Falls Prevention Policy for Use by Staff Working in Domiciliary Care and Day Centres
Derbyshire County Council - Adult Social Care

If you would like to make any comments, amendments, additions etc please email ASCH.adultcare.policy@derbyshire.gov.uk

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Aims

This policy has been produced for operational staff working within Derbyshire County Council's regulated domiciliary and day care services for adults. The purpose of the policy is to support staff to identify service users who are at risk of falls and to identify the range of interventions that may be required, to reduce the risk of falls and reduce the severity of harm where harm does occur.

The policy applies to all adults being cared in their own home or at day Centres by Derbyshire County Council and aims to promote a culture that falls are not an inevitable sign of ageing whilst acknowledging that not all falls can be prevented, and that a **proactive rather than reactive** strategy should be implemented.

For the purposes of this policy a 'fall' is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level (World Health Organisation 2018).

This policy has been produced in consultation with relevant medical, safety and regulatory bodies and incorporates guidance from:

- Derbyshire and Derby Joint Strategic Needs Assessment Falls in Older People 2017
- NICE Guidance; Falls and Falls risk assessment in Care and Hospital settings 2015
- Five Steps to Risk Assessment Health and Safety Executive 2011
- Falls in Older People NICE Guidance CG161 June 2013
- Falls in Older People NICE Quality Standard QS86 updated January 2017
- Falls prevention lead for DCHS

Risk and Risk Management

The management of risks involves identifying and controlling hazards before an incident arises. A hazard being anything with the potential to cause harm (this could be a matter that relates to the individual, such as drug prescription or to an environmental hazard such as a cluttered environment). Completing and regularly reviewing risk assessments will ensure that information is up to date and takes account of any developments with the service user's presentation.

When a person receives a service these risks are assessed in a number of ways and the following assessments are completed where appropriate;

- DIAG moving and handling plan,
- environmental risk assessment,
- a multi factorial falls risk assessment.

Person Specific Risk Factors

Person specific risk factors can be related to:

- drugs and alcohol use, including prescribed medication
- physiological changes which can be age related e.g. vision, incontinence
- medical conditions e.g. stroke, Parkinson's disease, and epilepsy
- cognition, memory and mental health problems including dementia
- psychological difficulties resulting in anxiety and/or agitation
- instability, balance and physical inactivity
- footwear or foot care issues
- lack of or incorrect use of mobility aids and postural care
- pain
- nutritional status (MUST score)

Fractures and Osteoporosis

The risk of fracture is highest in those with osteoporosis so approaches to injury prevention must address the force of the fall, the incidence of falling and bone fragility. Osteoporosis affects 1 in 3 women and 1 in 10 men

In practice this means:

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

Assessment and Care Planning

Service users should be assessed using the multifactorial falls risk assessment available on MOSIAC where a risk of falls is identified.

The assessment includes the identification of the following risk factors in accordance with NICE guidelines:

- identification of falls history
- cognitive impairment
- continence problems
- footwear
- medication
- visual impairment
- balance mobility problems

- environmental factors
- health problems including a diagnosis of osteoporosis

The multifactorial risk assessment should inform the personal service plan which should include any safeguards to be put in place following the identification of risk. All appropriate referrals should be made at the initial assessment stage and at subsequent reviews. The service user (and their family where appropriate) should be involved as much as possible with the assessment and any falls prevention strategies which can be followed.

Evaluation and re-assessment

The service user's initial risk assessment must be reviewed in the following circumstances:

- after a fall (whether this is reported by the client or witnessed)
- after an admission to hospital
- when the service user's environment changes e.g. move house rooms or bed position
- when there are any significant changes in a service user's health which may impact on their mobility

Assessment and Management following a Fall

Where a service user has fallen and this is witnessed by a care worker, the worker in attendance must ensure that a primary survey is carried out prior to any attempt to move them unless there is deemed to be a life threatening risk to the service user. The primary survey of the fallen service user should follow the principles of 'look, feel, move' and staff should gain an account of the fall from the service user or any witnesses to assist in detection of the possible injuries.

Look - any signs of bleeding, bruising, swelling or deformity of limbs

Feel - is there any loss of sensation or pain reported

Move - is the service user able to get up of the floor and move their limbs without discomfort

If, on initial assessment, there are no serious injuries present and the service user is able to stand, the worker in attendance should make a decision about what action is appropriate. This may include:

- contact 111 for professional advice and guidance to inform the decision making process if this is considered appropriate
- decide whether additional monitoring of the service user is required as a result of the fall
- If the person is on an anticoagulant and/or anti-platelet therapy they are at risk of internal bleeding and medical advice must be sought on every occasion - (anti-coagulants include; Warfarin, Rivaroxaban, Herparin, Enoxaparin

(Clexane), Dalteparin (Fragmin) and Anti Platlet drugs include Aspirin, Clopidogrel, Aspirin+Dipyridamole (Asasantin)).

