Falls competences for Nurses working in Adult Social care in North Central London

Please ensure you adhere to your local protocols, policies and guidelines relating to Falls

Understanding the definition of a fall A fall is defined as an event which results in a person coming to rest accidently on the ground or floor. Falls can be fatal or non-fatal where the resident/service user can sustain injuries.	**For further recommended training please access:** https://www.who.int/news-room/fact-sheets/detail/falls **Video:** what is a fall and why is it important to think and react to prevent falls? https://vimeo.com/305051968 React To Falls - Best Practice in Managing Falls for Care Home Residents | React To
Know your resident/service user's life story and how this can impact on their day to day lives and falls A life story tells the story about your resident/service users' life. This includes their background, interests what is important to the resident/service user. A life story document as a 'fact file' gives staff a clearer understanding on the resident/service users life and experiences and how to meet their needs.	Creating a life story for a person with dementia - Dementia UK **Video** Life story (youtube.com) **Life story template:** dementia-uk-my-life-story-template.pdf (dementiauk.org) .
Why a resident/service user might fall. Think! **Environment** Lighting Flooring and doorways Potential Hazards Footwear and Footcare Alarm (is your resident able to access their alarm, and are they able to use it?) Heating and body temperature **Equipment** **Transfers and stairways** Does your resident need help on or off a chair, bed, or toilet? Are they unsteady when transferring or do they tend to rush? Is your resident unsteady on stairs? Is the mobility equipment in good working order? Are Ferrules worn out?	**Video:** Why do residents fall and what are the risks https://vimeo.com/305058322 https://reactto.co.uk/react-to-falls

Communication and understanding **Vision and hearing** Are they seeing things properly, or mishearing? **Cognition** Does the service user have dementia, as this can impact on Judgement? **Comprehension** Does your resident speak in a logical and consistent way? **Communication** Is your resident communicating efficiently? Is your resident able to express their needs verbally or do they have difficulty making themselves understood? **Review medical history and physical health** **History of falls** Has your resident fallen before? **Recent falls** When was the last time they fell? **Medical History** Does your resident have any new health conditions? **Medication** What drugs do your residents take? Does any affect their level of consciousness or judgement? **Pain** Is your resident experiencing a specific of general pain? Can they report pain? **Does your resident have any fractures?** Has your resident had any broken bones because of a fall? Are their feet in good condition? Any bunions, pressure ulcers, overgrown nails, which might impact mobility? **Personal hygiene** **Check continence needs** is your resident visiting the toilet regularly? **Access to the toilet** Is your resident able to access the facilities? **Management** Do your residents have difficulty getting on/off the toilet? **Activity** **Balance** Does your resident hold furniture when moving or are they unsteady when walking? **Dizziness** Do they complain of dizziness or are they dizzy on first standing?	

Stumbling Do you notice them trip or stumble even if there is no obstacle? **Gait** How does your resident walk? **Sleep** Is your resident getting a good night's sleep? **Walking (indoor and outdoor)** is supervision needed when walking? **Walking aids** Does your resident need a walking frame or stick?	
Why we need a falls risk assessment? **What is a falls risk assessment?** Each person who is at risk of falling, newly admitted or changes in their mobility will have a falls risk assessment completed by the whole team. A falls risk assessment assesses the risk of falls by identifying risk factors for falling and making recommendations. **What is a multifactorial risk assessment?** Once it has been highlighted from the falls risk assessment that the resident/service user are at risk of falls or having falls they should be referred to the physiotherapist team to complete a multifactorial risk assessment. This risk assessment will assess multiple components such as Environmental and equipment, communication and understanding, review of medical history and physical health, continence and personal hygiene. A multifactorial risk assessment allows interventions to target a person's specific risk factors to prevent future falls. **Multifactorial interventions.** Resident/service users at risk of falling again or has been assessed to be at risk of falls should be referred for an individualised multifactorial intervention once the multifactorial assessment has been completed. This includes: Strength and balance training Muscles strengthening and balance. Home hazard assessment and intervention Vision assessment and referral Medication review	https://www.nice.org.uk/guidance/cg161/chapter/recommendations#multifactorial-assessment-or-multifactorial-falls-risk-assessment:~:text=Multifactorial%20interventions,withdrawal.%20%5B2004%5D

