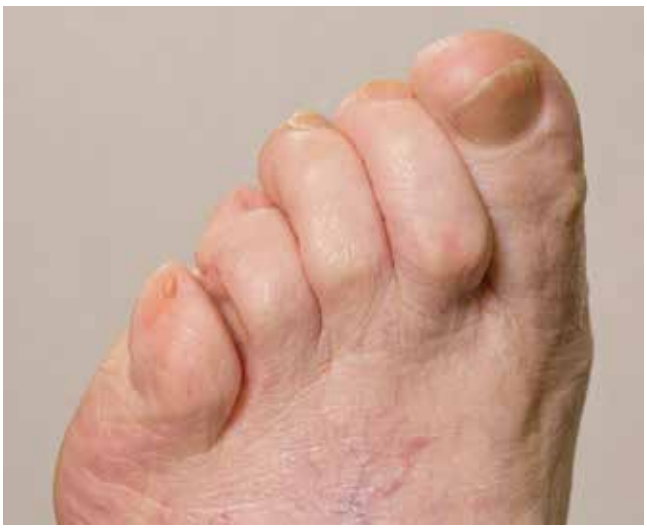
Key things to remember

- Daily foot care and inspection to check foot health is important to prevent falls.
- Every resident should have their own toe nail clippers and nail file/emery board for their own personal use.
- File toenails once a week.
- Look out for changes in residents' feet such as pain or soreness, redness or leakage of fluid from the foot or toes. Contact an NHS or other HCPC registered podiatrist if concerned.
- Footwear should fit well, have a supportive heel and secure fastenings. Slippers should only be worn for short periods of time.
- Footwear should be checked regularly for wear, tear and fit.

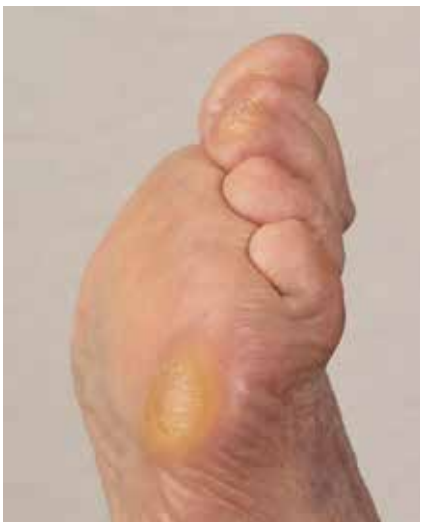
Why is good foot care and footwear important to prevent falls?

Looking after feet can help to prevent problems such as corns, calluses, bunions and ingrown toenails that can make residents unsteady on their feet and at risk of a fall. Foot pain and loss of sensation (numbness) can also contribute to a fall.

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



A common foot deformity: hammer toe (second toe)



Heavy callus on the sole of the foot and a hard corn on the tip of the third toe

Image courtesy of NHS Greater Glasgow and Clyde

Supporting residents to look after their feet is very important. Do not ignore minor foot troubles as they may get worse if proper attention and treatment is not provided. Provide your residents with support to help keep feet clean and healthy, and to maintain their toenails and skin in good condition.

Things to consider

What is good foot care?

A good foot care regime includes:

- washing and drying the feet carefully daily
- inspecting feet thoroughly for any sores, corns and calluses daily
- checking heels for any signs of pressure damage, daily
- if skin is dry, applying a good emollient cream around the soles of the feet and the area around the heel. Don't apply cream between the toes
- wearing clean tights and socks, daily
- filing toenails, weekly.

Every resident should have their own toe nail clippers and nail file/emery board. These should be kept clean and for each resident's personal use only. These can be purchased from high street stores, local pharmacies and on the internet.

Look out for any change in the condition of your residents' feet. Note if there is any complaint of pain or soreness. Notice if there is any redness or leakage of fluid from any area of the foot or toenails. Contact your NHS podiatry service or an HCPC registered podiatrist for advice if you note any of these changes, particularly if the person has diabetes or poor circulation.

Socks should be made of a high proportion cotton or wool mixture. Make sure socks fit well and are not too tight at the top as this can cause discomfort to the individual or may restrict their circulation. Wide top socks are available in high street stores and specialist suppliers.

What is good footwear?

Shoes should:

- fit well
- give full support to the foot
- be deep and roomy at the toe area
- have a low broad heel, and
- have a flexible non slip sole.

Footwear should be secured to the foot with laces, strap or velcro fastenings. This will help keep the heel to the back of the shoe and prevent the foot slipping forwards. The uppers should be made of leather or breathable natural or synthetic materials with seam free linings.

Slippers should only be worn for short periods of time at the beginning and end of the day. Avoid worn and stretched slippers as they are a serious falls risk. Slip on shoes or slippers can cause the foot to slide forward causing the toes to curl up which can result in nail problems, friction/pressure lesions such as corn/callus on the tops of the toes.

Resources

You can access short films, resources and more information on good foot care and footwear at www.lookafteryourfeet.info

Your local NHS podiatry service may be able to provide you with some education on looking after someone else's feet.

For information on specific foot conditions visit the MSK zone on the NHS Inform website https://www.nhsinform.scot/healthy-living/preventing-falls

The Society of Chiropodists and Podiatrists provide valuable information on podiatry and foot care and can provide details of local HCPC Podiatrists. www.scpod.org

Age Scotland provides useful information and advice to enable and support older people to be as active, mobile and well as they can be. www.ageuk.org.uk/scotland

Dizziness, blackouts and heart palpitations (C6 in the self assessment)

This section describes some of the cardiovascular symptoms (symptoms relating to the heart and blood vessels) a resident may experience that can lead to a fall. It highlights the importance of recognising these symptoms and taking appropriate action.

Key things to remember

- Symptoms such as dizziness, blackouts and heart palpitations can lead to a fall; it is important to ask a resident if they had any of these symptoms prior to their fall.
- Changes in behaviour, mood or unsteadiness when walking or transferring may be a sign that a resident is experiencing symptoms of dizziness and heart palpitations.
- Look out for signs of seizures such as twitching, tongue biting, incontinence.
- Orthostatic hypotension (postural hypotension) can cause dizziness and is common among frailer older people. Dehydration, medication or illness may cause or worsen orthostatic hypo tension.
- Vestibular disorders can also cause dizziness and vertigo.
- Staff should always report residents' heart palpitations, dizziness and blackouts to their GP as there are often treatments available.

In some cases, residents will experience cardiovascular symptoms that lead to a fall. Some people will describe specific symptoms of dizziness, heart palpitations, feeling faint or actually losing consciousness. However, others will describe feeling generally unwell, or "not quite right".

What are faints and blackouts?

A faint or blackout (sometimes called syncope) is a brief loss of consciousness, which typically happens suddenly and doesn't last long, with the person regaining consciousness naturally. It can be due to a decrease in blood flow to the brain, usually due to low blood pressure. First aid treatment is to lie the person on the level and if possible raise their legs.

What is dizziness?

There are a number of causes of dizziness but orthostatic hypotension is common among older people.

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

The drop in blood pressure usually occurs shortly after getting up from a lying or sitting position or after the person has been on their feet for some time. Sitting down again or going into a lying position relieves symptoms in most cases. Dehydration, medication and illness may cause or worsen postural hypotension. Often people with postural hypotension 'just go down' or may be found on the floor with no explanation. In severe cases it can occur while sitting. Bathing or a hot shower may also bring on the symptoms.

Resources

Tool 10: Protocol for measuring lying/standing blood pressure (BP) (checking for postural hypotension)

Dizziness caused by vestibular disorders

Dizziness can also be a symptom of a vestibular disorder. The vestibular system includes the parts of the inner ear and brain that help control balance and eye movements. If the system is damaged by disease, ageing, or injury, vestibular disorders can cause a number of symptoms including dizziness and vertigo, feeling sick, loss of balance, visual disturbance and hearing changes.

