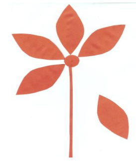
Training Goals:



For staff to realise that:

1. **Falls ARE preventable**
2. Falls prevention strategies MUST be put in place after the 1st fall to PREVENT more. We may consider EVERYONE a falls risk (high or low)
3. Falls cause human distress, loss of confidence & pain.
4. It is **VERY** important to document every fall.

Definition of FALL:

"Unintentionally coming to rest on the ground [or at some lower level]".

- Falls may be unharmed
- Falls may mean a bruise or a skin tear.
- Falls can result in fracture. [Serious Harm]

Exclusions: A catastrophic medical event – e.g. heart attack or stroke. This does not include falls medical condition such as Parkinson's. [Medically unwell fallers should still be counted to show how much effort is needed looking after frail people].

THE DELEMNA: what to do when any / every journey may end as a fall?

Problem Based Learning

Trainers Instructions - read this to the group (set the scene)

Read each paragraph slowly so that everyone is familiar with Mary and her troubles over the weekend. Read each one twice if this helps.

Mary is usually well and can get about easily using a walking frame.
She fell at the weekend. She got up early in the morning on Saturday and tripped on her walker on the way to the toilet. She was not hurt.

Staff filled in an incident form and wrote under the heading How could this be Prevented ………………..??? "**We told Mary to ring the bell when she needs the toilet".** The Manager would see it on Monday.

Later, on Saturday morning, Mary fell again rushing to get to the toilet, forgetting her walking frame. She sustained a nasty skin tear. Staff dressed it and told Mary that she **"Must use the bell when she wants to get up so we can help her".**

Two more incident forms were filled out by the afternoon shift. Both times Mary failed to ring the bell for help.

On Sunday morning, at 5am, Mary was found on her toilet floor with a broken hip. She was admitted to hospital.

Note: This real life 'Serious Harm' Accident was investigated by Healthcare Help in 2008.

Trainers: Now discuss each of the points with your group:

- Allow the group to suggest the answers
- Discussion often finds answers
- Individuals learn as they realise from Problem Based Incidents
- Assessment of Knowledge documents understanding

Assessment of Knowledge:

How many times did Mary Fall?

How many opportunities for fractured hip were there?

How many opportunities for fractured hip should there have been?

How could we have prevented these opportunities for fractured hip (falls)?

1. …

2. …

3. …

4. …

What was the biggest mistake that staff on duty made?

Good Monitoring **Regular & frequent**	**Involvement in regular activities - exercise**	**Thoughtful social management**	**An environment free of hazards.**
Regular Toileting **Regime if needed**	**Good nutrition** **Nutritional assessments**	**Optimal medical management**	**Call bell handy** **Sensor mats**
Adequate food and fluids	**Attention to positional comfort**	**Up to date care planning for falls prevention**	**Keep in public area as much as possible**

Look at the table above: Please put a cross through the boxes where you think Mary could have been given better support but missed out.

Signed: ______________________________ Desig. : _________________ Date: _________

Trainer: _____________________________ Date: ______________________

Discussion Questions with trainers prompts [**answers**]:

How many times did Mary Fall?

[5]

How many opportunities for fractured hip were there?

[5]

How many opportunities to fracture hip (fall) should there have been?

Possibly the first fall and the other 4 prevented. None if staff were REALLY on to it!

How could we have prevented these fall opportunities?

1. By taking Mary to the toilet on a toileting regime – every hour [if necessary]
2. By realising her toileting patterns had changed [maybe she had urine problems] so she needed lots of fluids and a dip stick of her urine.
3. By reporting to an RN, Team Leader or manager that a resident had fallen so that they could update care planning & give NEEDED support.
4. With the use of a sensor mat – to know immediately that she was on the move.

What was the biggest mistake that staff on duty made?

Discussion:

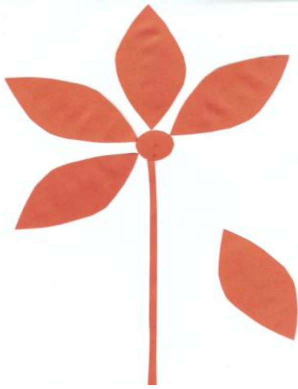
- They trusted Mary to call for assistance when Mary was too independent, too forgetful and in too much of a hurry.
- Not having a help line / not calling a help line
- Only dealing with falls on their own shifts and not handing over well enough to realise the danger Mary was in.
- Not knowing what to do about it.

