

# Falls prevention training resource

A guide for care staff



My life  
a full life®

# Contents

<b>3</b>	<b>Introduction</b>
<b>4</b>	<b>The impact of falling</b>
<b>6</b>	<b>Why do older people fall?</b>
<b>6</b>	Risk factors
<b>7</b>	History of previous falls
<b>8</b>	Infections
<b>8</b>	Medical conditions
<b>9</b>	Fear of falling
<b>9</b>	Postural hypotension
<b>10</b>	Incontinence
<b>11</b>	Malnutrition and dehydration
<b>12</b>	Poor balance and restricted mobility
<b>13</b>	Cognitive impairment
<b>13</b>	Osteoporosis
<b>14</b>	Visual impairment
<b>17</b>	Hearing impairment
<b>17</b>	Medicines
<b>21</b>	<b>The how-to guide to preventing falls and fractures</b>
<b>22</b>	<b>How do we prevent falls?</b>
<b>26</b>	<b>In the event of a fall...</b>
<b>27</b>	<b>Assisting the person off the floor</b>
<b>28</b>	<b>Recording and reporting the fall</b>
<b>29</b>	<b>Suggested guidelines for managing a person who has fallen in a care home setting</b>
<b>30</b>	<b>Useful links</b>

# Introduction

Falling is not an inevitable part of growing older

Sustaining a fall in later life is often seen as a natural part of ageing, frequently remaining unreported and accepted as the norm. However falling is often a sign of an underlying health problem and every fall should trigger the question 'why?' By questioning and investigating the cause of each fall, we will be able to generate actions to reduce the risk of such an event happening again.

As people grow older, the risk of falling increases. Statistically, one in three people aged 65 and over are predicted to fall each year. The risk increases to one in two for the over 80s<sup>1</sup>. The statistics for an adult with a learning disability may be different again. A recent Scottish study found that 41% of community based adults with a learning disability had experienced a fall in the previous 12 months<sup>2</sup>.

Sadly, once an older person has fallen, the chances of falling again within the year dramatically increases. It is predicted that half of all people who fall will fall again within the next 12 months. Recurrent falls are also associated with increased mortality, increased rates of hospitalisation and higher rates of institutionalisation<sup>3</sup>.

With increasing age, the reasons why falls occur also tend to change. In our more active population, people are much more likely to fall as a result of losing balance during high level balance challenge activities such as falling off a bike and other sporting activities or slipping on ice. In our older, potentially housebound or even care home population, the causes of falls tend to be much more closely associated with deteriorating health. Examples may include taking too many medicines, having dementia, being unable to see clearly, having poor balance, or having a fear of falling.

Ladies and gentleman who have a home within a care setting often have complex health and social care needs. It is thought that a history of previous falls and being unable to manage at home contributes to approximately 40% of all placements into care<sup>4</sup>. Falls rates among care home residents are also much higher than among older people living in their own homes. Due to the complexity of this population's particular needs, it is best practice to assume that **all** residents are at risk of falls. By working in this way you will be able to take proactive steps to offer each and every person the best possible chance to keep them safe, whilst giving yourself as staff the reassurance and confidence to know that you are providing high quality and effective care.

1 NICE. Falls: assessment and prevention of falls in older people. NICE clinical guideline 161; 2013

2 Becker et al: Epidemiology of falls in residential aged care: analysis of more than 7000 falls from residents in Bavarian nursing homes. Journal of the American Medical Directory Association. 2012: 13(2)

3 Department of Health. Fracture prevention services: an economic evaluation. London: Department of Health; 2009.

4 American Geriatrics Society, British Geriatrics Society. Guidelines for the prevention of falls in older persons. Journal of the American Geriatrics Society. 2001: 49; 664-72.

# The impact of falling

Injury caused by falls is the leading cause of accidental death for people aged 75 and over<sup>5</sup>

The consequences of an older person falling are far reaching and frequently have an impact on the person themselves, and the family and/or carers around them.

## Impact on the individual

Some of the consequences to the individual of suffering a fall and/or being on the floor for a prolonged length of time are listed below:

Physical effects	Psychological effects
<ul style="list-style-type: none"><li>• Death</li><li>• Immobility</li><li>• Incontinence</li><li>• Cuts, bruises, soft tissue injuries</li><li>• Fractures</li><li>• Head injuries</li><li>• Dislocation</li><li>• Pneumonia/chest infection</li><li>• Pressure ulcers</li><li>• Dehydration</li><li>• Hypothermia</li><li>• Moving into care</li></ul>	<ul style="list-style-type: none"><li>• Increased dependency</li><li>• Emotional distress</li><li>• Loss of control</li><li>• Social isolation/withdrawal</li><li>• Fear of further falls</li><li>• Low esteem</li><li>• Embarrassment</li><li>• Anxiety/depression</li><li>• Loss of confidence</li><li>• Worries of increased care costs</li></ul>

<sup>5</sup> Department of Health. Improving care and saving money: learning the lessons on prevention and early intervention for older people. London: Department of Health; 2010.

## Impact on friends, family and/or carers

Friends and family of a person who has fallen are often just as affected by the fall as the person themselves. Stress, anxiety and worry are frequently terms that carers report, particularly in relation to whether the person is able to remain within their own home, and any increased care costs associated with higher dependency levels.

Carers in a care home setting are often worried about the threat of litigation in the event of a fall, especially if injury has occurred. Anxiety is regularly higher post- fall, especially regarding supporting the person to remain mobile.

# Why do older people fall?

There are known to be over 400 different reasons why an older person might fall, these reasons are known as **risk factors**. Early identification of these risk factors coupled with taking action to remove or reduce risk can prevent a fall. This is a core component of proactive, falls prevention management.