If a person has dizziness and vertigo caused by a vestibular disorder, they are likely to describe:

- a spinning or whirling sensation and/or
- a feeling that they are moving, or the world around them is moving when they're standing completely still, and/or

- light headedness, a floating or a rocking sensation, or a sensation of being heavily weighted or pulled in one direction.

The symptoms of vertigo can be barely noticeable or so severe that the loss of balance prevents the person from performing everyday tasks. Depending on the cause, an episode of vertigo may last several seconds, minutes, hours or days.

Contact the person's GP for a full assessment to understand the cause and provide the right treatment. Vertigo can often be treated successfully.

What are heart palpitations?
Heart palpitations are when a person becomes aware their heartbeat feels noticeably rapid, strong or irregular. This may be a sign of medical illness but can also be a symptom of anxiety in some cases.

What are seizures?
Sometimes a loss of consciousness may be due to a seizure. Look out for signs of twitching, tongue biting and incontinence. After the fall, look out for signs of sleepiness, confusion and/or difficulty with speech.

Things to consider
Always ask the resident if they had any of the symptoms described immediately before they fell. If a resident is unable to communicate that they have symptoms of dizziness, heart palpitations or feeling faint, look out for changes in behaviour, mood or unsteadiness particularly when rising from a chair/bed.

Around one third of older people who faint do not recall the pre-faint symptoms. If possible, speak to someone who witnessed the fall and ask if there was a change in the resident's colour, breathing or if they were sweating more. Also ask if the person lost consciousness, and if so, for how long.

Staff should always report heart palpitations, dizziness, blackouts and seizures to the resident's GP; steps can often be taken to reduce the risk of this happening again.

If you are measuring lying and standing BP follow an approved protocol (tool 10).

Vision and hearing (C7,F12 in the self assessment)

This section outlines visual problems that can contribute to falls and highlights the importance of looking after vision and hearing to reduce falls risk.

Key things to remember

- We rely on our vision and hearing for balance and moving around.
- Changes to a resident's vision or hearing can be due to age related changes or disease.
- It can be more difficult for a resident to concentrate on two tasks at the one time if they have difficulties with their vision or hearing.
- Residents should have regular sight and hearing tests and there should be written guidance on these.
- If you notice that a resident is misjudging things, bumping into things or losing their balance when moving around, it is recommended to have their vision checked.
- The moving and handling needs of a resident who has a visual and/or hearing impairment should be considered as part of the MFRS.

Why is vision and hearing important to falls prevention?

Vision and hearing problems can both contribute to a resident's risk of falls. We rely on our vision and hearing for balance and moving around safely. As we get older there can be changes to our vision or hearing due to either the natural ageing process or disease.

It can be more difficult for a resident to concentrate on two tasks at the same time if they have difficulties with their vision or hearing. For example, when walking and talking at the same time, or getting distracted, the person can lose focus on their balance, and fall.

What kind of visual problems can cause falls?

Visual problems can greatly increase a person's risk of falling. Research shows that older people are almost twice as likely to fall with even a minor loss in vision.

Visual problems increasing falls risk include:

- eyes taking longer to adjust to changes in the lighting levels — such as when moving from a darkly lit to a brightly lit room
- reduced visual field, which is a reduction in what you can see when the eye is looking forward, and includes your peripheral vision
- blurred vision or reduction in ability to see detail of objects (loss of visual acuity)
- reduced ability to see well in low contrast situations — such as distinguishing similar coloured fixtures and furnishing
- less accuracy when judging distances and depth — such as misjudging the height of a step or stairs

- poor balance can be caused by reduced central and/or peripheral vision. Eye movement disorders can affect balance
- wearing glasses with an outdated or wrong prescription (which is more common than you might think).

Visual problems are also common following a stroke. Further information is available in the Stroke Association factsheet 'Visual problems after stroke'. You can find this at www.stroke.org.uk/information/our_publications/factsheets/visual_problems.html

Some people with dementia experience problems with vision. Some experience double vision and difficulty with depth perception and judging distances from objects. These symptoms can often go undiagnosed even in a routine sight test. Visual problems could be either a neurological symptom due to their condition or a problem with the eyes. The effect on their likelihood of falling is the same. More information is available at www.alzscot.org

Things to consider

Vision

It is important to ensure that a resident's vision is as good as possible by making sure:

- regular eye tests take place, at least every year for residents aged sixty or over.
- separate glasses are worn for distance and reading. This is usually safer than bifocals or varifocals, unless the person is used to wearing them. A sudden change either way could increase their likelihood of falling.
- the person is wearing their own glasses.
- glasses are cleaned regularly.
- rooms, walkways and stairs are clutter free. However, if a resident is known to have problems with their vision, then be aware that furniture may be their "map" for navigating their environment and any sudden change could lead to increased difficulties.
- a good overall level of lighting – use 100 watt bulbs if possible. Natural daylight is very important. Ensure windows are kept clean and pull back curtains.
- edges of steps or stairs where accidents could happen are highlighted, with highly contrasting colours wherever possible.

If you notice that a resident is misjudging things, bumping into things or losing their balance when moving around it is recommended they have their vision checked.

Hearing

Ask the GP to refer the resident to an audiologist if their hearing has not been assessed within 12 months.

If a resident uses a hearing aid, ensure they wear it, that it is cleaned regularly and the batteries are changed at regular intervals.

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

If a resident is hard of hearing it can be helpful to keep noise levels to a minimum when communicating important information.

Resources

Healthcare Improvement Scotland, best practice statement, Maximising communication with older people who have a hearing disability: http://tinyurl.com/5tqsfqd

RNIB, Dementia and Sight Loss Leaflet: http://www.rnib.org.uk/services-we-offer-advice-professionals-social-care-professionals/working-older-people

Thomas Pocklington Trust, Dementia and Sight Loss publications and design guides http://www.pocklington-trust.org.uk/researchandknowledge/ publications/ RF42DesignForDementiaAndSightLoss.htm

Stroke Association factsheet 'Visual problems after stroke'. www.stroke.org.uk/information/our_ publications/factsheets/visual_problems.html

The environment

This section outlines issues relating to the environment that can have a significant impact on the prevention and management of falls and the prevention of fractures. It covers environmental assessment, hazards, safe use of equipment, moving and handling and technology enabled care.

Key things to remember

- Falls can happen anytime and anywhere in a care home environment.
- Falls may be due to a person's interaction with their environment or hazards around the care home.
- Falls can be reduced by maintaining a safe environment.
- Falls tend to increase when there are new or unfamiliar care home staff in attendance, during respite stays and in the first three months of admission to a care home.
- When there are new staff members, residents and families, it is important to orientate them quickly to the care home environment.
- An environmental assessment can focus on a) the general care home environment and/or b) an individual resident. These assessments should be done regularly.
- When carrying out environmental assessments it is important to do this at different times of day to ensure all potential hazards are identified.
- To reinforce good practice there should be written guidance on bedrails, restraints, low profiling beds, walking aids and other equipment used to support the resident.
- Regular checks of equipment such as walking aids, wheelchairs, commodes and other moving and handling equipment should be carried out.
- Technology enabled care and support, which includes telecare, can ensure a resident is as safe as possible and help to maintain their independence.

Falls can happen anytime and anywhere in a care home environment. This can be due to how a resident interacts with the environment or hazards around the care home. However, there are a variety of environmental measures that can be taken to manage and prevent falls and fractures in and around your care home. It is important to carry out your environmental assessment regularly to identify what measures are required. Falls often increase when there are new or unfamiliar care staff and/or new residents and families. Falls also tend to increase during respite stays and the first three months of a new admission to your care home. Therefore it is important to orientate them quickly to your care home.

What are environmental hazards?

