Category: Operational Policies

Subject: Policy for the Prevention and Management of Falls

Responsible for Review of this Policy: West Limerick Independent Living CLG Board

1.0 Purpose

The purpose of this policy is to direct the prevention and management of falls and to lessen the severity of associated injuries among West Limerick Independent Living service users.

2.0 Scope

The policy applies to all West Limerick Independent Living employees and service users.

This policy replaces all existing policies from the 1/9/2018 onwards. It is due for review annually in line with West Limerick Independent Living quality assurances practices. In the intervening months it kept under continuous monitoring and will be amended reflect any changes in best practice, regulatory regulations or the law as required.

3.0 Definitions:

Fall: An unexpected loss of balance resulting in coming to rest on the floor, ground or an object below knee level. This includes slips, trips, falling into other people, being lowered, loss of balance, and legs giving way. If a service user is found on the floor, it should be assumed that they have fallen unless they are cognitively unimpaired and indicate that they put themselves there on purpose.

Employee: An employee is anybody employed by West Limerick Independent Living (paid or unpaid) and includes volunteers.

Work Environment: Employer's premises and other locations where employees are engaged in work related activities or are present as a condition of their employment. It includes the equipment or materials used by the employee during the course of his/her work.

Risk Management Plans: Are tools to document the safe practices used in a service to manage a risk which cannot be eliminated.

4.0 Policy

Falls can be a frequent occurrence for people with physical disability, neurological conditions and acquired brain injury and can cause injury resulting in further short or long term disability.

It is the policy of West Limerick Independent Living to prevent and manage the frequency of falls within its services with the aim of eliminating or reducing the frequency of falls and their impact.

Proactive assessments form part of the West Limerick Independent Living policy for the prevention and management of falls. To assist staff with prevention West Limerick Independent Living assess all service users to identify those at risk using a Falls Assessment Tool.

In the event that a service user fall cannot be prevented it must be reported to the line manager for the area where the event took place and an Event Form must be completed.

On-going monitoring and analysis of data returned on Events Forms is used to inform and develop organisational support, including training and standard operating procedures, which up skill and inform staff on evidence based best practice in falls prevention and management.

This policy forms part of West Limerick Independent Living Service Policies and Procedures.

5.0 Specific Responsibilities

Managers:
It is the responsibility of Managers to ensure that Service Management and Staff receive appropriate instruction, information, supervision and support in implementing this policy and procedure.

Service Management:
It is the responsibility of the Service Manager to;

- Ensure arrangements made under the policy are implemented.
- Ensure that this policy is communicated to all staff and they sign a **'read and understood'** form.
- Ensure all service users are appropriately risk assessed.
- Ensure that all service users, employees and volunteers within their service are familiar with the contents of the policy & procedure and receive appropriate instruction, information, supervision and support in implementing this policy and procedure.

West Limerick Independent Living Care Staff:
It is the responsibility of all West Limerick Independent Living staff to make themselves familiar with this policy and procedure and to implement it.

6.0 Procedure

6.1 Two Falls Assessment Tools are in the appendices of this document:

a) **Initial Falls Assessment, Appendix 1.**
b) **Advanced Falls Assessment, Appendix 2.**

6.2 Use of the Falls Assessments Tool. Falls Assessment Tools are completed by Service Managers and Service Coordinators.

6.3 Initial Falls Assessment **(appendix 1): must be carried out on all West Limerick Independent Living service users. It is aimed at identifying service users who are at risk or who may become vulnerable to falls over time.

6.4 Advanced Falls Assessment **(appendix 2):** must be completed if there is a **YES** answer to three or more of the questions in the Initial Falls Assessment or where a service user has a history of two or more falls in the past 4 weeks and has not had an Advanced Falls Assessment in the past 3 months.

6.5 Where an Advanced Falls Assessment is required a full risk assessment which identifies any **specific risk controls required to prevent and manage the risk of falls for this person must be completed.**

6.6 When both the risk assessment and the Advanced Falls Assessment are completed the **Service Manager or Service Coordinator will develop a risk management plan.**

6.7 The risk management plan will describe the plan the service has developed to support the person to minimise the frequency and potential for injury in the event of the person falling.