- wherever possible, ascertain what caused the fall so steps can be taken to minimise the chance of this happening again
- the falls risk assessment must be reviewed and any revisions considered appropriate must be made within 24 hours of a fall
- the care worker in attendance should complete the form at appendix B if they are present or attend upon a client who has fallen
- the domiciliary services officer should complete the client incident and action record and review the falls risk assessment within 24 hours of the incident
- notify family where appropriate

If emergency treatment is required 999 should be called.

Client Incident and Action Record

Every fall a Derbyshire County Council (DCC) employee is made aware of, either because it has been witnessed, or where the employee is the first person to attend the client following a fall, must be recorded on the client incident and action record along with the action taken following the fall. Where the worker in attendance at the person's property or at the day center does not have access to MOSAIC, a hand written note of all the relevant circumstances should be taken. The form at appendix A could be used for these purposes. If this is not possible, the worker in attendance at the property should contact the Domiciliary Services Organiser (DSO) by phone and the DSO must record the incident on a case note. A client incident and action record must be completed by the appropriate member of staff within 24 hours of the incident.

There are a number of actions that **may** be taken following a fall and this will depend upon a number of factors, including, but not limited to:

- the nature of the fall
- the frequency with which the person falls
- the severity of any injury

The DSO ***may*** consider one or more of the following actions to be appropriate:

- a referral to a GP for a medication review
- use of technology such as alarms may be trialed
- strength and balance exercises
- A referral to the local falls team
- Initiate a review of the DIAG Moving and Handling Assessment

It may be that the domiciliary care organiser does not consider any further action is required upon completion of the client incident and action record and review of the person's falls risk assessment. Any changes made to the falls risk assessment should be updated in the

personal service plan.

Head Injury Guidance

Where a person may have banged their head as a result of a fall then the head injury guidance at appendix B should be followed. Where a paramedic or any other health professional attends to review the person, the medical professional in attendance will make a decision about whether or not the person requires attention at A&E.

Awareness and Training

All staff should have completed all mandatory falls training relevant for their role including refresher courses in accordance with the requirements set out on Derbyshire learning online.

Conclusion

Many slips, trips and falls are preventable. Injuries arising from a fall can be reduced by prior intervention. Post fall assessment, review and remedial action can reduce the likelihood of further falls. It is important that those persons who have fallen and those who may be at risk from falling in the future have regular reviews of all risk factors.

The most effective way to manage falls is to take a preventive approach, looking at the wide range of contributory risk factors that relate to the individual and the environment in which they live.

Falls should always be considered as everyone's responsibility.

If you consider that you are unable to follow this policy for any reason please raise this directly with your line manager.

References

Management of health and safety at work. Management of Health and Safety at Work Regulations 1999. Approved Code of Practice L21 (second edition). HSE Books 2000. ISBN 0 7176 2488 9

Successful health and safety management HSG65 (second edition). HSE Books 1997. ISBN 0 7176 1276 7

Health and safety in care homes HSG220. HSE Books 2001. ISBN 0 7176 2082 4
Workplace health, safety and welfare. Workplace (Health, Safety and Welfare) Regulations 1992. Approved Code of Practice L24 (twelfth edition). HSE Books ISBN 0 7176 0413 6

The design of residential care and nursing homes for older people. Centre for

Accessible Environments 1998. Published for CAE by NHS Estates. ISBN 0 9534158 0 5 (

Lighting for communal residential buildings LG09. Published by the Chartered Institution of Building Services Engineers 1997. ISBN 0 900953 84 5 ()

A guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. HSE books 1999. ISBN 0 7176 2431 5

* HSE books, PO Box 1999, Sudbury, Suffolk, CO10 2WA; tel: 01787 881165; fax: 01787 313995; website: /

Managing falls in Care Homes NHS Bexley PCT

The 'How to guide' for implementing Human Factors in Healthcare. Patient Safety First 2009

Further Reading Information Sources

The Health and Safety Executive provide a wide range of free advice, including access to many information sheets:

Age Concern provide a wide range of information and reference sources

For accident reporting and information

Prevention Package for Older People – Falls and Fractures Effective Interventions in Health and Social Care Department of Health 2009

Pain experiences factsheet for people with learning disabilities and dementia

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

Derbyshire Falls Prevention DCHS

Falls and fracture consensus statement: Supporting commissioning for prevention

Falls and fracture consensus statement: resources

NICE Head Injury – Guidelines CG56

NHS Minor Head Injury – NHS Guidelines

NHS Severe Head Injury – NHS Guidelines

Appendix A

If you are unable to speak to a manager immediately please give further details below:

Please tick to indicate what the incident was:	
	Fall
	Shouting/verbal
	Client was hurt accidently or non-accidental
	Other

Completed by: _____

Appendix B - Head Injury Guidance

Who should go to the Emergency Department?