Environmental hazards can be inside or outside your care home and can contribute to the risk of falling. It is important to assess for and consider all environmental hazards. Everyone can be involved in identifying environmental hazards, including residents and relatives.

Hazards in the surrounding environment could include:

- poor lighting – for example dull lighting, lights that cause shadows, dark places, bright lighting that causes glare.
- extreme temperatures - high temperature can cause fainting or low temperature can affect muscle function.
- floor surfaces – for example high thresholds, poorly fitted and/or patterned carpets, changes in floor covering/colour, slippery floors and rugs.
- clutter and obstructions – for example furniture, clothing, medication/food trolleys, wheelchairs, manual handling, mobility aids and other equipment.
- poorly maintained equipment – for example commodes, toilet seats, wheelchairs, walking aids, grab rails and shower seats.
- access areas – for example poorly lit hallways, uneven paths, steep stairs and thresholds at door ways.
- outdoor areas – for example grass, stones, uneven and/or poorly maintained paths and poorly maintained gardens.

What causes a resident's interactions with their environment to increase their risk of falls?
There are many reasons why a resident may be more at risk of falls because on their interaction with the environment.

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

What is an environmental assessment and when should it be carried out? (C8 in the self assessment)
An environmental assessment is a process to systematically identify hazards that may increase the risk of falls within your care home. Environmental assessments can be specific to an individual resident or can assess the general environment in your care home.

An individual assessment is essential when a person is admitted to your care home, if there is any change in circumstance such as illness, room change or returning from hospital, or when someone has fallen. If a resident has fallen, analysing their falls history and pattern will help to determine if the environment is a contributing factor to them falling. Read more about learning from falls on page 82.

An assessment of the general environment should be carried out and documented on a regular basis, for example, monthly, or according to local policy. It is helpful to identify a member of staff to do a regular environmental risk assessment to ensure areas are as safe as possible.

A general environmental assessment should include:

- seating
- toileting
- showering/bathing
- bed transfers
- dining areas.

Risks identified from environmental assessments and actions to reduce risk should be recorded, actioned and reviewed.

Consideration should be given to the time of day, with checks carried out at different times of day to ensure all hazards are considered. Regular assessment of high risk areas may help to prevent falls.

There are tools in this resource pack to help you do both types of environmental assessment (tools 11 and 12).

Things to consider

- Fire safety is paramount and should be considered if you are making any environmental changes. It can be helpful to speak to your local Fire and Rescue service representative for advice. To request a home fire safety visit call 0800 0731 999

- You may feel it is necessary to request an occupational therapy and/or physiotherapy assessment. An occupational therapist can assess a person's ability to take part in daily activities in your care home and make suggestions for adapting the environment, if this is required. A physiotherapist can assess a resident's walking and balance to determine what they are capable of and, if required, the most suitable walking aid for them. The physiotherapist will also instruct the resident and staff on the proper use of the aid.

- It is important to consider the resident's routines as part of the environmental assessment. See Active Resident Care page 32.

Resources

Tool 11: Resident environment and orientation tool

Tool 12: Generic falls environmental risk assessment

Health and Safety Executive booklet 'Preventing slips and trips at work
http://www.hse.gov.uk/pubns/indg225.pdf

Safe and appropriate use of equipment (F5 in the self assessment)

There should be written guidance on the safe and appropriate use of equipment to prevent falls and injuries, such as bedrails, lap straps, harnesses and specialist seating and hip protectors. Guidance will help residents, staff and family to make the right decisions about using equipment to prevent falls and injuries.

Residents in care homes may be at risk of falling from beds and chairs. This may be for many reasons including poor mobility, dementia or delirium, visual impairment or side effects of medications. There are pieces of equipment available that can reduce this risk in certain circumstances.

Bed rails

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

There are two types of bedrails.

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

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

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

We recommend you do not use bedrails if:

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

Resources:

Tool 13: Bedrail risk assessment

Things to consider

Decisions about bedrails are a balance between competing risks. The risks for individual residents can be complex and relate to their physical and mental health needs, the environment, their personality and their lifestyle. Staff should use their professional judgement to consider the risks and benefits for individual residents. It is recommended you review risk assessments after each significant change in a

resident's situation, for example, if a resident attempts to climb over the bedrail or out of the bottom of the bed – remove bedrails. As a minimum requirement, you should review the use of bed rails weekly.

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

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

Resources

MHRA Bed Rails: Management and Safe Use
https://www.gov.uk/government/publications/bed-rails-management-and-safe-use

NPSA safer practice notice; using bed rails safely and effectively
www.nrls.npsa.nhs.uk/resources/?EntryId45=59815

NPSA bedrails literature review
www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61400&type=full&servicetype=Attachment

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

Mental Welfare Commission publication:A34426:Consent to treatment:
www.mwcscot.org.uk/web/FILES/Publications/MWCConsenttotreatment.pdf

GMC (2008) Consent: patients and doctors making decisions together
www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

Specialist seating

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

Things to consider

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

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

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

Consider seeking advice from an occupational therapist if:

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

Resources:

Tool 14 – Seating matters

Restraints

The definition of restraint is 'the intentional restriction of a person's voluntary movement or behaviour'[15].

Restraints are designed to protect residents from falls and harm. However, the risks associated with restraints may outweigh the benefits. Rather than protecting residents, restraints can place them at risk of physical and psychological harm. Best practice is to perform an assessment of the risks and

[15] Counsel and Care UK (2002) Showing restraint: challenging the use of restraint in care homes. London

benefits for each individual resident, and decide along with the resident and/or family if restraint is appropriate.

When a person is restrained and denied the ability to get up, sit down or walk about freely, their quality of life and psychological wellbeing may be affected. In addition, limiting a resident's freedom of movement can lead to muscle weakness and reduces physical activity, which in turn increases the risk of falling.

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

Drugs are considered inappropriate chemical restraints when they are:

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

Things to consider

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

The policy should address the following.

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

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

Alternatives to using restraint

- Additional supervision/observation of activities.
- Involving family members or volunteers.
- Daily physical activity or exercise.
- Structured activity.
- Day to day activities.
- Instruction on safe transferring.

- Appropriate toileting.
- Orientation to environment.
- Obstacle free environment.
- Different seating options.
- Bed and chair alarms.
- Falls detector alarms.
- Accessible call buttons.
- Moving and handling alternatives for example, lower height bed, mattress on the floor.

Low-profiling beds (F6 in the self assessment)
Low beds help prevent injuries because they are as low as 14 inches to the ground. If a resident did fall out of bed, injuries would be minimal.

Things to consider
Assess each resident individually to ensure this is the most appropriate method of preventing falls from bed or harm from falls.

The assessment should include:
- physical stature
- psychological illness or distress
- discomfort or pain
- disabilities/capabilities
- resident's wishes
- previous accidents/injuries
- any variation in status over a 24 hour period for example, nocturnal confusion.

If a resident requires a low-profiling bed they may need additional support to get in and out of bed. If this support is not available it may mean the resident's freedom to move is restricted and they could become less active or at greater risk of falling.

Walking aids
Read more about walking aids on page 38.

Wheelchairs other equipment
Read more about wheelchairs and other equipment on page 38.

Resources

Tool 7a – Wheelchair safety inspection guide

Tool 7b – Wheelchair safety inspection record

Tool 8 – Falls Prevention Monitoring form (walking aids/footwear/wheelchairs/commodes/chairs)

Technology enabled care and support (F7 in the self assessment)

Technology enabled care and support, which includes telecare, can help to support a resident to remain independent and ensure they are as safe as possible. It is not an alternative to direct care and will not remove all risks. It can however be used effectively when included as part of a personalised plan of care and support and regularly reviewed.

Examples of devices include:

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

Things to consider

To be effective, telecare requires:

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

Resources:

Tool 16 – Telecare matters: A quick guide to technology enabled care and support

Nutrition and Hydration (C11, F13 in the self assessment)

This section outlines the importance of good nutrition and adequate hydration in preventing falls and fractures.