6.8 Implementation of a risk management plan recognises that, for this person, the only strategies available for the service to eliminate the risk of falling would have serious negative consequences, which would be more detrimental than the risk of a fall for the person, if used.

6.9 The strategies outlined in the Risk Management Plan will be incorporated into the mobility section of service user's Care Plan.

6.10 All records relating to Falls Assessments and Risk Management Plans are stored in the person's medical history file.

7.0 **Procedure in the Event of a Service User Falling**

7.1 Ask the service user if they are hurt and visually examine them to assess if they are hurt e.g. cuts, obvious severe swelling and bruising, obvious broken limb, extreme pain.

7.2 If the person is clearly injured, make them as comfortable as possible and call emergency services.

a. If there appears to be no obvious injury and the person is clearly indicating they are not hurt, they can be assisted up.
b. Ask the person who has the mobility to get up, to come up onto their hands and knees. Once in this position, bring them a chair and ask them to take their time using the chair to pull themselves into a sitting position.

7.3 If the person does not have the mobility to get up using a chair, they must be hoisted from the floor using a full body sling, which will provide them with head support.

7.4 Once the service user has been helped up from the floor, check with them again to see if they are hurt or report pain. Do a full body check paying close attention to points of impact to assess for bruising, swelling cuts or lacerations.

7.5 Ask the person if they banged their head. Report any bang on the head to the GP and seek advice on monitoring the person.

7.6 Report all cuts, bruises, red marks or swelling seen and record them on the service user's daily communication sheet and ask the person if they wish to see their GP.

7.7 If the pain or swelling on or near the affected area is severe, call the person's GP for advice.

7.8 Complete an Incident Report form reporting the full details of the incident and the action taken to this point.

7.9 Family should be informed of the incident and requested to observe the person for any signs of head injury (headache, unusual sleepiness, and unusual confusion) and any reports of pain, swelling and bruising on the affected area for the **next three days** and to report these to GP and the staff.

7.10 The presence or absence of these signs and symptoms should be recorded in the person's daily communication sheet. The Incident Report from should be returned to the Service Coordinator following the fall.

7.11 Where a service user shows signs of a head injury or is reporting on-going pain in the 12 to 24 hours following the fall, their GP should be advised and requested to see the person, review their injuries and advise staff on the next steps to take.

7.12 If there is any sudden or marked deterioration in the person following a fall the emergency services should be called immediately.