## Risk factors

‘Risk factors’ can be subdivided into intrinsic or extrinsic risk factors. **Intrinsic** risk factors are described as **internal** causes, individual to that person. Here are common examples of intrinsic risk factors (not an exhaustive list):

### Intrinsic risk factors

- History of previous falls.
- Infections – urine, chest infections.
- Medical conditions – stroke, diabetes, Parkinson’s disease.
- Medicines.
- Incontinence.
- Cognitive impairment – dementia, memory problems.
- Visual and hearing impairment.
- Foot conditions – bunions, callouses, painful feet.
- Poor muscle strength.
- Poor balance.
- Mental health conditions – depression, anxiety, fear of falling.
- Constipation.
- Malnourishment.
- Dehydration.
- Postural hypotension.
- Behaviour – challenging behaviour, risk takers.
- Premature physiological ageing process (learning disability).

**Extrinsic** risk factors are described as causes **external** to that person. Here are examples of extrinsic risk factors (not an exhaustive list):

### Extrinsic risk factors

- Environmental hazards – trailing cables, wet floors.
- Other environmental influences – poor lighting, shadows, patterns on carpets.
- Loose clothing, trailing dressing gowns, poorly fitting footwear.
- Walking aids in poor condition or the person using the wrong walking aid.
- Inappropriate use of equipment.
- Not putting the brakes on a wheelchair.
- Time of the year (learning disability).

## History of previous falls

Once a person has had a fall, the chances of falling again within the following year are exceptionally high. It is therefore essential that people are proactively asked about any previous falls and the circumstances under which they occurred. You may need to gather this information from a friend or carer. Use SPLATT to prompt the discussion:

<b>S</b>	Symptoms immediately before fall. Any dizziness? Do they remember hitting the floor?
<b>P</b>	Previous falls history. How many falls in the previous year?
<b>L</b>	Location of fall. Indoors? Where? Outdoors? Where?
<b>A</b>	Activity at the time of fall?
<b>T</b>	Time of fall. How long on the floor?
<b>T</b>	Trauma or injury resulting from the floor?

Remember to ask about 'red flag' scenarios such as blacking out, not remembering landing on the floor or feeling dizzy before the fall. These scenarios are often indicative of an underlying medical or pharmaceutical problem needing investigation, usually by a doctor or pharmacist.

### Suggested actions to reduce risk:

- Use the falls history to build up a picture of prior events for the person.
- Consider requesting a medical review to check/eliminate underlying health problems.
- Review medicines.

## Infections

Any infection (commonly urine and chest infections), can trigger a fall in a person with complex health needs or frailty. One of the first signs could be that the person is generally off-colour or may be becoming confused. If any change of behaviour is noted in the person, it is well worth investigating early to exclude and/or treat an infection, before a fall occurs.

### **Suggested actions to reduce risk:**

- Investigate potential infection source.
- Request a medical review if necessary.
- Increase supervision levels until condition has improved.

## Medical conditions

Some medical conditions such as stroke, Parkinson's disease or other neurological conditions can cause muscle weakness, movement disorders and reduced balance. Movement can be affected to an extent that the person requires assistance to walk and transfer, even hoisting in severe cases. Falls frequently occur as a result of the person losing balance, often when turning or negotiating obstacles. People may also have delayed or absent saving reactions. Subsequently, if a fall occurs, the person may fall directly onto their head/face rather than putting a hand out to save themselves resulting in more traumatic injuries.

Medical conditions such as diabetes can affect sensation in limbs, particularly the feet. Being unable to clearly feel the feet has a detrimental effect on walking and balance and places the person at risk of falling.

Any condition that affect the joints such as osteoarthritis and rheumatoid arthritis, or postural changes secondary to back pain, vertebral fractures or physical disability will increase risk of falls. The presence of restricted joints creates muscle weakness which in turn has a negative impact on balance, confidence and function.

### **Suggested actions to reduce risk:**

- Optimise health and wellbeing by working with GP or other relevant health care professionals.
- Review medicines regularly to reduce risk of unwanted side effects.



## Fear of falling

Anxiety and a fear of falling can lead to a reduction in activity and willingness to mobilise. Loss of confidence following a fall can also become disabling. Being supportive and reassuring can help to reduce anxiety accompanied by appropriate supervision for mobility.

**Suggested actions to reduce risk:**

- Provide reassurance and encouragement.
- Enable regular and safe opportunities to mobilise.
- Consider referral to a Physiotherapist for assessment of mobility.
- Consider referral to an Occupational Therapist for confidence building whilst participating in activities of daily living.

## Postural hypotension

Postural or orthostatic hypotension is frequently implicated in many unwitnessed falls yet it is often undiagnosed and managed. It is a condition whereby a person's blood pressure falls secondary to a change in position. Commonly this occurs upon sitting up first thing in the morning or when standing up from a chair. The change in position accompanied by a shortfall in blood supply to the brain can cause symptoms such as dizziness (although many people do not become dizzy), blackouts, or sudden collapse.

The causes of postural hypotension include dehydration, cardiac conditions, certain medications, diabetes, neurological conditions such as Parkinson's disease, or an infection.

The gold standard assessment of postural hypotension includes recording blood pressure when the person is lying down, immediately on standing and then after standing for three minutes. In practice it may be difficult to record all these readings, particularly if the person has restricted mobility or cognitive difficulties.

A significant fall in blood pressure is 20mmHg drop in systolic blood pressure and 10mmHg drop in diastolic blood pressure.

**Suggested actions to reduce risk:**

- Request a medical review to determine cause of postural hypotension.
- Prompt person to pump ankles up and down before standing up.

## Incontinence

As with falling, there is a misconception that incontinence is a natural part of ageing. Incontinence is very treatable but it is essential that it is diagnosed properly.