Key things to remember

- If we eat well and stay hydrated, it will help to maintain good health, give energy and enable us to stay active for longer, especially as we grow older.
- It is important to consume a wide variety of food and fluids, as demonstrated on the Eatwell plate (see resources section).
- The Care Inspectorate currently recommends that a minimum of 1500ml of fluid should be taken daily.
- If residents are well hydrated it can reduce falls.
- Individual therapeutic dietary advice may be required from a dietician for residents who have specific medical conditions such as stroke, diabetes, coeliac disease.
- Speech and language or occupational therapists can provide advice for swallowing and functional difficulties with eating and drinking.
- Energy, protein, fibre, fluid and vitamin D are essential to maintain good health of residents.

Why is it important to eat well?

Eating a balanced diet, rich in calcium, reduces the risk of falls and fractures, especially as we get older. Food gives us energy for life and all the things we want to do. If we eat well and have a wide variety of food and fluids (see Eatwell plate in resources section) we are likely to feel healthier and stay active for longer.

What aspects of nutrition are particularly important for older people?

- Energy (calories) - activity levels tend to reduce as we get older therefore we require less calories, however for some residents their requirements increase as a result of certain medical conditions such as Parkinson's and dementia where their activity levels may rise.
- Protein - adequate amounts of protein are needed to maintain muscle mass. Dietary sources include meat, fish, cheese, eggs, pulses, nuts, milk and fortified breakfast cereals.
- Fibre - constipation is a common problem for older people. Residents should be encouraged to eat a variety of fibre-rich foods such as fruit, vegetables, nuts and pulses (peas, beans, lentils). Bran is not recommended as it can affect the absorption of minerals.
- Calcium- milk and dairy products are the best source of calcium especially if eaten at least 3 times a day. Other sources include eggs, pulses, nuts, and enriched breakfast cereals. A lack of calcium can cause osteoporosis which is a reduction in bone mass, which may cause broken bones in older people; more commonly in women. Calcium or vitamin D supplements may be prescribed for those affected by osteoporosis.
- Vitamin D – this is important for good bone health. The best source of Vitamin D is sunlight and residents should be offered the opportunity to spend time outside, especially during May-September. Sources of Vitamin D include oily fish, such as mackerel, kippers, salmon, eggs, full fat milk and fortified breakfast cereals.

Why is it important to stay hydrated?

An adequate fluid intake will help to keep residents hydrated and therefore help to:

- reduce the incidence of constipation and urinary tract infections
- maintain normal body temperature
- prevent headaches, confusion, dizziness and irritability.

To stay hydrated it is recommended that residents drink at least six to eight cups of liquid every day. These should include water, fruit juice, milk, tea and coffee. The Care Inspectorate currently recommends that a minimum of 1500ml of fluid should be taken daily. This amount may need to be increased due to:

- warmer weather conditions
- extra physical activity
- vomiting and diarrhoea
- large stoma output or wound exudates.

Some residents may be more at risk of becoming dehydrated if they:

- are unable to maintain an adequate fluid intake independently
- avoid drinking to avoid incontinence
- choose to remain in their own room
- have swallowing problems and require either a pureed diet or thickened fluids
- have a reduced sense of being thirsty and require their fluid intake to be monitored by staff.

Signs of dehydration may be misinterpreted as irritability and confusion. It can easily be resolved by regularly offering and supporting residents to take a range of drinks throughout the day and night.

More information can be found at:
http://www.h4hinitiative.com/everyday-hydration/water-requirements-daily-life

Care home story

Active Resident Care ensures that care home staff regularly ask residents if they would like a drink and ensure that they have one available at all times. This approach has been used in Dumfries and Galloway care homes and it has been found to reduce urinary tract infections and falls (see page 32).

Care home story

DRINK UP PROJECT – This project tested an intervention designed to increase residents' fluid intake, and evaluated its effectiveness on a range of outcomes. Twenty four residents at Hill View Care Home in Clydebank took part in the study, which aimed to increase their fluid intake by 300-500ml per day for 24 weeks. In total, the participants had 51 UTIs in the six months before the project began, and in the six months of the project this was reduced to 37. During the same period, the number of falls reduced from 52 down to 28 – a significant decrease. The results of the project have stimulated further research to investigate these findings in a larger group of residents.

Source: http://www.qnis.org.uk/resources/delivering-dignity/drink-up/

Things to consider

- **Personalised dietary advice**. Individual therapeutic dietary advice from a dietitian may be required for residents who have specific medical conditions such as stroke, diabetes and coeliac disease. Residents requiring palliative care should have their nutrition and hydration needs assessed on an individual basis.
- **Observe the resident's functional ability to eat and drink**. Are they able to eat with their current cutlery, manage food on their plate and drink from their cup? Some residents may have visual problems which can make it harder to see the food and drinks. Others may be affected by symptoms from specific medical conditions for example, tremor or weakness in hands. It may be helpful to ask advice from an occupational therapist about specialised equipment to enable residents to feed themselves. Speech and Language Therapy can also provide advice on safe swallowing and texture modification.
- **Residents with smaller appetites** may prefer to eat three smaller meals plus snacks in a day. This can offer a wide variety of food choice and the opportunity to consume a range of nutrients. Finger foods can be helpful for residents who prefer to 'graze' rather than eat a full meal. Colourful food is more attractive to eat, for example a fruit platter with chopped strawberries, grapes and melon.
- **Cultural or religious aspects** may affect a resident's diet therefore it is important to know the person and find out what they are able to eat.

Resources

The Scottish Government recommendations related to vitamin D intake and supplementation for at risk groups including care home residents
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213703/dh_132508.pdf

British Dietetic Association Vitamin D fact sheet
http://www.bda.uk.com/foodfacts/VitaminD.pdf

NHS Scotland. Vitamin D resource
http://www.healthscotland.com/uploads/documents/20275-VitaminDProfessional.pdf

Eatwell plate
http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx

Keeping bones healthy

This section outlines why keeping bones healthy is important and provides some ideas for action.

Key things to remember

- Know which residents have been diagnosed with osteoporosis.
- Ensure people with osteoporosis are prescribed bone protective treatment when appropriate.
- Ensure bisphosphonate treatments are given correctly and that calcium supplements are not given within two hours of the bisphosphonate.
- Identify people at risk of osteoporosis who are not on treatment and request referral for fracture risk assessment and/or DXA scan.
- Identify people who get insufficient calcium from food, or vitamin D from sunlight; they may benefit from a prescription for calcium and vitamin D supplements.
- There should be written guidance on the use of hip protectors.

Why is it important to keep bones healthy?

A broken bone (also called a fracture) is one of the more serious results of a fall. A hip fracture caused by a fall can lead to considerable suffering for an older person, loss of the ability to get about on their own and greater dependence on others to carry out day-to-day activities. Shockingly, 20% of older people who have a hip fracture die within six months[16].

[16] Parker M, Johansen A. Hip Fracture (2006). Clinical Review. BMJ. 2006;333:27–30. doi: 10.1136/bmj.333.7557.27.

Care home residents who fall are ten times more likely to have a hip fracture than older people living in their own homes. Residents with dementia who have a hip fracture are more likely to die within the first six months than residents without dementia. Life expectancy is also reduced in residents who have a vertebral fracture.

Bone health, osteoporosis and fractures

What is osteoporosis?

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

Osteoporosis is very common. In the UK, one in two women and one in five men over the age of 50 will break a bone, mainly because of osteoporosis[17]. Most of these breaks are described as 'fragility fractures', which is a broken bone occurring from a fall from standing height or less. Osteoporosis is known as the silent disease as people often do not realise that they have it until they break a bone. However, common signs include an outward curve of the spine (kyphosis), loss of height and sometimes back pain. Often people who have broken a bone before are at greater risk of a further break.

