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Agincare
Caring in your community

Falls Management Policy and Guidance

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1. INTRODUCTION

The purpose of this policy is to advise and guide staff about falls prevention strategies and safe falls management; this guidance is relevant to all Agincare Services

The World Health Organisation defines a fall as: '*an event which results in a person coming to rest inadvertently on the ground or floor or other lower level'.* Falls represent the most frequent and serious type of accident in people aged 65 and over. Falls are the main cause of disability and the leading

cause of death from injury among people aged over 75 in the UK. After a hip fracture, 50 percent of people can no longer live independently.

Falls destroy confidence and can increase isolation and therefore all possible steps should be taken to prevent falls. Every year, more than one in three (3.4 million) people over 65 suffer a fall that can cause serious injury, and even death. Every minute, six people over the age of 65 suffer a fall.

Falls are costly for the individual, the NHS, and the care and support system. Falls cost the NHS and social care an estimated £6m per day or £2.3bn per year. However, this figure represents the cost associated with hip fractures alone. It does not take into account other costs associated with falls that do not result in hip fracture but that may still require treatment or care.

Bed rest associated with inpatient stays or prolonged periods in bed at home or care home can increase the risk of reduced bone mass and muscle strength, reduced mobility and demotivation and therefore it is also vital to ensure that when a resident or person using services has fallen, the most appropriate care pathway is followed in order to maintain independence. Prolonged bed rest in hospital has been tagged with the term 'PJ paralysis', a term coined in late in 2016 which lead to an international call to action. The premise of #endPJparalysis is about enabling hospitalised patients to get up, dressed and moving in order to prevent deconditioning; this is easily translatable to social care environments. The evidence of harm from deconditioning has been known for decades and yet we still allow people to be immobile for up to 90% each day. This immobility will have a negative impact, not only to the person, but potentially to the wider health and social care system as older people will often need increased support. Registered services are encouraged to sign up to the movement where they will find useful resources for staff training and motivation to keep people moving. https://endpjparalysis.org/join/

This document is written using guidance from South West Ambulance NHS Foundation Trust on falls management; NICE guidelines (CG161) Falls in older people: assessing risk and prevention; Post Falls Protocols – Hampshire County Council and the Health and Safety Executive Moving and Handling Guidance.

2. POLICY STATEMENT

This policy will support Agincare in meeting its statutory duties under the Health and Social Care Act, the Health and Safety at Work Act 1974 and the Manual Handling Operations Regulations 1992.

It is a statutory requirement that staff should be suitably trained, equipped and of sufficient numbers at all times to carry out required manual handling operations and support people to mobilise, in a safe manner in compliance with their duty of care.

This policy sets out the main principles, objectives and responsibilities of Agincare with regards to the management of slips, trips and falls within its group of companies. The policy highlights the legislative and management safeguards that are in place to protect individuals from slips, trips and falls and to manage such situations when accidents occur.

3. FALLS PREVENTION

A person-centred approach: People should have the opportunity to be involved in planning and designing their own care and make informed decisions in partnership with other health and social care

professionals and the people who are important to them. If someone does not have the capacity to make decisions, the code of practice that accompanies the Mental Capacity Act (2005) and the supplementary code of practice on deprivation of liberty safeguards should be followed**.**

3.1 Assessing the risk

In AUK Ltd and Agincare Live in Care, a Falls Assessment must be carried out for all people using the service who meet any of the following criteria:

- Has a history of 2 or more falls when mobilising/transferring within the last six months
- Is unsteady/unsafe when they try to walk alone
- Has a history of 2 or more falls from bed within the last three months
- Has not had medicines review in the last 12 months
- Has been referred for a falls assessment
- Is living alone
- Has a 'lifeline' (or another alarm/alert system)

In AHH, all residents should have a falls assessment completed unless there is good reason not to do so; such reasons can include younger adults who are fully, independently mobile or people who are cared for in bed/at end of life care (where they do not attempt to get out of bed).

Falls Assessments must be reviewed as required but no less than annually; where an assessment has been completed and remedial measures put in place in the care plan, but the person experiences further falls, the Falls Assessment must be reviewed.
The Falls Assessment is available on Share-point

All people who use services will also have a Risk Assessment of their moving and handling needs where required; this includes assessment of how the person, if uninjured, can be supported up after a fall.