Examples of types of incontinence:

Type	Symptoms
Stress incontinence	Occurs when urine leaks as pressure is put on the bladder, for example, during exercise, coughing, sneezing, laughing, or lifting heavy objects. It's the most common type of bladder control problem in younger and middle-age women. It may begin around the time of menopause.
Urge incontinence	Happens when people have a sudden need to urinate and aren't able to hold their urine long enough to get to the toilet. It may be a problem for people who have diabetes, Alzheimer's disease, Parkinson's disease, multiple sclerosis, or stroke.
Overflow incontinence	Happens when small amounts of urine leak from a bladder that is always full. A man can have trouble emptying his bladder if an enlarged prostate is blocking the urethra. Diabetes and spinal cord injury can also cause this type of incontinence.
Functional incontinence	Occurs in many older people who have normal bladder control. They just have a problem getting to the toilet because of arthritis or other disorders that make it hard to move quickly.

There is a very strong link between urinary incontinence and falls in the older person. The type of incontinence most greatly implicated is urge incontinence. Nocturia (needing the toilet at night time) is also considered a falls risk. Even if an older person hasn't fallen, the risk of falling in the presence of urinary incontinence is high and actions should be proactively taken to support the person in achieving optimal bladder management.

It is common for a person with urinary incontinence to limit the amount of fluid that they drink. This in turn can lead to dehydration and postural hypotension which are both risk factors for falls.

The diagram demonstrates the link between incontinence, dehydration, postural hypotension and falls.



**Suggested actions to reduce risk:**

- Consider referral to incontinence service.
- Develop a toileting regime.
- Ensure adequate hydration during the day.
- Provide commode if necessary/sit near the toilet.

## Malnutrition and dehydration

One definition of malnutrition is having a body mass index (BMI) of less than 18. As with falling, unintentional weight loss is not a normal part of ageing. The reasons for malnourishment can be complex:

Physiological reasons	Social reasons
<ul style="list-style-type: none"> <li>• Decreased sensation of thirst.</li> <li>• Decreased taste and sense of smell.</li> <li>• Decreased appetite due to lower energy expenditure.</li> <li>• Illnesses such as stroke, cancer, respiratory conditions.</li> <li>• Eating problems such as difficulties chewing and swallowing.</li> </ul>	<ul style="list-style-type: none"> <li>• Difficulty getting to the shops.</li> <li>• Low income.</li> <li>• Social isolation and loneliness.</li> <li>• Lack of cooking skills.</li> <li>• Difficulty in preparing and eating food due to mobility problems.</li> </ul>

Being malnourished is a falls risk due to the lower muscle mass associated with the condition. Lower muscle mass has a negative impact on walking speed and power and in the event of a fall, the risk of fracture is higher due to a lack of 'padding' over bone.

Dehydration is commonly associated with multiple pre-existing medical conditions, some medications, onset of dementia, mobility difficulties and fear of incontinence. Many older people who are dehydrated have lost their sense of thirst. It is often the underlying cause of symptoms of dizziness, confusion and urinary tract infections.

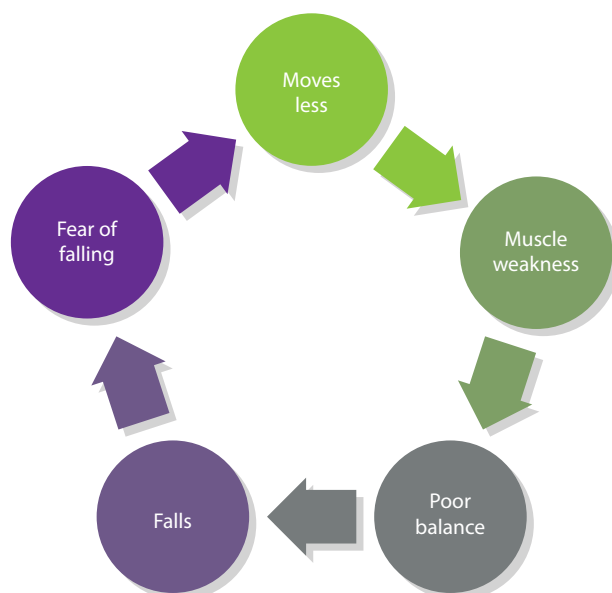
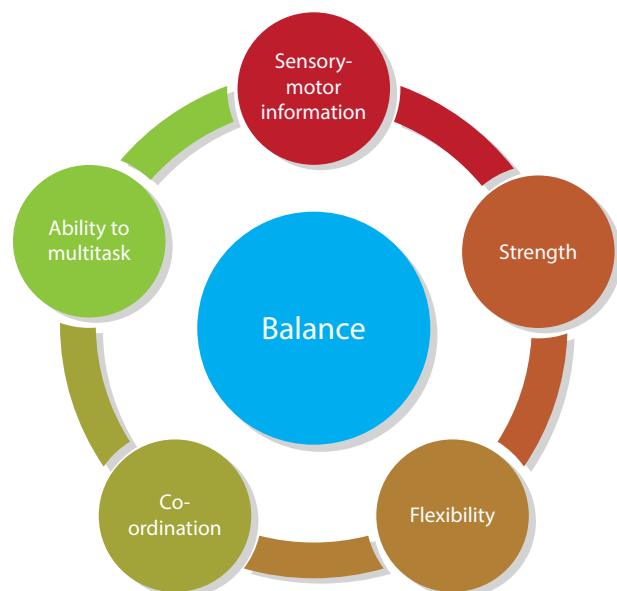
**Suggested actions to reduce risk:**

- Discuss condition with GP and dietician.
- Commence food record chart.
- Consider other strategies for encouraging appetite such as small meals more often, dining with other people.

## Poor balance and restricted mobility

Maintaining balance requires a complex interaction between a number of different systems in the body. The main systems that provide important information to control balance are the eyes, the vestibular system in the ear and proprioceptors (joint receptors) found deep within the joints. If any of those systems are disrupted, for example visual impairment, the others have to work harder to compensate.

Balance should be automatic and spontaneous. Conditions such as diabetes, stroke, Parkinson's disease or physical presentations associated with learning disability require the person to have to concentrate on their balance which is why the ability to multitask (for example walking and talking at the same time) can be so difficult.