Who is at risk of osteoporosis?

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

- Being older.
- Previous fragility fractures.
- A history of osteoporosis in the family (especially parents with osteoporosis).
- Thin body type and a body mass index (BMI) of less than 19.
- Lack of physical activity.
- Smoking.
- High intake of alcohol.
- An early menopause or having a hysterectomy with ovaries removed (before the age of 45).
- Low levels of testosterone in men (sometimes following surgery for some kinds of cancer).
- Some medical conditions, including rheumatoid arthritis, diabetes, parathyroid disease, hyperthyroidism, conditions that affect the absorption of food such as Crohns or coeliac disease, conditions that cause long periods of immobility.

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[17] National Osteoporosis Society. Online [Cited 2106, April 2nd]. Available from: https://www.nos.org.uk/about-osteoporosis

- Some medicines:
  - Taking corticosteroid tablets for other medical conditions for over three months.
  - Anti-epileptic drugs.
  - Breast cancer treatments such as aromatase inhibitors.
  - Prostate cancer drugs that affect either the production of the male hormone testosterone or the way it works in the body.

Information from 'An introduction to osteoporosis'. The National Osteoporosis Society (2010). https://www.nos.org.uk/~/document.doc?id=402

How can osteoporosis be prevented?
Keeping active, safe exposure to natural sunlight and taking a healthy balanced diet can help stop the bones weakening. Calcium and vitamin D supplements (if required and as prescribed by a doctor) and regular exercise can also help.

It is important to take sufficient calcium to help maintain healthy bones. However, as we get older, calcium can be absorbed less efficiently. Many older people also have smaller appetites.

Vitamin D is vital to help the body absorb calcium. It also helps muscles to work effectively. The main source of vitamin D is the sun. Older people can become deficient of vitamin D, especially if they do not go outdoors very often.

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

There are tools available to help find out if a person is at high risk of breaking a bone. One of the tools in use is QFracture, which uses a number of risk factors to calculate the likelihood of a person breaking a bone in the next ten years.

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

The main drug treatments used in the management of osteoporosis are bisphosphonates, which slow down bone loss. This reduces the person's risk of having a fracture in the future. The most common drugs used are Alendronate or Risedronate.

What are hip protectors and how do they prevent fractures?
If you are at high risk of falling and breaking a hip, hip protectors aim to cushion the force of a fall. They usually come in the form of hip protector pants. Two protective shells or pads are built into specially designed underwear. The shells should cover your hips and absorb or divert the impact of a fall – to prevent a broken hip.

To be effective, hip protectors must be fitted properly and worn all the time. Correct positioning of the shells or pads is very important. Some people find that hip protectors are uncomfortable, however modern hip protectors have tried to address this problem.

Many versions are available.

Research about hip protectors suggests that they may be effective when used by frailer older people living in care homes. It is less clear how effective hip protectors are for people living in their own homes.

A brief summary of the research is provided below.

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

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

In older people living at home, providing a hip protector:

- probably has little or no effect on hip fractures

Poor acceptance and adherence by older people offered hip protectors is a barrier to their use. Better understanding is needed of the personal and design factors that may influence acceptance and adherence."

Source: Santesso N, Carrasco-Labra A, Brignardello-Petersen R (2014) Hip protectors for preventing hip fractures in older people accessed at

http://www.cochrane.org/CD001255/MUSKINJ_hip-protectors-for-preventing-hip-fractures-in-older-people

If a resident is willing to wear hip protectors all the time then they may benefit.

Things to consider (B2, C12, C13 in the self assessment)

Including bone health in the multifactorial falls risk screen
Your MFRS and falls care plan should include a bone health section, in order to answer these questions.

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

To find out if you could be using the QFracture online screening tool, speak to your local GP or osteoporosis nurse specialist where available.

Safe sun exposure for vitamin D
The main source of vitamin D is the sun. Older people can become deficient of vitamin D, especially if they do not go outdoors very often. Exposure to sunlight every day between May and September will increase vitamin D levels and keep bones healthy. Where possible encourage and support residents to spend some time outdoors.

Here is guidance for safe and effective sun exposure from the National Osteoporosis Society.

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

Calcium and vitamin D supplements
Calcium and vitamin D supplements (as prescribed by a doctor) can help prevent hip fractures in frail older people who live in care homes.

Guidelines published in 2015[18] recommend considering Calcium and vitamin D supplements to reduce the risk of non-vertebral fractures in people who are at risk of a shortage of:
- calcium (due to insufficient calcium in their diet) and,
- vitamin D (due to limited exposure to sunlight).

[18] Scottish Intercollegiate Guidelines Network (2015).Management of osteoporosis and the prevention of fragility fractures. Edinburgh: SIGN; 2015.(SIGN publication no. 142). http://sign.ac.uk/guidelines/fulltext/142/

Taking osteoporosis medication effectively and avoiding side effects

To be effective and prevent side effects, alendronate and risedronate tablets must be taken in a very specific way.

The medication will only be effective if taken on an empty stomach, therefore:

- the tablets should be taken on their own at least 30 minutes before the first food or drink of the day. This does not include plain tap water, which can be taken. Other medications should not be taken at the same time.

To prevent irritation of the gullet (oesophagus):

- the tablets should be swallowed whole with a glass of plain tap water
- the person taking the tablets needs to stay upright (sitting, standing or walking) for at least 30 minutes after taking the tablet.

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

If a resident is prescribed calcium supplements as well as alendronate or residronate, Scottish Guidelines advise that calcium supplements should not be taken within two hours of the alendronate and residronate. Taking calcium around the same time will prevent the alendronate or residronate from working effectively.

Using hip protectors to prevent a broken hip (F5 in the self assessment)

Your care home should have written guidance on the use of hip protectors. The decision to use hip protectors must always be based on an assessment of a resident's individual needs, as well as their wishes. At all times you must respect residents' rights and involve them in the decision. In many cases, the resident or their family will need to pay for hip protectors.

When using hip protectors:

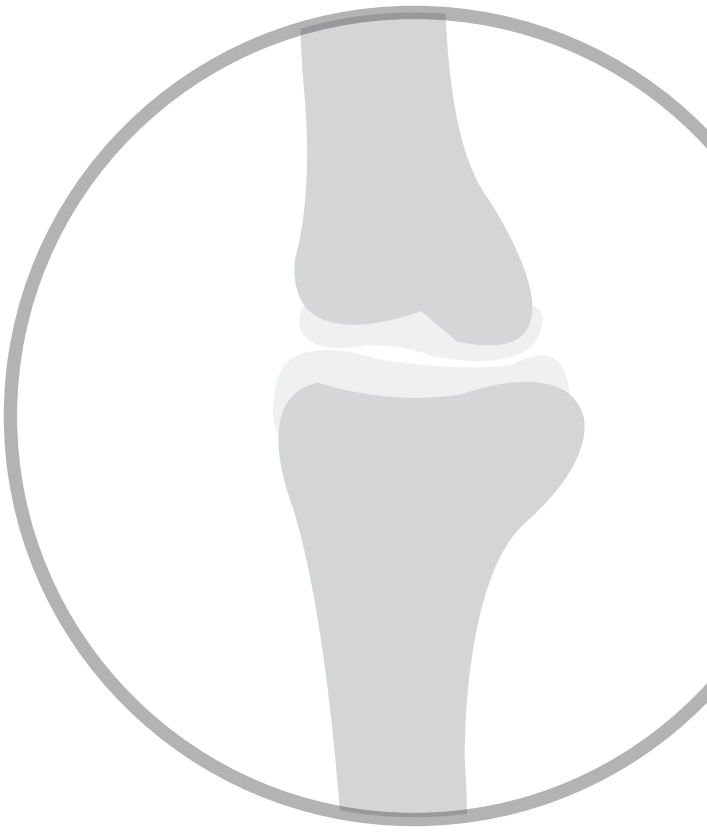
- ensure they fit the resident properly. Check the manufacturers guidance on measurement, positioning and use
- check the hip protectors are comfortable and not harming the skin
- if the resident dresses and uses the toilet independently, check he or she is able to remove the hip protectors and replace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

Resources

QFracture
http://www.qfracture.org/

SIGN142 – Management of osteoporosis and the prevention of fractures:
http://sign.ac.uk/guidelines/fulltext/142/

National Osteoporosis Society fact sheet on Osteoporosis and Hip fractures:
https://www.nos.org.uk/document.doc?id=1361



Section 5: Management of Falls and Fractures

This section outlines:

The immediate care of a resident who has fallen, including what to do at the time of a fall when someone is on the floor and requires assistance. The actions taken at the time of a fall and after a fall are critical to a resident's wellbeing and future risk of falling.