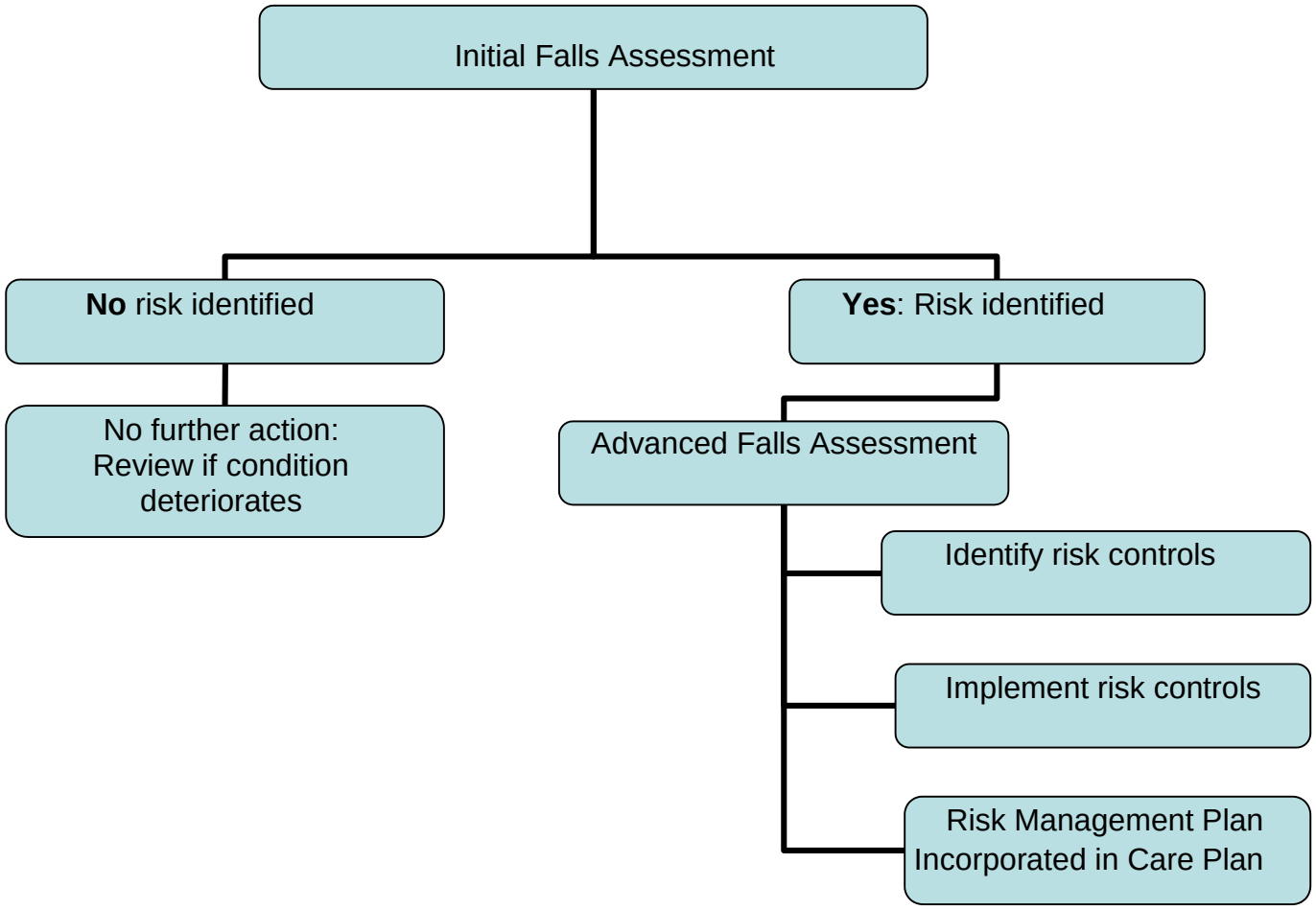
8.0 Key indicators:

- Evidence that a copy of this document is available to all care staff, service users and family members.
- Evidence that the policy has been communicated to all staff and they have signed a **'read and understood'** form.
- Evidence that initial falls assessments have been carried out.
- Evidence that advanced falls assessments have been carried out when required.
- Evidence that risk assessments have been carried out where required.
- Evidence that risk management plans have been developed and incorporated into care plans where required.
- Evidence that Event forms have been full completed for fall events.
- This policy replaces all existing policies from 14/09/18 onwards and is due for review annually. It will be reviewed during this time as necessary to reflect any changes in best practice, law, substantial organisational, professional or academic change.

Bibliography:

- Preventing Serious Falls 2010, Nice Guidelines.
- Risk Assessment Protocols, *HSE 2010.*
- Safer, Better Care, *HIQA 2010.*
- Strategy to Prevent Falls and Fractures in Ireland, *HSE 2008.*

ALGORITHM SUMMARISING THE FALLS PREVENTION PROCESS



Note: This process must be in place for every service user and must be repeated if a service user falls.

Appendix 1 Initial Falls Assessment Tool

Service User Name: _____ Address: _____

	INITIAL FALLS ASSESSMENT	**YES**	**NO**
1	Is there a history of falling in the previous year?		
2	Does the service user/care staff report problems with dizziness or vertigo?		
3	Does the service user/care staff report problems with muscle weakness which affects the person's balance?		
4	Does the service user report a fear of falling which restricts their movement?		
5	If the service user has a visual impairment, have they reported deterioration in their sight in the past 12 months?		
6	Does the service user have a urinary/bowel frequency or urgency?		
7.	Does the service user / care staff/ family report that the service user can become disorientated or lost in familiar surroundings?		
8.	Is the service user taking two or more of the following **a.** Antidepressants, sleeping pills? **b.** Anti-psychotics? **c.** Diuretics? **d.** More than four types of medication a day?		
9.	Is this person's moving and handling assessment more than 12 months old?		

If the answer is yes to three or more of the above questions, then progress to the Advanced Falls Assessment (Appendix 2).