Restricted mobility can result from underlying medical conditions that reduce joint movement and cause muscle weakness. Inactivity, being afraid of moving, being malnourished, depression and grief/bereavement can all cause a decrease in a person's ability to move.

The adjacent diagram highlights the spiral of inactivity that is present in many care home residents.

### Suggested actions to reduce risk:

- Ensure mobility aids are used correctly.
- Ensure mobility aids are in good repair.
- Provide supervision as required.
- Offer regular opportunities to mobilise.
- Refer to Physiotherapist.
- Ensure people who are known not to ask for help are not left unsupervised on commodes etc.

## Cognitive impairment

Cognitive impairment may be associated with learning disability or may be caused by a number of different conditions, for example different types of dementia, stroke, multiple sclerosis, and alcoholism. People with a learning disability are at risk of developing early dementia. The presence of cognitive impairment can result in the person being unable to remember safety advice such as: “please use your zimmer frame when you walk about;” “please don’t rush;” “please remember to use your call button if you need the toilet;” “please don’t try to get up on your own.”

Cognitive impairment can also produce variations in the way our environment is perceived. For example, it is not unusual for people with dementia to find it extremely difficult to judge distances so a step may seem further away than it really is. Others may find patterns on the floor disorientating, or misperceive shadows to be slopes, steps or holes in the ground. An environment of contrasting colour will help people with dementia orientate themselves more easily to their surroundings.

### **Suggested actions to reduce risk:**

- Do not leave the person unattended on commodes, in showers.
- Request a medical review of cognition – monitor for any changes in behaviour.
- Medicines review.
- Investigate the person’s previous patterns through liaison with friends and family. Incorporate into daily routine wherever possible.
- Consider the need for falls prevention equipment such as chair sensors.
- Keep friends and family informed as appropriate.
- Dementia friendly environments.

## Osteoporosis

Osteoporosis is a condition in which bones lose their strength and are more likely to fracture, usually following a minor bump or fall. Fractures that occur because of reduced bone strength are described as ‘fragility fractures’ and many of these will be caused by osteoporosis. One in two women and one in five men over the age of 50 experience fractures, mostly as a result of low bone strength. People with a learning disability have an increased risk of developing osteoporosis and their fracture rate is 1.7 times higher than the general population<sup>6</sup>.

Although fragility fractures caused by osteoporosis can happen in various parts of the body, the wrists, hips and spine are the most commonly affected sites. The effect of a hip fracture can be devastating. Approximately 30% of people who sustain a hip fracture have died within a year and approximately a third of people who were independent prior to fracture become totally dependent. Bone tissue is made up of protein hardened by calcium salts and other minerals to make it strong.

<sup>6</sup> Lohiva et al: Fracture epidemiology and control in a developmental centre. The Western Journal of Medicine: 1999; 170(4), 203-209

Bone tissue is alive and constantly changes through life to make sure it remains as healthy as possible. After the age of about 35 years, the difference between the amount of bone that is removed and the amount of bone that is laid down starts to get slightly out of balance as part of the ageing process. As a result, the total amount of bone tissue starts to decrease. This is often described as 'bone loss' or 'bone thinning'. This change in the quality of your bones is much more likely and more significant as you move into later life, which explains why bones become more fragile and fractures become more common in old age.

Suggested actions to reduce risk:

- Discuss fracture risk with GP.
- If person is already diagnosed with osteoporosis, support person to take medication as prescribed.

## Visual impairment

An older person with visual impairment has an increased risk of having a fall. The rate of falls in older people with visual impairment is 1.7 times higher than other older people of the same age. The percentage of nursing home residents with visual impairment is much higher than people of a similar age living in their own home. For example 30% of nursing home residents aged 75 to 84 years have visual impairment. This compares to 8% to 13% for people dwelling in their own homes. The following pictures show some of the most common types of visual impairment:

### Normal vision





### Age-related macular degeneration

The central part of the back of the eye (the macular, which plays an important role in central vision) stops working properly.



### Cataract

Here cloudy patches can form on the lenses of the eyes.



### Glaucoma

Fluid builds up inside the eye, damaging the optic nerve (which relays information from the eye to the brain).



### Diabetic retinopathy

Blood vessels that supply the eye become damaged due to a build-up of glucose.



### Hemianopia

Half the visual field is lost commonly due to stroke.



Suggested actions to reduce risk:

- Ensure the person has an annual eye test.
- Ensure glasses are worn according to recommendation for use.
- Ensure glasses are kept clean.
- Maintain a clutter-free environment.
- Use contrasting colours to optimise the environment.



## Hearing impairment

An older person with hearing loss has an increased risk of having a fall. In a study of 40 to 69 year olds it was found that people with mild hearing loss were nearly three times more likely to have a history of falling.

Certain things including age, illness and genetics, may contribute to hearing loss. Over several generations, modern life has added a host of ear-damaging elements to the list. Other causes of hearing loss include increasing age, certain medications, health conditions such as high blood pressure and diabetes, skull trauma, infections and ear wax.

Suggested actions to reduce risk:

- Establish whether the person would benefit from a hearing test.
- GP review in the presence of hearing loss.
- Introduce communication strategies such as ensuring a person can see your face when talking.
- Remove avoidable background noise.
- Ensure hearing aids are worn and in good condition.

## Medicines<sup>7</sup>

Some drugs are more likely to be associated with falls. The chart below will help you identify those drugs that may cause problems in the elderly. Relevant drugs have been graded using a traffic light system according to their potential to cause a fall.

**Patients on four or more medications are at greater risk of having a fall. Medication review can play an important part in falls prevention. We recommend the following guidelines on medication review:**

- People with a newly recognised falls risk who are taking four or more medications, of which at least one is graded as moderate or high risk (amber and red sections below) should be referred for medication review as soon as possible. That medication review should give consideration to falls risk alongside the patient's other medical history.
- Patients with a newly recognised falls risk taking four or more medications, where none of those medications have been graded as moderate or high risk (amber and red sections below), should continue to have their medication reviewed as normal.