The importance of learning from falls, including how you can prevent further falls by recording information about falls when they happen and learning from it. There are four case studies to illustrate how learning from falls can take place.

The immediate care of a resident who has fallen (D1, F9 in the self assessment)

Key things to remember

- Action taken at the time of a fall is critical to a resident's wellbeing and future risk of falling.
- Safe moving and handling and prompt, appropriate care and attention can greatly improve a resident's chance of making a full recovery.
- It is important to have a post fall pathway available for staff to follow.
- Only carry out procedures stated in the post fall pathway if trained to do so.

What do you do at the time of a fall, when someone is on the floor and requires assistance?

What you do at the time of a fall is really important. Safe moving and handling and prompt, appropriate care and attention can greatly improve a resident's chance of making a full recovery. The immediate care of a resident, following a fall, should include safety at the scene and addressing any injuries sustained. An inappropriate response can delay the diagnosis and treatment of serious injuries. The responses made should be in keeping with an individual's Palliative Care Summary (PCS), Anticipatory Care Plan (ACP) including Verification of Expected Death and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision recording and guidance.

Steps to take:

- ensure safety at the scene
- assess for and attend to obvious injury
- ask for additional help as required
- safely move the resident from the floor (where appropriate)
- report and comprehensively record the fall and the consequences of the fall, including completing:
  - an accident/incident report form required by the organisation

  - a post falls report
  - the falls diary/update the database
- analyse the causes and compile and implement an action plan to prevent further falls
- review the MFRS and falls care plan
- refer to other services as required
- discuss with the resident and the resident's family the circumstances, consequences of the fall, and the action plan to reduce further risk (including referral to other services).

What is a post fall pathway?
(See tool 15 Post fall pathway for managing a resident who has fallen or who has been found on the floor.)

A post fall pathway provides a step-by-step guide to caring for a resident who has fallen, from finding them to raising family awareness and monitoring. It is a clear, concise and easy to follow guide which should include:

- written guidance on immediate essential care when a resident has fallen or has been found on the floor (Stage 1 on tool 15) F9 in self assessment.
- written guidance on further actions to be taken after a resident has fallen (Stage 2 on tool 15) F10 in self assessment.

The development of a post fall pathway should involve care home staff and appropriate members of the wider multidisciplinary team. There may be local variations depending on the skills and competence of the care home staff and the support that can be provided by the wider team in an emergency situation. The pathway should be readily accessible to all staff in the care home including for example housekeeping, maintenance and administrative staff. A laminated version should be put on a wall where all staff can see it.

What should you consider when developing a post fall pathway?
The National Patient Safety Agency (NPSA)[19] and guidance developed by a number of care homes suggest the following are important components to be included in a post fall pathway.

1. **When a resident has fallen or has been found on the floor**
   - Check first for ongoing hazards or dangers.
   - Check if the resident is responsive.
   - If responsive, provide reassurance and comfort to the resident who has fallen.
   - Summon help from other members of staff.
   - If unresponsive, check the resident's airways, breathing and circulation (see section on unconscious and unresponsive).
   - Do not move the resident before checking for pain, loss of sensation (feeling), loss of movement in arms and/or legs, and observe for swelling, visible injury and deformity.

[19] National Patient Safety Agency (2011) Rapid response report NPSA/2011/RRR001: Essential Care After inpatient fall supporting information. http://www.nrls.npsa.nhs.uk/resources/type/alerts/

Shortening and outward rotation of the leg can indicate a hip fracture.

- Check for nausea, confusion, drowsiness, delirium and agitation.
- Commence routine observations such as resident's temperature, pulse, BP and respirations as appropriate.
- Call the emergency GP, NHS24 or an ambulance if appropriate.
- If the decision is taken to move an injured resident from the floor, ensure staff have the expertise and equipment to do so safely, and that moving and handling guidelines are followed.
- Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.

2. **If unconscious or unresponsive**
   - The response should be in keeping with the recorded Anticipatory Care Plan (ACP) for the individual including their Verification of Expected Death, Do Not Resuscitate (CPR) and care home policy and their Palliative Care Summary (PCS).
   - If indicated necessary and appropriate undertake Cardio Pulmonary Resuscitation (CPR).
   - If consciousness is transient and resident appears to recover back to full functional level contact GP or NHS 24.
   - If ongoing impaired conscious level, worsening cognition or new focal neurological signs phone ambulance and inform ambulance staff of the ACP or PCS.
   - Record resident's temperature, pulse, BP and respirations.
   - Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.

   NB: Only undertake procedures if trained to do so

3. **If injury or change in health suspected**
   - If head trauma, spinal damage or lower limb fracture is suspected make the resident comfortable on the floor. DO NOT MOVE THE RESIDENT.
   - If there is a suspected head or spinal injury begin neurological observations ie Glasgow Coma Score (GCS).
   - If there is a suspected upper limb fracture, immobilise the limb (if trained and confident to do so) and return the person to bed/chair. If not trained and confident to immobilise the limb make the person comfortable on the floor.
   - Ascertain if the resident has a completed ACP or PCS.
   - According to local agreement call emergency GP or NHS 24 (if out of hours) or an ambulance as appropriate and inform emergency staff of the ACP or PCS.
   - Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.
   - Continue to follow stage 2 of tool 15: Post fall pathway for managing a resident who has fallen or has been found on the floor.

4. **If minor injuries are apparent**
    - If minor injuries are apparent such as bruises, cuts or abrasions provide appropriate care, continue routine observations and inform the resident's GP as per care home policy.
    - Seek advice from GP or NHS 24 (if out of hours) at any point if there are concerns.
    - Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.
    - Continue to follow stage 2 of tool 15: Post fall pathway for managing a resident who has fallen or has been found on the floor.

5. **If no injury or change in health suspected**
    - If there is no apparent injury and no signs of a change in health, assist the resident to the bed or chair safely according to moving and handling guidelines. If the resident can get off the floor independently allow them to do so.
    - Continue to monitor for symptoms of nausea, atypical confusion, drowsiness, delirium, agitation and pain through a proportionate schedule of observation. This observation may need to be more intensive for those who are at a higher risk of bleeding such as people taking warfarin or residents with cognitive impairment or communication difficulties. Continue to observe residents where head injury cannot be excluded (for example, following an unwitnessed fall).
    - Perform and record appropriate measurements: for example pulse, blood pressure, temperature, respiratory rate and blood glucose.
    - Some injuries may not be apparent at the time of the fall therefore continue to monitor the resident regularly. Observe for changes in mobility or difficulty taking weight through the legs.
    - Complete accident/post falls report form, record in the care plan and inform next of kin as agreed.
    - Continue to follow stage 2 of tool 15: Post fall pathway for managing a resident who has fallen or has been found on the floor.

NB: Only undertake procedures if trained to do so.

Throughout all stages of the process, explain to the resident what is being done and why, making sure they are in agreement with the decisions being made.