Falls Assessment Completed by:

Name (Block Capitals) _____ Date: _____

Position: _____ Signature _____

Reviewed by Service Manager Name:

Name (Block Capitals) _____ Date: _____

Signature _____

Service Users Name _____ Address: _____

	ADVANCED FALLS ASSESSMENT: Service user factors			
		YES	**NO**	If 'YES' the following control measures are required.
1	Has the service user fallen two or more times in the past year?			Review incidents of recent falls and look at measures which can be implemented to reduce potential for further falls.
2	Does the service user have difficulty communicating mobility or continence needs?			Review Communication in the person's care plan with the person. Consider need for further referral to GP and/or a neurological consultant where deterioration in service user's disability is evident.
3	Does the service user frequently visit the toilet?			Review Continence in the person's care plan with the person, consider increasing assistance with and frequency of toileting opportunities and referring the person to the local Continence Promotion Unit/ local Continence Specialist Nurse or PHN for advice on how to support and improve this difficulty for the person.
4	Is there a history of falls when service user is alone, related to toileting?			
5	Is the service user's Moving & Handling plan over 12 months old?			Review the M&H plan and Mobility in the person's care plan with them and update as required.
6	Does the person drink less than 2 litres of water per day on average?			Review Eating and Drinking in the person's care plan with the person and encourage a balanced diet, regular meals and adequate fluid intake.
7	Has the service user been losing weight over last two months?			Review Eating and Drinking in the person's care plan with the person and refer to dietician if losing weight and commence twice monthly weight checks.
8	Is the service user taking more than 2 units of alcohol a day?			Request the service user's GP to discuss with the person the risks of mixing alcohol with medication and provide the person with advice on the immediate and long term falls risk due to dulling of neurological capacity.

ADVANCED FALLS ASSESSMENT Contd : Environmental factors		
SU Name: Location of Service	**Y/N**	**Possible Control Measures**
1. Are the floor surfaces level? **2.** Are the door thresholds level? **3.** Are the floor surfaces slip resistant? **4.** Is the floor covering in good repair?		Take any reasonable cost neutral measure to address. If this is not sufficient contact Risk Manager / Health and Safety Officer for advice
5. Is the footwear and floor covering compatible?		

Appendix 2: Advanced Falls Assessment Tool

ADVANCED FALLS ASSESSMENT Contd : Environmental factors		
SU Name: Location of Service	**Y/N**	**Possible Control Measures**
6. Is there clutter around the floor area which could cause trip hazards?		Remove all trip hazards and tidy clutter.
7. Are rugs and mats presenting a hazard?		Remove mats and rugs from through ways in room.
8. Are there cables which could present a trip hazard?		Move cables and fix to walls / skirting board in room.
9. Is furniture placed in appropriate positions for use?		
10. Is there sufficient lighting?		Ask the person if the lighting is sufficient for them to see clearly.
11. Is the bathroom layout suitable for use? **12.** Are there sufficient grab rails and/or transfer aids? **14.** Are hoists safe and suitable for use?		Consider if OT advice would be beneficial.
13. Is there an appropriate means of calling for help?		
15. Are items which are used regularly by the person in accessible positions for them e.g. remote controls / call bell / glasses?		Move into positions that do not require the person to stretch or lean to get them.

CLINICAL ASSESSMENTS REQUIRED			
	Yes	**No**	
The following referrals for clinical assessment must be considered following an advanced falls assessment. Please indicate Yes or No if a referral is required by this person.			**General Practitioner** - For review of Medications Regime and general health. OT – For assessment of independence in activities of daily living. **Optician** - If the person needs glasses and /or has not been reassessed in the past 6 months. **Audiologist** - If the person has not had a hearing test in the past 6 months. **Chiropodist / Podiatrist** – If the person has problems with in-growing toenails, bunions, ill-fitting footwear or problems with sensations in their feet and has not been seen in the past 6 weeks. **Physiotherapist** - Assessment of balance & mobility.

Risk Management Plan Require Y/N

Completed by: (Block Capitals) _____Signature_____ Date_____

Service Manager: (Block Capitals) _____Signature_____ Date: _____

Appendix 2: POST FALLS PROTOCOL

SERVICE USER HAS A FALL

Before moving the client, wait at least 6 minutes. During that time, check for injury. If client 's fall was un-witnessed, they have sustained injury or you are concerned, a full assessment must be completed & action taken as below:

No apparent injury sustained:

- No bruising
- No apparent head injury
- No pain
- Mobility unaffected
- No wounds or bleeding
- No limb deformity

- Assist client to a comfortable place (using hoist/handling aid as appropriate)
- Complete 'Post Falls Assessment Tool' and fax to GP for information
- Observe client for duration of visit
- Inform relatives and document all actions.