For people in receipt of care at home, appendix 2 'Post falls flow chart (home care)' should be included in their home files for staff reference if the person is deemed at risk of falls.

3.2 Managing the risk

On completion of a falls risk assessment, care can be planned around minimising any risks identified. Depending on the individual and the level of risk, action plans could include:

- A referral to the local falls service for screening and to the person's GP for medicines review.
- Checks and monitoring of urinalysis, blood pressure and blood glucose levels where appropriate.
- Ensuring that the call bell/lifeline and required items such as food, drinks, spectacles, remote control, walking aids etc are in close proximity & accessible whilst ensuring space is clutter free.
- Consider alternative methods of alerting staff such as contact or sensor alarms
- Consider use of bed rails (assess bed rails safety)
- Ensuring that the bed is at its lowest level and a crash mat in place if appropriate if bed rails are not in use.

- Ensuring that footwear & clothing is appropriate.
- Supporting access for foot health (chiropody/podiatry).
- Maintaining safety of mobility aids.
- Working in collaboration with OT/physio.

4 MANAGING FALLS

Despite robust risk assessment and careful care planning, accidents still happen and these have to be carefully managed. (see Accident, Incident and Near Miss Guidance)

4.1 Instant on the spot (dynamic) risk assessment

An instant on the spot risk assessment should always be carried out and is relevant to almost any situation; it is something we do using our judgement and based on our knowledge and experience. There is no expectation for this to be written on a standard format. We all carry out risk assessments every day, for example we all cross the road, what is the hazard? What is the risk? The hazard is crossing the road; the risk is the likelihood of a vehicle hitting us whilst crossing; we therefore undertake the task of crossing the road with the required caution. These day to day 'instant' assessments of risk are known as Dynamic Risk assessments.

In situations relating to Falls Management and Moving and Handling where you have to make a dynamic risk assessment such as a person who is on the floor, you must mentally review the following:

- The Task - Your individual capability including
  - Your physical capability (consider previous back injury/pain, pregnancy etc)
  - Your knowledge and training (can you assess for injury, your first aid knowledge)
- The load (the weight and ability of the person, ensuring they are uninjured)
- The environment (including availability of equipment if required)
- Other factors such as, is the fallen person in imminent danger, is there anyone else available to help you.

4.2 First aid assessment

As a minimum you will have completed basic first aid awareness as part of your induction training (Care Certificate – Standard 12) and 2 yearly Health and safety refresher training which includes basic first aid. A first aid assessment as detailed below can be carried out by any person.

Call 999 in the following circumstances:

- Loss of consciousness
- Reduced levels of consciousness
- Airway or breathing problems
- Signs of head injury
- Severe or/and uncontrollable bleeding
- Suspected head injury; and always inform the call handler if the person is prescribed anticoagulants
- New onset chest pain

- New limb deformity
- New neck or/and back pain
- New extensive swelling to a limb
- New extensive bruising
- New immobility and/or new numbness to a limb
- New dizziness or vomiting
- Any fall from a height above 2 metres
- New signs of a stroke (FAST positive)

For other minor injuries or concerns as outlined in the flowchart in appendix 1, contact the persons GP (or 111 during the out of hours period).

Where a person objects to intervention, then advice should be sought from your Line Manager. Staff should consider what is in the person's *best interests* even where the person has capacity. The Manager should ensure that arrangements are made for relatives or friends of the casualty to be advised fully of the situation if applicable i.e. where the person has capacity to consent, or where it is deemed in their best interests, and should ensure that an 'Accident and Incident Report form' and any other relevant paperwork is completed as soon as possible.

Mental Capacity: Where the person is unable to provide a reliable account of why they are on the floor (unwitnessed falls) or any pain they may be in, the staff member should use their knowledge of the person, their known/usual methods of communication and any evidence of visual signs of pain and/or discomfort such as facial expression, negative vocalisation (moans and groans) and body language. Even if the person appears uninjured, in this situation, additional advice from GP or NHS 111 may be required.