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

Resources

Tool 15 – Post fall pathway for managing a resident who has fallen or has been found on the floor.

The importance of learning from falls (A2, F8, F10 in the self assessment)

Learning from falls: recording, reporting, gathering and analysing falls information

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

Key things to remember

- All falls in your care home should be recorded, reported and analysed routinely and a timed action plan should be created and acted on to tackle the causes of the falls.
- Gathering and analysing falls data (information) can help to anticipate and prevent future falls. There are tools in this resource to help you do this.
- Use any falls data to have improvement conversations with your staff and the wider health and social care team.

Why is learning from falls important?

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

Agreeing the definition of a fall – why is it important? (D5 in the self assessment)

To enable consistent reporting and recording of falls, you must define and agree what you mean by a fall. This should be shared with all staff in your care home.

The Prevention of Falls Network Europe (ProFaNE) and Outcomes Consensus Group recommended a fall is defined as:

'an unexpected event in which the participant comes to rest on the ground, floor, or lower level'.

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

It is useful to include unwitnessed falls in your reporting. Although in some cases the resident will have placed themselves intentionally on the floor, not including unwitnessed falls in your reporting may miss an opportunity to learn from the incident and prevent further falls.

Things to consider

Do you have a system to record, report and analyse falls?

Care homes should have a system in place to (a) report a fall, (b) record the details of the fall, and (c) use this information to understand why the fall happened and take steps to prevent further falls. This enables staff to follow the correct procedure every time after a fall. It also allows staff to monitor the frequency of falls over time, look at the overall pattern of falls and identify any recurring factors, for example, the time or location of falls. The resulting increase in awareness of residents who fall frequently will prompt staff to take appropriate action. This information may also be used to inform and review care home policies and guidelines and write reports.

What actions should be taken following every fall? (D2, D4 in the self assessment)

At the time of a fall the priority is to provide good care to the resident. After that it is important to try to find out the causes of the fall so that actions can be taken to reduce the risk of further falls. To help you do this, following every fall:

- record the details of the fall (in a falls diary or database)
- report the fall (on an incident/accident form or database)
- carry out an environmental check of the site of the fall
- analyse the fall to establish causes and take action to prevent further falls.

Resources

Tool 17a – Guidelines for completing a post fall/incident report form
Tool 17b – Post fall/incident report form
Tool 18a – Care home monthly falls diary guidance
Tool 18b – Care home monthly falls diary
Tool 19 – Falls data spreadsheet
Tool 20a – Procedure for the use of measles chart/falls plotting
Tool 20b – Measles chart example
Tool 21a – Guidance on completing the falls safety cross
Tool 21b – Falls Safety Cross

What details of a fall should be recorded? (D8 in the self assessment)

The record of a fall should include:

- the date, time and place of the fall
- a description of the fall, including the activity at the time of the fall
- any injuries at the time of the fall
- possible causes of the fall
- assessment of cognitive function

- if a doctor or ambulance was called
- if the resident attended the Emergency Department
- if the resident was admitted to hospital
- if the next of kin has been informed
- what has been learnt from the fall
- what actions have been triggered by the fall, for example, changes to the resident's care plan, the environment, procedures and/or policies.

Completing the Post Fall/Incident Report Form
Following a fall the possible causes will need to be considered. The Post fall/incident report form (tool 17b) can be used to record the details of the fall. The form acts as a trigger for staff to consider what factors may have contributed to a fall and will help to identify why the fall happened.

Recording the fall in the resident's falls care plan (D3, D9 in the self assessment)
It is very important to record the fall in the resident's falls care plan. Once complete, a copy of the Post fall/incident report form can be included in the resident's file to help maintain a full falls history. As well as recording the fall, the MFRS and the falls care plan should be reviewed and updated as necessary.

Recording the fall on a central electronic or paper-based falls diary (D6, D7, D11 in the self assessment)
Recording every fall in the care home in a falls diary will help you to analyse your falls data and identify patterns more easily. For example, identify residents who fall frequently and identify locations and times where and when falls are more frequent. This information is also helpful to have when discussing falls with the multidisciplinary team, such as GPs, physiotherapists and occupational therapists.

The Care home monthly falls diary (tool 18b) helps you to gather falls data on a monthly basis. This can also be adapted to record and monitor individual resident's falls history.

Tool 19 is an electronic spreadsheet that will help you to record and analyse your falls. You can find tool 19 and instructions for it's use at **www.careinspectorate.com/index.php/guidance?id=2737**

Recording the fall on a measles chart or safety cross
The measles chart (tool 20a/b) will enable you to visually identify areas in the care home where falls are happening frequently. This helps to pinpoint where environmental risk assessments should be carried out. If you would like to use this tool you will need a floor plan of your care home.

The safety cross (tool 21a/b) is a visual tool that enables you to monitor falls in your care home on a monthly basis.

Reporting a resident's falls

You may also have to report falls using an incident or accident form or database.

Carrying out an environmental check of the site of the fall

The Generic falls environmental risk assessment (tool 12) can be used to carry out an environmental check at the site of the fall to identify environmental factors that may have contributed, such as poor lighting, uneven or slippery floor surfaces.

Analysing the fall to establish causes and prevent further falls (D10 in the self assessment)

It is very important to use all the information you have gathered to try to establish all the factors contributing to a fall and take action to reduce the risk of further falls. Some of these may not be immediately apparent, however you need to make clear the facts:

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

The Post fall/incident report form (tool 17b) will help you to systematically identify some of the things that contributed to the fall. To help you consider other possible factors, keep asking the 'why' question until you are confident you have found the root cause/s of the fall (see Mrs D's case study below). You can do this informally with a colleague or as a group.

What are the next steps?

When everyone is satisfied that all the causes have been identified:

- create an action plan with agreed timescales to tackle the causes and carry out your plan. Any changes to the resident's falls care plan should be recorded
- record and communicate to all staff in your care home any changes to working practice, internal policies and/or procedure
- use your falls data (information) to inform your own improvement plans and discuss this with your team. A completed action plan can provide evidence that actions have been taken to manage and reduce falls. This can be helpful in discussions with your inspector.

It is important to note that as falls awareness among staff improves, more reliable recording of falls may make it appear that the number of falls in your care home has risen. However, the thorough analysis of your falls data should mean you are able to give an explanation for any increase in the number of falls.

> Completing the post fall/incident report form helped to fill in the formal accident report form in a more informative way and helped us discuss incidents with staff
>
> Care home staff member

> I had a light bulb moment about the importance of collecting good information – it helped spot patterns and the causes of falls
>
> Care home staff member

> The data which we find very useful is the time of day that the resident's falls occur. This shows us if there is a pattern for example a specific time in the day when a resident is most at risk of falling. Then we can link this information to our active resident care times to ensure residents are being checked at high risk times and for example supported to use the toilet to reduce risk. We also use the data to review if there is a certain area of the home were falls are more prevalent and then we can review these areas at certain times of day and see if there is a pattern of movement to and from these areas.
>
> Care home manager

Practice examples

Mr A - involving the service user and family

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

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

They identified these issues.

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

Actions taken

- The home met Mr A's daughter to discuss the incident and what action they would take to reduce the risk of a further fall.
- Staff spent time with Mr A to ensure he was familiar with his bedroom layout and moved his bed side furniture to suit him.

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

Mrs B – procedural issue

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

Actions taken

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

Miss C – environmental issue

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

Later that day she fell again.

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

Actions taken

- The senior member of staff questioned the value of advising the resident to call for assistance.
- She also reviewed the individual's falls care plan and observed that the lady was in many ways independent in toileting and dressing. She looked for a change in the individual's well-being and environment.
- She also noticed from the measles chart that there had been a number of falls in the toilet over the past few days.
- She observed that the toilet the lady normally used had just been redecorated and was now looking much fresher with lightly patterned pastel wallpaper, nice white porcelain, toilet seat and handrails, and light coloured non-slip polished vinyl.
- During the refurbishment, the lighting was upgraded and the room was much brighter.
- She brought the issue to the manager's attention.
- Mrs B's falls care plan was amended to include actions taken.