Minor Injury sustained:

- Signs of bruising
- Minor wounds to skin inc. face
- Slight discomfort

- Administer first aid and assist client to a comfortable place (using hoist/handling aid as appropriate)
- Complete 'Post Falls Assessment Tool and observe client for duration of visit and document on care plan
- Inform relatives and document discussion

Major / Serious injury sustained:

- Airway or breathing problems
- Loss of consciousness or unresponsive
- Acute confusion
- Suspected head injury to resident taking anticoagulant. Warfarin; Apixaban; Rivaroxaban; Dabigatran.
- Head injury or trauma (other than shallow injuries on the surface of the face - NICE 2007)
- Pain in limbs or chest
- Bleeding or extensive bruising
- Unable to move limbs on command

DO NOT MOVE THE RESIDENT (except for resuscitation)

Call 999 for ambulance

Follow instructions from Ambulance Control (meet paramedics at door and escort to resident)

Inform relatives and record discussion

ANY Change in condition causing concern – call GP or 999

Complete incident form

Personal Assistant / Care Assistant Checklist (response to falls)

DANGER	**check for dangers, seek advice**	**999**
RESPONSE	**unresponsive**	**999**
AIRWAY	**compromised airway**	**999**
BREATHING	**absent or difficulty breathing**	**999**

- **UNCONSCIOUS** **999**
- **REDUCED LEVEL OF CONCIOUSNESS** **999**
- **HEAD INJURY AND TAKES ANTICOAGULANT** (Warfarin, Enoxaparin, Dabigatran, Rivaroxaban, Apixaban) **999**
- **HEAD INJURY / TRAUMA** **999**
- **MAJOR HAEMORRHAGE** **999**
- **CHEST PAIN** **999**
- **OTHER SEVERE PAIN** **999**
- **LIMB DEFORMITY** (inc shortening and rotation) **999**
- **EXCESSIVE SWELLING AND BRUISING** **999**
- **DIZZINESS / VOMITTING** (after fall or head injury) **999**
- **FALL GREATER THAN 2 METRES** **999**
- **CONDITION -** causing serious concern for staff **999**

ADMINISTER FIRST AID AND RESUSITATION APPROPRIATE TO NEED
Do not move the client and follow the emergency treatment and instructions given by Ambulance Control

IF NO REQUIREMENT FOR AN EMERGENCY AMBULANCE RESPONSE

- Administer first aid as appropriate
- Complete the post falls assessment with client (blood pressure and blood sugar - Nurse only)
- Assist client to a comfortable place (using a hoist and manual handling aids as required)
- Inform relatives and document the discussion in the care plan
- Email the completed post falls assessment to the GP Practice
- Observe client for duration of shift and ask family to observe client for 24 / 48 hours using the post fall observation log (blood pressure - Nurse only) - keep in care records
- Complete body map - keep in care records
- Complete incident form and follow incident reporting procedure

IF AN AMBULANCE CLINICIAN HAS ATTENDED THE CLIENT, THERE IS STILL A REQUIREMENT TO FULFILL THE FOLLOWING ACTIONS

- Complete post falls assessment documentation and body map
- Observe client for duration of your shift and ask family to observe client for 24 / 48 hours
- If no family is available seek advice from emergency services
- Inform relatives and document the discussion in the care plan
- Complete incident form and follow incident reporting procedure