Remember also that the person may have fallen to the floor as a result of an underlying health condition; the staff member should use their knowledge of the person to assess whether there are any other untoward signs such as increased confusion or signs of infection or unusual symptoms. Whilst a person may be uninjured from their fall, they may require medical attention for another condition and this information must be relayed to the Ambulance Service when calling. See below – 'Waiting for Assistance'

5 ASSISTING AN UNINJURED PERSON FROM THE FLOOR

Staff are not expected to lift a person from the floor using just bodily force; there are a number of options for assisting an uninjured person from the floor. If the person is unable to self-assist with prompts and verbal cues it may be necessary to use moving and handling techniques with support equipment or handling aids or from additional members of staff.

Do not try to get the person up immediately, wait at least 5 minutes; ask them to try and relax and take some deep breaths, and you can do this with them to begin with. Circular breathing can help; breathe in through the nose and out through the mouth. While they are doing this, you can check them over for any skin discoloration, swelling, or other sign of injury.

Using a Hoist:

In care homes a mobile hoist with appropriate sling can be used to support a person from the floor; care homes will have hoists available and a selection of slings in use for residents which can be 'borrowed' if

the person themselves does not have an allocated sling for general moving and handling needs; select a clean sling appropriate for the size and weight of the person and return to laundry after use for infection control purposes .

In Home Care where the person has a hoist available, this can be used to raise them from the floor to an appropriate comfortable place.

Self-assisting

- Let them get up in their own time, without being hurried.
- Place a chair near their head, and one near their feet.
- Ask the person to roll onto their side.
- Support the person so that they can kneel on both knees facing the chair.
- Using the seat of the chair to support them, ask them to bring one leg forward placing their foot firmly on the floor.
- If they can, ask them to push up to standing position while you place the other chair behind them to sit on.

6 OBTAINING ASSISTANCE

If injured the person should be left in the position they were found in and not moved unless in imminent danger.

If the person has agreed a 'Responder List', consisting of family and friends who have agreed to be contacted in case of a fall they should call to see if any are available to attend.

The staff member at the scene (home care) can call their line manager for support where the person is unable to get from the floor with verbal prompts and encouragement or where use of the hoist requires 2 people or the care worker is not trained in the use of the hoist; the manager can arrange to:

- Contact the persons agreed 'Responders' if family and friends have previously agreed to be contacted in the event of a fall (the staff member can call Responders directly without first calling their line manager; a persons named 'Responders' will be listed on the front of the care plan)
- Get another Care Worker to attend to assist with the use of equipment that is already in situ in the person's home.
- Telephone the person's Care Manager, if funded, and ask for Social Services support in getting the person from the floor

Where an uninjured person is unable to raise them self from the floor using the methods above and where there is no hoisting equipment available; the Care Worker may call 111 (Non-emergency healthcare advice line) for advice.

> **Do NOT simply say a person has fallen and you want the ambulance service to come and lift them – THE EMERGENCY SERVICE IS NOT A LIFTING SERVICE.**
>
> **Do NOT** tell the emergency services (999) or the non-emergency service advice line (111) that we have a 'no lifting policy'; this is incorrect

S-BAR

SBAR is a communication tool that enables information to be transferred accurately between individuals. SBAR was originally developed by the United States military for communication on nuclear submarines, but has been successfully used in many different healthcare settings, particularly relating to improving patient safety. SBAR consists of standardised prompt questions in four sections to ensure that staff are sharing concise and focused information. It allows staff to communicate assertively and effectively, reducing the need for repetition and the likelihood for errors.

Always provide the emergency services with full details about the person and the situation

Situation
Background
Assessment
Recommendation

See Appendix 3

7. WAITING FOR ASSISTANCE

The Ambulance Service will respond to 999 calls from where the person is in a life-threatening situation, injured or suspected injured. If however the person has been assessed at the scene as being uninjured, they should be assisted from the floor. Staff can call 111 for advice if they are not sure/confident in their assessment and the responder will support the staff member through a clinical review to assess for injury. Staff should stay with the person if no other person (relative/friend/first responder) and give reassurance until the Ambulance Service arrives at the scene.

If the person is injured:
Resuscitation or other first aid procedures should be commenced as necessary provided that staff have the appropriate skills and competence.

On arrival at the scene the Ambulance Service will complete their assessment and take whatever action is necessary for the person's immediate health and well-being.