Example case study – Mrs D

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

Falls History

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

Description of recent fall

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

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

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

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

Example action plan for Mrs D

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

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

Section 6: Working together
(F4 in the self assessment)

This section outlines the benefits of working together. It suggests ways to develop and improve links with local health, social care and community services that may have a role to play in managing and preventing falls and preventing fractures.

Why would you contact the wider health and social care team?
You may find it helpful to link with members of the wider health and social care team for their expertise and advice and to get support. For example, to complete your self assessment and/or a resident's MFRS and falls care plan for specific residents.

Other reasons for contacting the wider health and social care team:
- advice and information on aspects of falls prevention
- training and education on aspects of falls prevention
- to work together on improvements.

What local services could support falls prevention and management and fracture prevention?
Many areas have a multidisciplinary team in the local community or hospital that will assess an older person with a falls-related problem and provide advice and/or treatment. Some areas may have a dedicated falls service or team.

Here are a range of services which could be involved in supporting your care home. Availability and access to these services varies across Scotland.

- Multi-disciplinary teams (MDT) - based in day hospitals, hospital outpatient clinics, or the community for example you may have a community rehabilitation team, rapid response team or integrated care team.
- Falls leads or falls co-ordinators - available in some local health and social care partnerships.
- Allied Health Professionals for example physiotherapist, dietician, occupational therapist, podiatrist, speech and language therapist, orthotist for splints, prosthetist (for residents with amputations).
- Community exercise services - including those provided by local authorities.
- Continence services.
- Audiology.
- District nursing.
- Fracture liaison service (and other osteoporosis services).
- Doctor.
- Mental health services.
- Optician.

- Pharmacy.
- Psychology services.
- Telehealthcare services (often provided by local authorities).
- Voluntary sector organisations.

Things to consider

Create a directory of local services (E1 in the self assessment)
It may be helpful to build a directory of useful falls prevention and management and fracture prevention services in your local area (tool 24). Once you have your service directory, a system needs to be in place to help you review it regularly and keep it up to date. Your service directory should be available for all staff in the care home to use.

The service directory is most useful if it includes the following information about each service:

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

Local care home collaboratives or networks
A care home collaborative or network is a group of interested people from care homes and the wider health and social care team in a local area.

The groups come together regularly to:
- share knowledge, learning and ideas to improve the quality of care
- support one another with improvement work
- to share improvements, what has worked well or not so well and learn from one another.

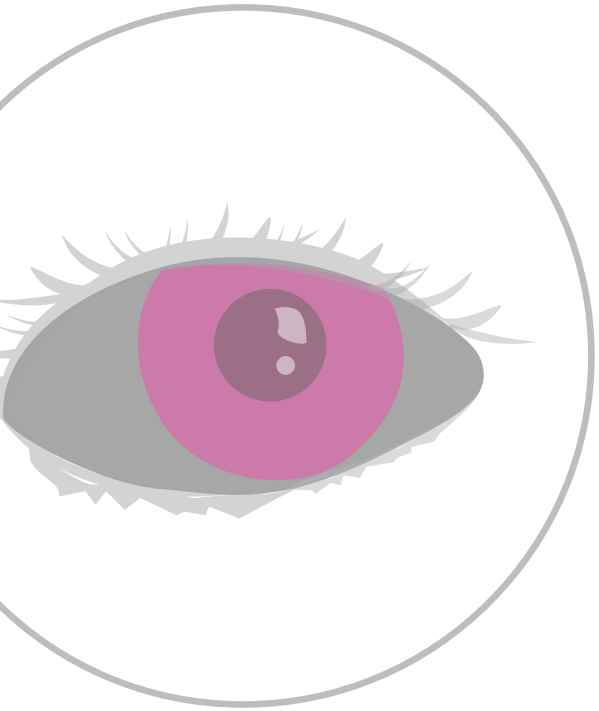
Network example
Perth and Kinross Care Home Activity Network (P&KCHAN) was established in 2010 to provide a network for activity leads to get together, share best practice, activity ideas, resources, training and offer support to one another. The ultimate aim of this network is to improve the quality of life for residents in care homes in P&K. The network has resulted in an increase in care homes working together, community involvement and intergenerational practice and has been the catalyst for many new initiatives including national pilots. There are thirty four care homes across P&K involved in the CHAN.

Collaborative example

Three collaborative networks have been established in different areas in Scotland, West Dunbartonshire, Dumfries and Galloway and Highland, through the 'Up and About in care homes project'. Different health and social care staff meet to discuss resident case studies (respecting confidentially) identified through using a falls diary. They problem solve together finding solutions to manage and prevent falls and prevent fractures. Also, information on local initiatives is shared and training may be available on topics such as foot care.

Resources

Tool 24: Service Directory



Section 7: Education and written guidance

(F1, F2, F3 in the self assessment)

This section outlines the importance of education for all staff, which provides the correct level of knowledge and skills, for the management and prevention of falls and the prevention of fractures. It also highlights the importance of education for residents, family and others. In addition it emphasises the need for written guidance. This can contribute to staff education as well as support consistent good practice.

Why is education important?

Education and training for staff, residents and their families in the management and prevention of falls and the prevention of fractures is very important. Having the right knowledge and skills can improve care and in doing so the health, wellbeing and quality of life of residents. Education to support the prevention and management of falls and the prevention of fractures can be wide ranging. It can focus specifically on falls and fracture prevention practices such as MFRS, or on a range of wider topics which contribute to management and prevention such as foot care and dementia. All staff would benefit from a level of training; the management and prevention of falls and the prevention of fractures is everyone's business and everyone has a part to play. It is good practice to keep a database to record and monitor staff training (tool 22).

What education is available?

Staff can complete various levels of training.

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

It is important to ensure that residents and families/carers have information about managing and preventing falls and fractures. Tool 5 Falls: information for friends and family may help you.

Support for training can come from a number of sources including your local health and social care team, depending on local arrangements. Online training may be available in some areas.

The Managing falls and fractures awareness DVD is available on line at **http://www.careinspectorate.com/index.php/guidance/9-professional/2737-falls-and-fractures** which outlines the key messages in this resource pack. Tool 23 is an education pack that supports you to deliver basic training in your care home in line with the falls awareness DVD.

As well as supporting people in care homes to live a good quality of life, falls prevention and bone health education will help staff to develop professionally in line with the Continuous Learning Framework. It can provide underpinning knowledge for an SVQ.

Resources

Tool 5 – Falls information for friends and family
Tool 22 – Training database
Tool 23 – Managing falls and fractures in care homes for older people - DVD Education pack

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

What is written guidance?
It is important that care home staff have written guidance on aspects of falls prevention and management and the prevention of fractures. Written guidance may include existing policies, guidelines and protocols.

The aim of having specific written guidance is to:

- help staff to understand and comply with good practice in falls prevention and management and the prevention of fractures
- identify individual residents at risk of falling in a care home and implement a care plan to address the risk
- reduce the risk of residents falling in a care home
- reduce the risk of serious injury as a consequence of falling
- promote communication between staff and the wider multidisciplinary team members in relation to falls
- involve the resident and family whenever possible in falls risk reduction, and
- increase awareness of falls risks among staff, residents and relatives through education.

Most organisations will have existing policies in place that will address the good practice statements in this resource, for example moving and handling, nutrition, the use of restraint and health and safety. When completing the self assessment, care homes should review existing supporting documentation and cross reference information relevant to F1-15 in the self assessment where possible. Section F of the self assessment can also act as a prompt for you to review and update your existing supporting documentation.

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