<sup>7</sup> [www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/adultsocialcare/Managing%20Falls%20In%20Care%20Homes%20Toolkit.pdf](http://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/adultsocialcare/Managing%20Falls%20In%20Care%20Homes%20Toolkit.pdf)

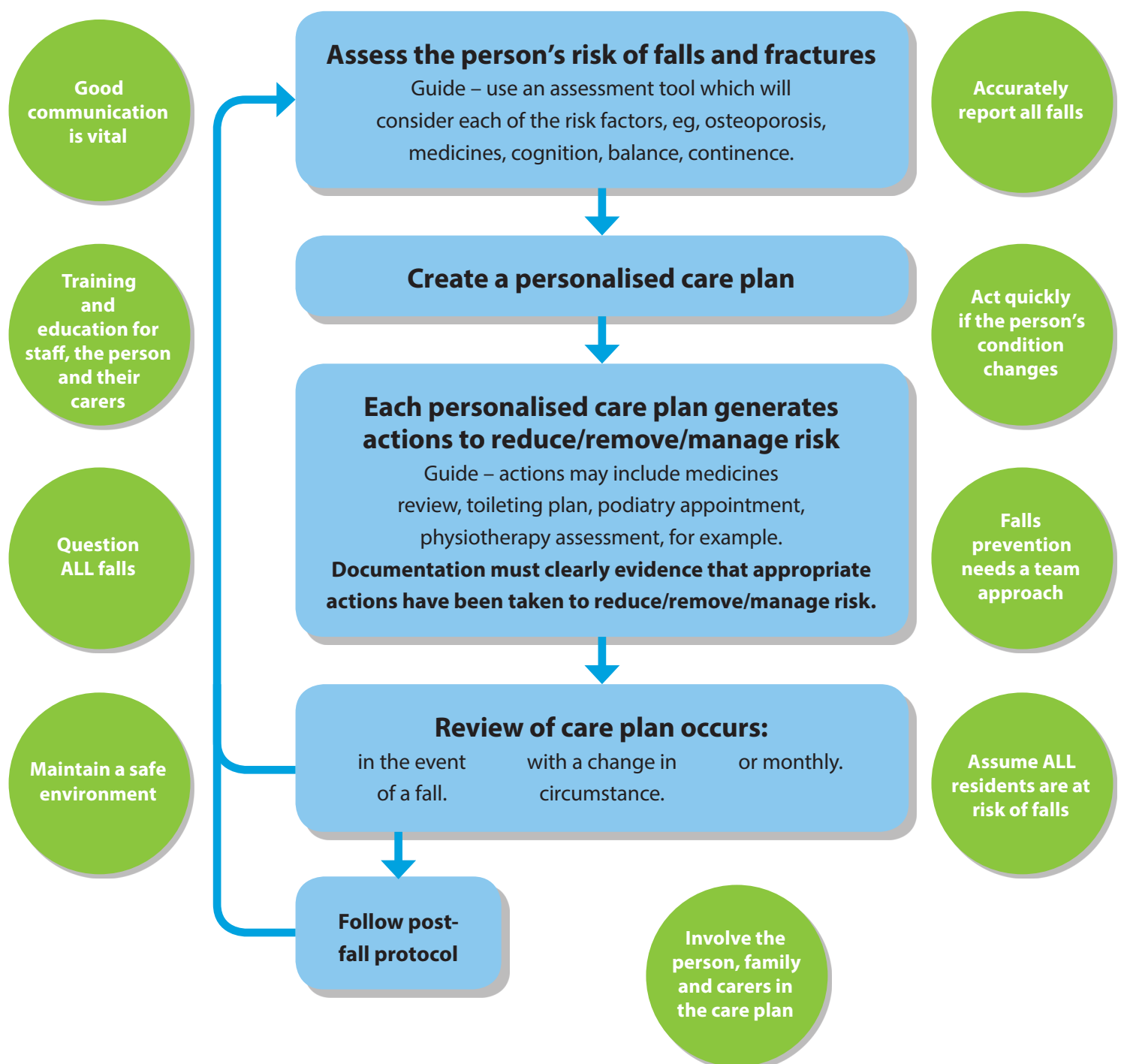
Drug Class	Drugs
<b>Antidepressants</b> Used to lift mood <b>Also used to treat nerve pain.</b>	<b>Tricyclic (TCAs) &amp; related antidepressants:</b> amitriptyline, clomipramine, dosulepin, lofepramine, imipramine and nortriptyline. <b>SSRIs:</b> fluoxetine, paroxetine, citalopram, sertraline, fluvoxamine <b>Others:</b> duloxetine, mirtazapine, trazodone, venlafaxine. TCAs may cause drowsiness & blurred vision. SSRIs slightly less sedating. May also cause blurred vision.
<b>Antipsychotics including atypicals</b> Used to treat or help control symptoms of schizophrenia, manic depression, paranoia.	<b>Typicals:</b> chlorpromazine, haloperidol, promazine, trifluoperazine, sulphiride. <b>Atypicals:</b> amisulpride, aripiprazole, clozapine, olanzapine, risperidone, quetiapine. Prochlorperazine is frequently prescribed for dizziness due to postural instability and the most frequently implicated drug in causing drug induced Parkinson's disease. Antipsychotics can cause postural hypotension, particularly in the elderly, causing dangerous falls. Dizziness and drowsiness can also contribute to falls. Even if drugs cannot be stopped completely attempts to reduce the dose to the minimum effective dose should be made.
<b>Anti-muscarinic drugs (anti-cholinergics)</b> Used in treatment of incontinence and in Parkinson's disease.	<b>Oxybutynin, tolterodine, orphenadrine, procyclidine, trihexyphenidyl, duloxetine, solifenacin.</b> Oxybutynin may cause acute confusion in the elderly, especially those with pre-existing cognitive impairment. Antimuscarinics in general can cause blurred vision, dry eyes, drowsiness and dizziness which can contribute to falls.
<b>Benzodiazepines and hypnotics</b> (anxiety or sleeping tablets).	<b>Benzodiazepines:</b> Diazepam, lorazepam, nitrazepam, temazepam, chlordiazepoxide. <b>Others:</b> zolpidem, zopiclone. May cause hangover effects next morning. May cause unsteadiness if getting up in the night. Reduction in dose and frequency and use of medication as necessary rather than regularly should be made even if the medication cannot be stopped entirely.
<b>Dopaminergic drugs</b> Used in Parkinson's disease to slow the progression of the disease.	<b>Dopamine-boosting drugs:</b> Amantadine, bromocriptine, levodopa (co-benelodopa, Madopar, co-careldopa, Sinemet), , pergolide, selegilin, rasagiline, apomorphine, cabergoline, pramipexole, ropinirole, rotigotine. Sudden excessive daytime sleepiness can occur with levodopa and other dopamine boosting drugs.