If the person is un-injured:

If there are no safe means of assisting an uninjured person from the floor; follow advice from 111. Assistance may be arranged and the call will be prioritised accordingly. If there is likely to be a long wait, the person's agreed Responder can be asked to stay with the person, where there is no Responder available; the line manager should arrange for the staff members subsequent calls to be covered by another care worker.

Whilst awaiting arrival of the Ambulance Service, the uninjured person should be left on the floor, given reassurance and kept warm and comfortable. On arriving at the scene, the Ambulance personnel will take charge of the situation and decide on the most appropriate method for raising the person from the floor.

Whilst waiting for an ambulance response, call 999 again immediately if the person's condition changes in any way.

Manual lifting of the person should be avoided unless the person is in imminent danger.

8. POST FALLS PROTOCOL

Following any fall or incident where a person has been found on the floor, and after ensuring their safety and comfort, the following must be undertaken:

Staff discovering the incident/fallen person or if present at the time must:

- Complete accident/incident form ensuring all details are included
- Complete the persons' care delivery records which must include what happened, what action was taken and who was informed (family, office, paramedics, GP etc)

- Complete the person's Falls diary if they have one. A falls diary may not be in place for a first fall; where a person experiences more than one fall in a short space of time (up to 6 months); a Falls diary should be commenced, this will help evidence specifically individual activity at the time of the fall to help inform future reviews.

Relevant person (this could be the manager of the service, deputy, senior care staff) is to:

- Arrange for post falls monitoring (see appendix 3)
- Send CQC notification and RIDDOR report if serious injury resulted
- Complete fields on reverse of accident/incident form starting investigation and identifying immediate cause, root cause and underlying cause
- Determine whether incident meets harm thresholds under Regulation 20 (Duty of Candour) and if so follow DoC process
- Review person's falls risk assessment and care plan

Training

The management team of Agincare believe that, in order to provide a quality service, Agincare requires high quality staff who are suitably trained, supervised and supported.

Agincare policies and procedures are referenced in the induction programme and are available for staff in their work place (Care Home or Branch office). Staff will be informed of how to access all policies, procedures and related documentation and of how to seek further advice regarding Agincare's agreed ways of working. Staff should be provided with regular updates to encourage continuous improvement and include latest good practice.

Agincare is committed to provide an ongoing programme of support for all staff. This includes supervisions, appraisals and training which will be in line with company policy, contractual obligations and current best practice

REVIEW OF THIS POLICY

Review of this document is recorded on the controlled index and reviewed annually as part of the management review process.