Reducing the risks of falls and fragility fractures The Rockwood clinical frailty scale helps staff identify the level of frailty on a scale from 1 (very fit) to 9 (terminal ill) and to meet the resident/service users' needs. Residents/service users who score a 5 or higher are considered frail. Once this has been completed this can reduce the risk of falls. The Frailty scale is easy to use as a score can be derived through a brief interview with resident/service user's family members, through observation or speaking with the individual. Being active can improve the residents/service user's strength and balance. Its important that we promote independence with their activities of daily living this would enable staying active and strengthening muscles. Eating well will help with the service user's energy and decrease the risk of malnutrition. Encouraging small snacks throughout the day to a resident/service user who may find it difficult to eat larger meals. Keeping service users/resident hydrated by increasing their fluid intake. Checking for hearing and vision problems (hearing is essential in maintaining balance).	https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf https://www.ageuk.org.uk/information-advice/health-wellbeing/exercise/falls-prevention/ **Video:** How to reduce your risk of falling | Age UK (youtube.com) **Video:** React to reduce the risk of falls https://vimeo.com/305063913
Understanding the relation of Postural hypotension and falls Postural hypotension is when a resident/service users blood pressure drops abnormally when standing after sitting or lying down (low blood pressure when standing from a sitting position) this can lead to a resident/service user to fall. Postural hypotension can be caused by: **Dehydration** **Heart problems** Some heart conditions can lead to low blood pressure and prevent your body from pumping blood quickly when you stand up. They include conditions causing a slower heart rate or heart failure. **Nervous system disorders** Residents/service users with Parkinson's disease are more likely to experience Postural hypotension because of the medication they take.	Orthostatic hypotension (postural hypotension) - Symptoms & causes - Mayo Clinic Dehydration - NHS (www.nhs.uk) **Video:** Good hydration! - Spotting the signs of dehydration - Part Two (youtube.com) **Video:** Good hydration! - Medicines, kidneys and urine - Part Four (youtube.com) Awareness of how to take a lying and standing blood pressure. **Video:**

Ways of increasing fluid intake in residents/service users It is recommended that an adult drinks 6-8 cups or glasses of fluids a day this includes water low fat milks, lower sugar or sugar free drinks, and tea and coffee. Offering resident/service users food with a high-water content e.g. soup, ice cream, jelly, watermelon, hydrating vegetables like cucumber, lettuce, celery, zucchini, tomatoes etc. **Remember:** There may be residents/service users who have a daily fluid intake restriction this should be taken into consideration when offering fluids.	How to take postural blood pressure | BMJ Learning (youtube.com) Good hydration: **Video**: Good hydration! - Improving hydration through structured drinks rounds - Part Six (youtube.com)
Management of falls Please ensure you adhere to your local protocols, policies and guidelines relating to the management of post Falls protocol **What to do if a resident/service user has fallen** When a person falls it is important that they are assessed and examined promptly to see if they are injured. This would determine what treatment and support they may need. If there is a Whzan box in the home this can be used to monitor the resident or service user. **Only use the Whzan box if you are trained to do so.** The National Early warning score (NEWS) 2 is a tool developed to detect and response to clinical deterioration. This can be used to monitor the resident/service user after a fall. NEWS2 has been incorporated in Whzan. NEWS2 monitors the resident/service user's respiration rate, oxygen saturation, systolic (top number of blood pressure reading) blood pressure, pulse rate, level of consciousness or new confusion, and temperature. Is the resident/service user Alert? Does the resident service user have new confusion? Are they responsive to voice? Are they responsive to pain? Is the resident/service user unresponsive?	https://www.newcrosshealthcare.com/care-advice/how-to-respond-to-falls/ https://www.gov.uk/government/publications/falls-applying-all-our-health/falls-applying-all-our-health#measuring-impact NHS England » National Early Warning Score (NEWS) Video: NEWS2 https://youtu.be/ujHhqTbS1xg **Video:** What should your home be doing to react to falls? https://vimeo.com/305072456

This will determine their level of consciousness. It is important to determine the type of fall that occurred and if the fall was a witnessed or unwitnessed fall. As with an unwitnessed fall the resident/service user may have hit their head. If head trauma, spinal damage or lower limb fracture is suspected make the resident comfortable on the floor. **Do not move the resident.** **Documentation when responding to a fall:** Please ensure you adhere to your local protocols, policies and guidelines relating to the management of post Falls protocol It is vital that the health professional reports and documents the fall incident at a timely manner. All staff involved in the care of the resident/service user should be informed of the incident and the outcomes.	