Signs that an ambulance should be called (dial 999)

After a person injures their head, an ambulance should be called if:

- unconsciousness, or lack of full consciousness (for example, problems keeping eyes open)
- problems understanding, speaking, reading or writing (since the injury)
- loss of feeling in part of the body (since the injury)
- problems balancing or walking (since the injury)
- general weakness (since the injury)
- any changes in eyesight
- any clear fluid running from ears or nose
- a black eye with no obvious damage around the eye
- bleeding from one or both ears
- new deafness in one or both ears
- bruising behind one or both ears
- any evidence of scalp or skull damage, especially when the skull has been penetrated
- a forceful blow to the head at speed (for example, a pedestrian hit by a car, a car or bicycle crash, a diving accident, a fall of 1 metre or more, or a fall down more than five stairs
- a convulsion or fit since the injury

If a person does not have any of the above but has one or more of the things in the next list, urgent medical attention and advice should be sought.

Signs that the person should go or be taken to an emergency department straightaway:

- any loss of consciousness (being ‘knocked out’) from which the person has now recovered
- a headache since the injury that won’t go away
- any vomiting since the injury
- previous brain surgery
- has or has had a problem with uncontrollable bleeding or a blood clotting disorder

- currently taking medicine that may cause bleeding problems (e.g. warfarin)
- special consideration for younger adults with an impairment who are unable to articulate injury or pain
- irritability or altered behaviour such as being easily distracted, not themselves, no concentration, or no interest in things around them
- the person is drunk or has taken drugs
- a suspicion that the injury was caused intentionally by the person or by someone else

Who should go to their GP?

If the person doesn't have any of the signs listed above, but they or the person looking after them has any worries about the head injury, they should consult the GP.

The GP or whoever sees them (for example, the practice nurse) may send the injured person to the hospital's emergency department if they are concerned. This could be by ambulance, car or public transport. Whichever type of transport is used, the injured person should be accompanied by an adult capable of looking after them (for example, a family member or a carer).

If the GP decides that the injured person can go home, they should give the person (or their carer) some advice about what to do and what symptoms to be aware of over the next few days.

Questions you might like to ask the GP.

1. What are the most likely effects of the head injury?
2. What should I look out for in the next 48 hours?
3. What should I do if any of these things happens?
4. Are there likely to be any lasting problems?

Discharge from Hospital after a Suspected Head Injury

A person will be able to go home when the doctors think it is safe. No one should be discharged until they have normal levels of consciousness, all other problems (such as other injuries) have received attention and there is someone to care for them.

Everybody should receive verbal advice and a written head injury advice card before discharge from emergency department or ward.

Discuss details of the advice card before discharge – this should include instructions on contacting community health services in the event of delayed complications.

Be aware of the possibility that some patients may make a quick recovery but go on to experience delayed complications.

Do's and don'ts for people who have had a head injury and have been discharged from hospital.

Do make sure you stay within easy reach of a telephone and medical help

Do have plenty of rest and avoid stressful situations

Do regularly review and monitor condition

Do review care plan to reflect current status

Don't stay at home alone for the first 48 hours after leaving hospital

Don't take any alcohol or drugs

Don't take sleeping pills, sedatives or tranquillisers unless they are given by a doctor

Problems after Leaving Hospital

If a person who has had a head injury gets any of the symptoms listed below after leaving hospital, urgent medical attention should be sought.

Signs that a person who has been discharged from hospital following a head injury should go or be taken to their nearest emergency department:

- unconsciousness, or lack of full consciousness (e.g. problems keeping their eyes open)
- any confusion (not knowing where they are, getting things muddled up)
- any drowsiness (feeling sleepy) that goes on for longer than 1 hour when they would normally be wide awake
- any problems understanding or speaking
- any loss of balance or problems walking
- any weakness in one or both arms or legs
- any problems with eyesight
- very painful headache that won't go away
- any vomiting – being sick
- any fits (collapsing or passing out suddenly)
- clear fluid coming out of the ear or nose
- new bleeding from one or both ears
- new deafness in one or both ears

Some people may feel other symptoms during the first few days after discharge, such as a mild headache, feeling sick (without vomiting), dizziness, irritability or bad temper, problems concentrating or problems with memory, tiredness, lack of appetite or problems sleeping.

Author History

Approval and Authorisation History

Authored by Jennifer Harper	Group Manager Quality and Compliance	June 2021
Approved by Tanya Henson	Assistant Director	June 2021
Authorised by SMT		July 2021

Change History

Version 1 July 2021	Jennifer Harper	New document created out of old falls policy