Drug Class	Drugs
<b>Anticoagulants</b> Used to help prevent stroke and blood clots.	<b>Warfarin, acenocoumarol, phenindione.</b> Anticoagulants do not contribute to falls but they must be reviewed following a fall as the patient of major is at risk of major bleeding if falling continues. Aspirin may be a suitable alternative.

Drug Class	Drugs
<b>ACE Inhibitors/angiotensin II antagonists</b> Used to treat hypertension, heart failure and following a heart attack.	captopril, enalapril, lisinopril, ramipril, perindopril, quinapril, fosinopril, trandolapril losartan, valsartan. irbesartan, candesartan, eprosartan, telmisartan. <b>Greater risk of hypotension if taking a diuretic, incidence of dizziness varies.</b>
<b>Alpha-blockers</b> Used in men to treat enlarged prostate gland, may be used to treat hypertension.	doxazosin, indoramin, prazosin, terazosin. Doses used for treatment prostate problems are less likely to cause hypotension and dizziness than those required to treat hypertension.
<b>Anti-arrhythmics</b> Drugs used to control how the heart beats and to help keep its rhythm.	digoxin, amiodarone, flecainide. <b>Dizziness and drowsiness are possible signs of digoxin toxicity</b> <b>Flecainide has a high risk for drug interactions and can also cause dizziness.</b>
<b>Beta-blockers</b> Used to treat hypertension, angina, heart irregularities and after heart attack.	atenolol, bisoprolol, metoprolol, nebivolol, acebutolol. <b>oxprenolol, propranolol, carvedilol, sotalol</b> <b>Reports of dizziness may be due to postural hypotension.</b>
<b>Diuretics</b> Used to treat hypertension, heart failure and fluid retention	bendroflumethiazide, chlortalidone, cyclopenthiazide, indapamide, metolazone, furosemide, bumetanide. amiloride, triamterene, spironolactone. Can cause dehydration, dizziness, confusion and postural hypotension.

Drug Class	Drugs
<b>Anti-epileptics (anti-convulsants)</b> These drugs help people with epilepsy to lead a normal life by reducing fit frequency and reduce the possibility of brain damage. Also used to treat nerve pain.	carbamazepine, clonazepam, gabapentin, lamotrigine, levetiracetam, phenobarbital, phenytoin, sodium valproate, topiramate, vigabatrin. <b>phenytoin side effects such as dizziness, blurred vision etc. may be signs of drug related toxicity.</b> <b>carbamazepine incidence of dizziness, drowsiness and blurred vision are dose related side effects.</b> Anti-epileptics can all cause drowsiness & dizziness so should be used at the minimum effective dose and reviewed frequently, especially when used for nerve pain.
<b>Anti-histamines</b> Used in hay-fever, itching and to control nausea, vomiting, and vertigo.	<b>Those most likely to cause drowsiness include:</b> chlorphenamine, diphenhydramine & promethazine. <b>Others include:</b> loratadine, desloratadine, cetirizine, cinnarizine. <b>Risk of hypotension with cinnarizine is dose related, short term use where possible.</b>
<b>Calcium channel blockers</b> Used in hypertension and angina.	diltiazem, verapamil, amlodipine, felodipine, lacidipine, nifedipine. <b>May cause dizziness or fatigue.</b>
<b>Nitrates</b> Used to ease angina.	glyceryl trinitrate, isosorbide mononitrate & dinitrate. <b>Dizziness may be due to postural hypotension.</b>
<b>Opiate analgesics</b> Used to relieve moderate to severe pain.	morphine, buprenorphine, codeine, co-codamol, co-dydramol, diamorphine, dihydrocodeine, morphine, tramadol. Drowsiness and sedation common when starting treatment. Confusion reported with tramadol.

# The how-to guide to preventing falls and fractures



# How do we prevent falls?

Falls prevention – the emphasis should be on anticipating and preventing problems rather than simply managing problems once they have occurred

Assessing a person's risk of falls and fractures followed by personalised care planning to reduce or manage risk, underpins fall and fracture prevention and management. It also contributes to residents' wellbeing aiming to maximise quality of life.

There is evidence that people are particularly at risk of falls and fractures in the first few months after admission to a care home. 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 their risk of falling is assessed immediately with appropriate actions taken.

## Start with a thorough assessment

Mr Smith is at risk of falling because...

The aim of a falls assessment is to clearly identify the individual risk factors that have placed the person at risk of falling. This information should be shared with the team as part of handover. Use handovers as opportunities to communicate clearly why a person is at risk of falls. Instead of stating "Mr Smith is at high risk of falls", consider "Mr Smith is at high risk of falls because..." This subtle change in language should improve staff understanding and will reinforce the rationale behind the care plan.