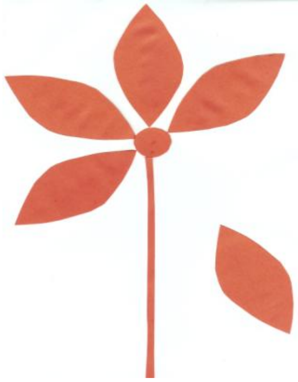
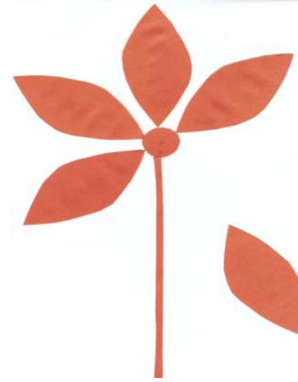
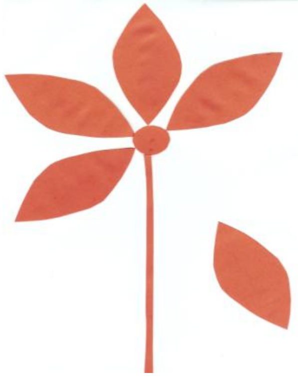
Good Monitoring Regular & frequent	**Involvement in regular activities – exercise**	**Thoughtful social management**	**An environment free of hazards.**
Regular Toileting Regime if needed	**Good nutrition Nutritional assessments**	**Optimal medical management**	**Call bell handy Sensor mats**
Adequate food and fluids	**Attention to positional comfort**	**Up to date care planning for falls prevention**	**Keep in public area as much as possible**

Look at the table above: The highlighted areas were not attended quickly enough.

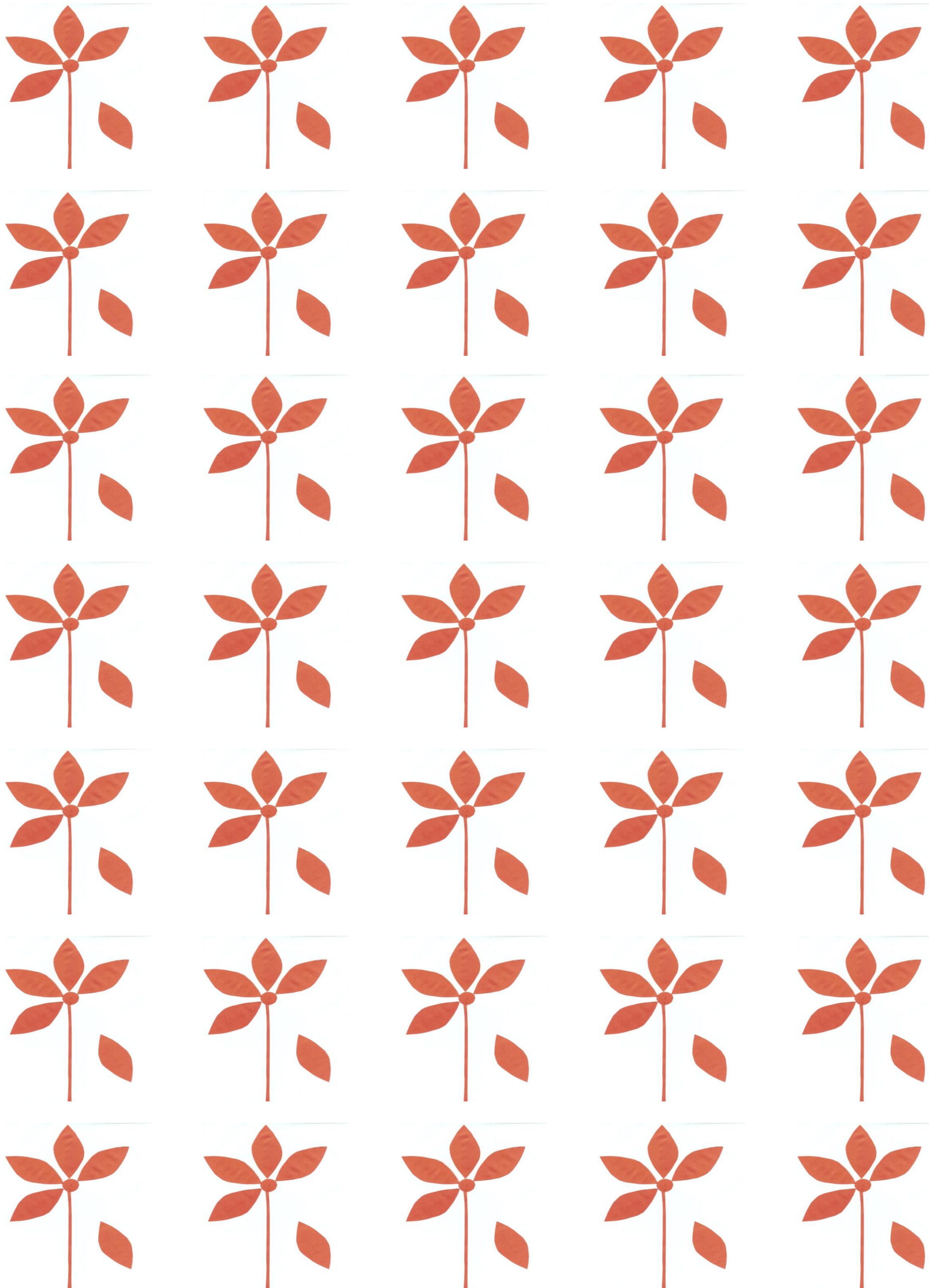
NB: It is the care staff's responsibility to know which residents are at risk of falling. Look for the Falling Petal's Sign on doors if in doubt:

Use discrete sign to post on doors of our High Falls Risk people.



Print this page & laminate but please and ask permission to flag high risk fallers using this discrete sign on resident doors and in charts.
We find most like the 'special' care it affords them.



Print this page and decide with staff which residents need them in charts.
Have staff put the falling petals on charts and doors (with resident & family agreement)

So what does a Falling Petal on the door / chart mean for residents? See next page.

NB: The falling petal sign can save lots of report writing as it indicates our guide, below.

Induction Training & Revision: Falls **Prevention**

- **Know our highest risk fallers.** If someone has fallen before (at home, in hospital or in the Home), then they are far more likely to fall again.

History of a fall = HIGH FALLS RISK

- High falls risks residents must receive special care and attention, otherwise they are highly likely to fall again. Residents may also need special care so as not to scrape fragile skin, which easily tears.

Essential Information for Care Staff: High Falls Risk can be reduced by:

- Good Monitoring – Some people must be watched almost all the time!

SUPERVISING JOURNEYS

- Some people WILL fall if they walk alone [supervise EVERY journey]
- Some people may need two staff to help them from one place to another
- As Needs Assessors tighten entry criteria the people in our care are more frail

TOILETING REGIMES

- Regular Toileting – decide how frequently and make sure everyone knows!
- One of the single biggest falls prevention success stories
- Regimes need to be flexible / alter as needed
- If lots of people need early morning toileting, arrange staff so we have enough people to do this without rushing or missing anyone.

NUTRITION

- Adequate food and fluids
- Well nourished people are stronger / beware those missing meals
- Elderly or disabled may quickly become dehydrated / everyone needs enough fluids EACH shift and staff need to be aware of this.

FOOT WEAR

- Sensible foot wear for each individual.
- RN / Risk assessment needs to check foot wear at entry to the Home.
- Residents and families often choose unwisely (possible say cannot afford).
- Sloppy slippers or shoes with no ankle support, walked over at the side or back encourage falling.
- Long socks hanging over toes are an accident waiting to happen
- Special foot ware may be needed [call for orthotics]

EXERCISE

- Regular (daily) activities – Otago Uni Falls Prevention Program / Yoga / Tai Chi / walking programs / exercises increasing strength & balance & fitness & flexibility.
- ACC fund classes in many areas for High Risk Fallers [free or nominal fee]
- If staff wheel people about for speed of doing work they are **robbing residents of valuable exercise opportunity**
- Reduces pain of stiff joints & increases feeling of well being
- Beware of physios / therapists who **SIT** everyone in a circle and conduct exercises [at the level of our least able]. This is will **not** prevent falls.

WELLNESS

- Medical Assessment & Physio Assessment
- Beware low blood sugar & postural hypotension [BP drops as resident stands]
- RN's & doctors carry responsibility for these risk factors
- Correct walking frame adjusted at best height [training in its use for resident]

PLACEMENT

- Thoughtful social management
- The bedroom is the highest risk place [alone / maybe the light is out / lost bell] where most falls happen.
- Residents are safer in the lounge where they can be watched and helped

HAZARD FREE

- An environment free of hazards.
- Walking frames need a parking place [where the resident can get it / not forget it] close by.
- Beware Walking Frame Hazard.

  Walking frames need to be the RIGHT FRAME, at the RIGHT TIME for the RIGHT RESIDENT. Wrong frame or wrongly adjusted may result in a fall, poor posture, less vital exercise and feelings of independence. Giving a resident an 'unused' frame may be short changing them unless you can assess BEST FRAME. The frame a resident has been using may need changing (with their condition) or maintaining (wheels turning freely).