Name: Policy Review Group

Date: August 2022

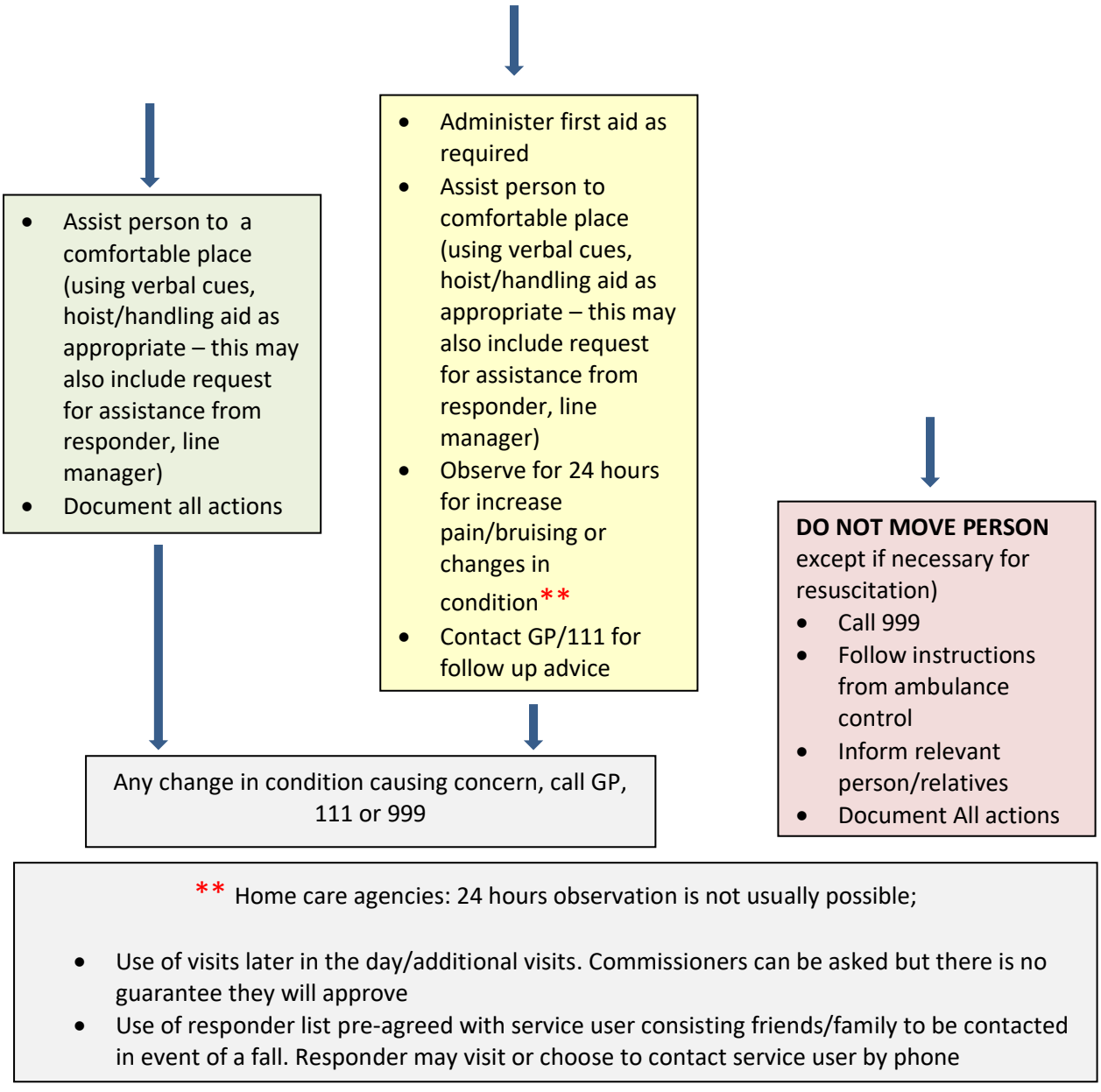
Appendix 1 - POST FALLS FLOWCHART

Service user has a fall - wait at least 5 minutes; during that time check for injury; take taken as below

No apparent injury:
- Conscious and responding as usual
- No apparent injury
- No head injury

Minor injury:
- Signs of bruising
- Minor wounds to skin (inc shallow injuries to face)

Major/Serious injury:
- Airway/breathing problems
- Loss of conscious or unresponsive



Appendix 2 - POST FALLS MONITORING

The following documents are to be used depending on circumstances of fall; all forms are available on share-point

1. **Falls Diary:** when a person experiences a fall, reassess falls risk and complete first entry on falls diary – the falls diary is to be completed with any subsequent falls which can build up a picture of antagonists such as time of day and level of activity for example:
   - If falls occur within a 1- or 2-hour window of time over one or more days, consider whether medication may have had an affect (dizziness/drowsiness etc) or whether it is the time of day when the person is undertaking a particular activity such as walking to dining table, going to bed and whether late day confusion (sometimes known as 'sundowning') may play a part

2. **Head Injury Monitoring Chart:** if the person suffered a head injury, use this form for 24 hours after the injury or from the time the person returns from hospital if the same day, monitoring is to continue for **48 hours where the person is prescribed anti-coagulant medicines.**

3. **Body Map**: Use this to record any marks or wounds that have resulted from the accident. The Body map can be used for other marks or wounds and is not just for recording falls injuries, the review time-scale is therefore not specified on the form as this would be flexible depending on the nature of the wound; it is expected that following a fall, the body map is reviewed within 24 hours

4. **Neurological Observations:** Care Homes with nursing are to carry out neuro obs for 24 hours (48 hours where anti-coagulants are prescribed)

Appendix 3: S-BAR Communication Tool

S

Situation:

- I am (name), a care worker/ nurse at Agincare (home,
- branch)
- I am calling about (X)
- I am calling because I am concerned that.....