For example:

Mr Smith is at risk of falling because:

- he's had a fall already this year;
- he's a new resident;
- he's fearful of falling again;
- he's dehydrated;
- he has postural hypotension;
- he has reduced balance when walking.

Your assessment will help to create a personalised care plan. The care plan should be used to demonstrate how risk is going to be reduced or removed. This is ultimately about generating actions to reduce risk. It might result in a toileting care plan for example. It could generate a physiotherapy assessment for additional support for mobility or a GP review of an underlying health condition. The care plan and actions will be and should be entirely individual and person-centred. For example, in Mr. Smith's case:

Risk factors identified	Suggested action plan (involve the wider team)
<b>He's had a fall already this year.</b>	Discuss with Mr. Smith why the previous fall happened. Ask GP to review to exclude any underlying medical reasons why Mr. Smith suffered a fall in the past year. Ask GP or community pharmacist to review medicines.
<b>He's a new resident</b>	Ensure Mr Smith is well orientated to his environment including location of toilets. Ensure Mr Smith always has a call bell to hand.
<b>He's fearful of falling again</b>	Ensure Mr Smith has appropriate supervision when mobilising and getting washed and dressed. Provide encouragement and reassurance. Offer Mr Smith hourly opportunities to mobilise. Ensure Mr Smith always has his call bell to hand. Ensure Mr Smith's environment is safe and well lit. Ensure Mr Smith uses the correct mobility aid.
<b>He's dehydrated</b>	Ensure Mr Smith always has access to drinking water. Encourage Mr Smith to drink regular small amounts. Monitor and record fluid intake. Offer Mr Smith hourly opportunities to mobilise to the toilet.
<b>He has postural hypotension</b>	Request GP visit to review cause of postural hypotension. Encourage Mr Smith to stand still and pump ankles on first standing up from a chair.

Risk factors identified	Suggested action plan (involve the wider team)
He has reduced balance when walking	Ensure Mr Smith has assistance of one person at all times when walking. Encourage Mr Smith to use his call bell to request assistance if he wishes to mobilise. Ensure Mr Smith always uses his walking stick when mobilising. Refer to Physiotherapist for mobility and balance assessment. Offer Mr Smith hourly opportunities to mobilise.

## Document your actions

**Always** ensure you have robust documentation in place. You will need to show evidence of assessment documentation and that the assessment links to a personalised care plan. Ensure you have written evidence of requesting input from other key professionals and request they document their finding and recommendations within the care plan.

## Review the care plan regularly

The care plan should be reviewed:

- following a fall;
- or a change in circumstance;
- or monthly (or according to local policy).

## Communicate!

Preventing falls requires a team approach whereby everyone's opinion is valuable. All staff on the premises have a part to play in falls prevention and this extends to visitors, maintenance staff, housekeeping team and kitchen staff. It is essential that any changes in a person are communicated, as are any changes to the care plan. Friends, family and staff should be encouraged to highlight any changes in behaviour or demeanour of the person – this could be the first sign of an underlying health problem which needs swift attention to avert a fall from happening.



## Are all falls preventable?

No. There will be cases when an individual remains at high risk of falling despite thorough assessment and management. In these instances, the service can try to reduce the risk of harm from falls by using suitable equipment and alarm systems, and ensure residents take osteoporosis medications as prescribed. Documentation must be able to show that all possible actions are being taken to reduce risk, and if risk remains that this has been communicated with the wider team including the person and family.

# In the event of a fall...

Sustaining a fall can be an extremely frightening time, both for the person who has fallen and the person who witnesses the fall or finds the person on the floor. Due to this event being stressful in nature, it is essential that all members of staff are familiar with their organisation's protocol describing how to safely manage a person who is on the floor. As part of staff induction and ongoing training, this should be highlighted so that all staff are aware of the required post-fall management procedure.

The following information will provide guidelines based on good practice. Included within this resource is a local example of a post-fall flowchart to support the decision-making process.

## Assessing the person for injury

The initial assessment of the person on the floor is an essential starting point of the decision making process. The initial assessment should evaluate levels of consciousness and potential injury. This initial assessment should be carried out by a person with appropriate skills. This may be a named practitioner within the organisation or a paramedic.

If the person is unconscious, proceed with basic first aid and adult life support as necessary. ALWAYS call for help and advice through 999 if you are in any doubt about the person's presentation and how to proceed. Check to see if the person has a DNACPR form.

If the person is conscious, the decision to move them or not is based upon whether that person has sustained an injury and how severe the injury is. For example if the person has sustained a skin tear during a fall, the decision to move that person may be taken after basic first aid has been administered. In the presence of a suspected fracture, the person should not be moved until appropriate medical advice has been sought, usually with the attendance of an ambulance crew. If the person hits their head during the fall, it is necessary to exclude a spinal neck injury which may also have occurred during the fall (particularly in this frailer population). If a spinal injury is suspected **do not move the person**, dial 999 and follow their advice.

**Be aware of the amount of time that a person is on the floor. Health complications such as hypothermia and dehydration can develop after only an hour. Pressure ulcers can develop after two hours on the floor. You may need to consider this if you are expecting a wait for help to arrive. Try to keep the person warm and encourage movement of limbs if it is safe to do so.**

# Assisting the person off the floor

Assisting the person off the floor must be done in a safe manner and must be in keeping with your organisations moving and handling guidelines.

Key points to consider include:

- Staff must be trained and assessed as competent to use moving and handling equipment.
- Organisations have a duty of care to ensure appropriate moving and handling equipment is made available for staff to use.
- Residents should **never** be lifted off the floor by staff without the use of appropriate equipment, for example the hoist or elk. This reduces the risk of injury to staff and the person during the manoeuvre.
- If the person has enough strength and flexibility to do so, he/she can be assisted off the floor with the use of furniture as assistance.