ALL WALKING FRAMES ARE **NOT** CREATED EQUAL

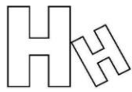
MORE HAZARDS

- Cleaners please beware of your vacuum cleaner cords.
- Clutter reducing access & egress [clear open walk ways]
- Trips hazards on paths outside.

GOOD COMMUNICATION

- Open channels of communication – call bell handy.
- Consider sensor mats / products for those who don't ask for help.
- Help line for care staff 24 / 7
- Have a way of letting everyone know that someone has fallen so BEWARE!

USE THE FORM BELOW TO DOCUMENT INDIVIDUAL PLANNING



Practical Assessment of Knowledge Falls

Short Term Care Plan to Reduce Falls

Resident Name: ____ Date: ______________________

Preferred Name:____ NHI No: __________________

Please tick the most appropriate care listed below. Age:

Good Monitoring

- ☐ Needs to be watched all the time
- ☐ Must be assisted to walk
  Needs ________ people to walk / transfer
- ☐ Check regularly while in bed. Every:
  ½ hour 1 hour 2 hours
- ☐ Use sensor mat when in bed
- ☐ Always have call bell handy
- ☐ Beware! May not use the call bell
- ☐ Encourage to be in lounge [supervised]
- ☐ Allocate 1 care staff available as needed

Exercise:

- ☐ Passive exercises in bed
- ☐ Exercise from sitting position
- ☐ Walks with care staff / physio
  2 hourly every shift for toileting & meals
  daily
- ☐ Falls prevention program of exercises
  Frequency:
- ☐ Walks unaided:

Overcoming Disabilities:

- ☐ Ensure walking frame within reach not parked out of the way.
  - ☐ Especially at night.
- ☐ Ensure other aids available [state]:
- ☐ Pain managed by:
- ☐ Poor balance managed by:
- ☐ Wanders:
- ☐ Poor gait:

Environmental

- ☐ Safe from hazards & clutter
- ☐ Encourage to be in public area

Toileting

- ☐ Assist after meals & at bed time
- ☐ Assist in the night. State times / frequency:
- ☐ Beware UTI: Report confusion, wandering
  Any different behaviour.

Footwear

- ☐ Sensible shoes
  - ☐ Orthotics
  - ☐ Preferred Footware:
- ☐ Beware of resident wearing socks
  - ☐ Too long so trips risk
  - ☐ Help with good fitting shoes or slippers
  - ☐ Help to put on or tie laces
- ☐ Other:

Injury Prevention Strategies

- ☐ Family well informed & sharing care planning
- ☐ Hip Protectors
- ☐ Special diet:
  - ☐ Encourage fluids
  - ☐ Small frequent meals
  - ☐ High protein
  - ☐ High calorie
  - ☐ Supplementary liquid food [state]:

  e.g. Arginaid Ensure
- ☐ Extra staff as needed:
- ☐ Special Instructions [Doctor / other]:

Sign: ______________________________ Desig.____________________ Date: ___________

Trainer: ______________________________________ Date: __________________

Practical Exercise to Reduce Falls Rates:

Staff should choose a resident – each staff member chooses a different resident.

STAFF fill in this person's 'Short Term Care Plan' to reduce falls. This helps gain 'buy in' from EVERYONE that this resident needs more support now.

NOTE: Family also need to be aware that their loved one has fallen, and what we are doing to prevent it happening again.

This exercise should be discussed and marked by a registered clinician [RN Physio]. This should be in addition to other short term care planning [there will be linkage]

- It is quick to fill in / documents FALLS PREVENTION PLANNING
- It is a précis of care that may not otherwise be thought of
- It flags the fall incident to other staff at hand over

Discussion Topic: Cost of Falls

Ask staff what they think falls cost your service?

Human Anguish cost possible answers

- Pain / Loss of confidence / fear / now does less / becomes less mobile
- Family anguish seeing their mum or dad with bruised face or torn skin or worse

Cost to Staff

- Anguish of seeing someone in their care hurt / battered looking / in pain
- Extra time to get them up / do dressings / settle them down
- Forms to fill in / questions to answer from Managers / disapproval felt maybe
- Difficult work where doctors and ambulances must be called / reports made
- Possibility of harming own back from difficult moving & handling not easily done

Cost to the Home

- Additional staff time needed – visiting in hospital / talking to families / treatments
- Reporting fractures [serious harm injuries] a legal responsibility to OSH takes time & energy better devoted to residents
- Cost of dressings for skin tears, especially if they get infected
- Additional doctor / specialist visits / physio / therapists not fully funded
- Loss of resident so empty bed
- Upset to other residents [less staff attention to them so more challenging behaviours as social programs are dropped while caring for the hurt people.