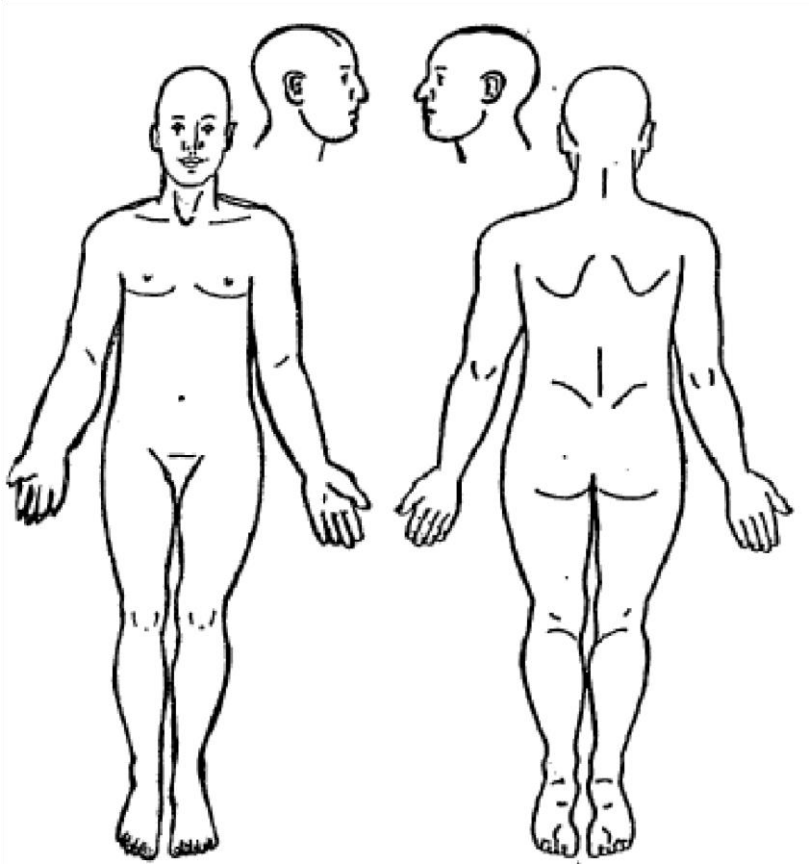
IN ALL CASES WHERE THE CILENT REMAINS IN THE CARE OF WEST LIMERICK INDEPENDENT LIVING, THE POST FALLS ASSESSMENT TOOL SHOULD BE SCANNED TO THE CLIENT'S GP PRACTICE

POST FALL ASSESSMENT TOOL SCAN & SEND TO CLIENT'S GP WHEN COMPLETE

Name of Client			
Date & Time of Fall			
Place of Residence			
Name & Signature of person assessing		Time & Date of Assessment	
			√ Tick and Sign
Level of Consciousness	Responsive as normal		
	Less responsive that usual		
	Unresponsive or Unconscious (call 999)		
Pain or Discomfort	No evidence of pain or discomfort		
	Showing signs of pain or complaining of pain		
Where is the pain?			
Injury or Wounds	No evidence of injury, bleeding or wounds		
	Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb		
Where is the injury or wounds?			
Movement and mobility	Able to move all limbs as normal for the client		
	Able to move all limbs but has pain on movement		
	Unable to move limbs as normal for the client or there is a major change in mobility		
Conclusion of Assessment			
No apparent injury or minor injury ☐	Give first aid treatment		
	Commence observations (use post falls assessment chart and complete body map)		
	Inform Service Coordinator/On-call and relatives		
	Complete an incident form		
Major Injury ☐	Give first aid / resuscitate and call 999 **DO NOT MOVE THE CLIENT**		
	Commence observations (use post falls assessment chart and complete body map)		
	Inform Service Coordinator/On-call and relatives		
	Complete an incident form		

Body Map – Assessment of Injury (keep in Client's care plan)

Name of Client		Date of Birth	
Address		Date and time of fall	



Marks or bruising on Client's body (describe, mark on map above with date observed)

Clients description of any pain/s or non-verbal signs of clients pain with date

Day number following fall, Date & Time	Action taken and Date	Signature

Post Fall Observation Log

Name of client		Date of Birth	
Address		Date and time of fall	

Observations should be done as soon as possible after the fall, then:

- **Every 15 minutes for one hour**
- **Once half an hour later**
- **Once one hour later**
- **Once two hours later**
- **Every four hours until 24 hours' post-fall. Wake the client up to do the checks. *Do not assume the client is simply asleep.***

Fill in the time observations are due in the 'Time' column on the chart

Date	Time	Reported Pain/ signs	Wounds/ Bruises	Comments	Signature
	ASAP				
	15 min later				
	15 min later				
	15 min later				
	15 min later				
	30 mins later				
	One hour later				
	2 hours later				
	4 hours later				
	4 hours later				
	4 hours later				
	4 hours later				