# Recording and reporting the fall

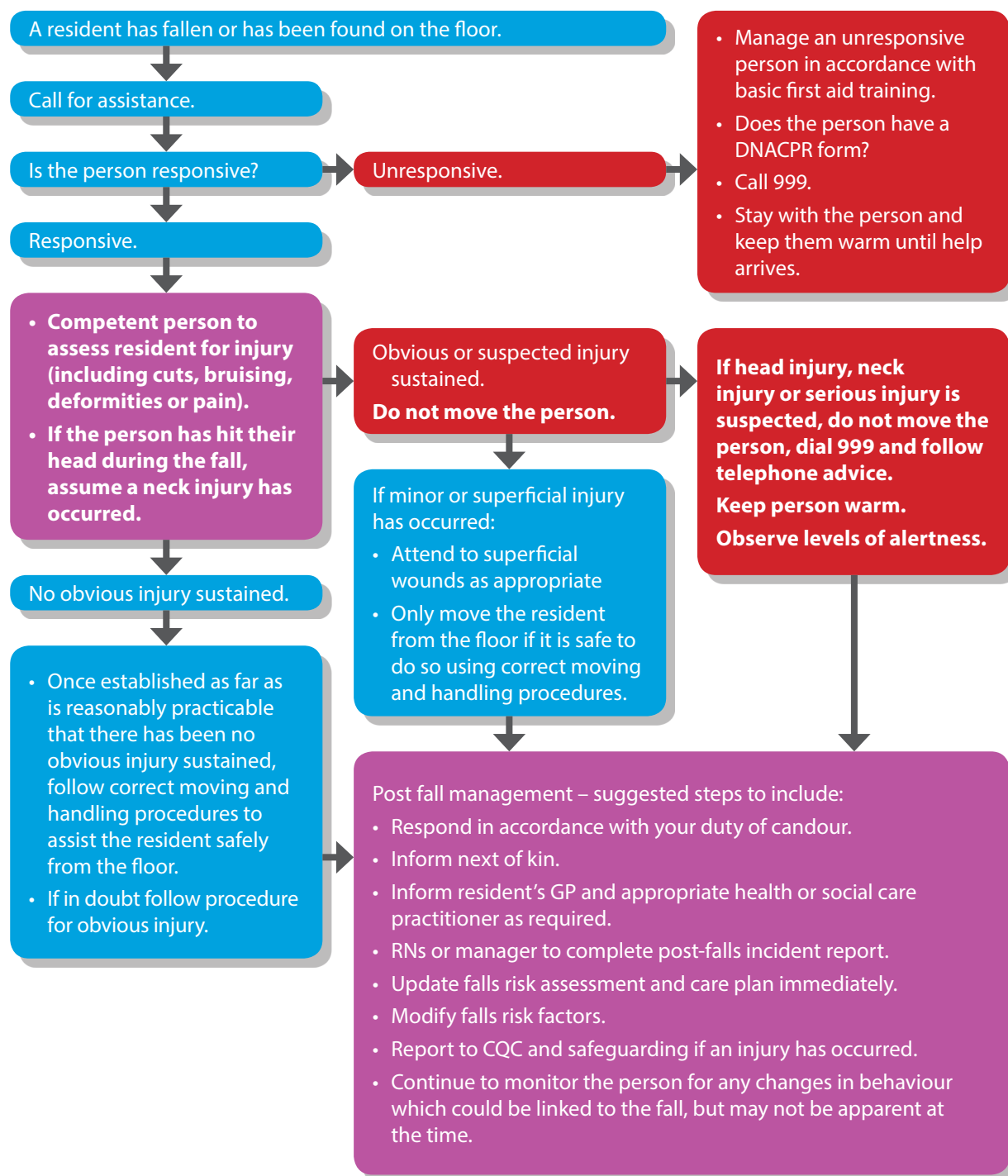
Every fall must be recorded accurately, including providing information regarding what the person was doing at the time of the fall, where were they, what time of day was it or did they have any red flags (for example dizziness before the fall, losing consciousness)? Thorough post-fall recording is essential to help identify trends and underlying causes, both individual and environmental. For example is there a particular room where falls occur more regularly than others? Could it be related to the flooring, lighting or layout of furniture?

After a fall has occurred, the person's falls risk assessment must be completed again indicating any necessary changes to the care plan following the fall. For example, the fall may have occurred due to the person becoming unsteady due to a urinary tract infection. The care plan may need to be changed to include ensuring the person sits in a communal area where staff visibility is good and that he/she is offered more regular opportunities to visit the toilet, ensuring that the person is supervised when mobilising.

A person's GP should be informed that a fall has occurred and the review of the risk assessment may also indicate the need for a medical review. The Adult Safeguarding team must be informed if the person sustained an injury during the fall, or if neglect or abuse were thought to be contributing factors.

The fall must also be communicated to friends, family and carers if appropriate along with any changes to the care plan.

# Suggested guidelines for managing a person who has fallen in a care home setting



# Useful links

**East Midlands falls prevention project in care homes:**

[www.youtube.com/watch?v=IW9tZkO\\_tCo](https://www.youtube.com/watch?v=IW9tZkO_tCo) (approx. 12 mins)

**Managing falls and fractures in care homes:**

[www.youtube.com/watch?v=197UOqyY9hY](https://www.youtube.com/watch?v=197UOqyY9hY) (approx. 55 mins)

**Minimising the use of restraint in care homes for older people: creative approaches (approximately 12 minutes)**

[www.youtube.com/watch?v=zgRBI7gSpqk](https://www.youtube.com/watch?v=zgRBI7gSpqk)

**The dementia environment in a care home (approximately seven minutes)**

[www.scie.org.uk/socialcaredtv/video-player.asp?v=dementiaenvironmentinacarehome](http://www.scie.org.uk/socialcaredtv/video-player.asp?v=dementiaenvironmentinacarehome)

**NICE guidance**

[www.nice.org.uk/guidance/cg161](http://www.nice.org.uk/guidance/cg161)

**The National Osteoporosis Society**

[www.nos.org.uk](http://www.nos.org.uk)





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